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Semi-Centennial.

PROCEEDINGS

OF THE

American Medico-Psychological Association,

AT THE

FIFTIETH ANNUAL MEETING

HELD IN

PHILADELPHIA, MAY 15–18, 1894.

PUBLISHED BY

AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION.

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The American Medico-Psychological Association,

1893-94.

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EDWARD COWLES, M. D. *GEORGE C. PALMER, M. D.

*Deceased.
NOTE.

The accompanying volume contains the proceedings, papers and discussions of the American Medico-Psychological Association at its Semi-Centennial meeting, and is printed by the Council with the approval of the Association.

HENRY M. HURD,
Secretary

Baltimore, April 1st, 1895.
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The Association convened at 10 a.m., May 15th, 1894, in Parlor C, at the Continental Hotel, Philadelphia.

The President, John Curwen, M. D., called the Association to order.

Prayer by Rev. T. C. Yarnall, D. D., of Philadelphia:

Almighty God, the Giver of every good and perfect gift, we bless Thy holy Name for all Thy mercies to the children of men. Especially would we now praise Thee for the knowledge which Thou hast permitted to be gathered for the relief of human sicknesses. We thank Thee that in the Gospel of Thy dear Son Thou hast taught us to sympathize with sorrow and suffering, and thus to imitate His example who went about doing good. We bless Thee that we are commanded, as Christ's followers, to bear one another's burdens, and fulfill His holy law.

We implore Thy gracious benediction upon those here gathered together to take counsel for the advancement of the interests of their high calling. Direct them, we beseech Thee, with Thy most gracious favor; enlighten and sanctify their minds; further them with Thy continual help; and grant that all their consultations here may be to Thy great glory.

We pray for Thy blessing upon those to whom they minister, and upon all whom Thou hast called to pass through deep sorrow. And grant, O most merciful GOD, that in all Thy dispensations towards us we may remember Thine infinite wisdom and Thy ever-enduring love; so that, putting our trust in Thy mercy, we may so live here that at last we may enter upon those fadeless joys which Thou hast prepared for them who unfeignedly love Thee.

Hear us we beseech Thee, in His Name who has taught us when we pray to say:

Our Father, who art in heaven, Hallowed be Thy Name. Thy kingdom come. Thy will be done on earth, As it is in heaven.
Give us this day our daily bread. And forgive us our trespasses, 
As we forgive those who trespass against us. And lead us not into 
temptation; But deliver us from evil: For thine is the kingdom, 
and the power, and the glory, for ever and ever. Amen.

Governor Robert E. Pattison, of Pennsylvania, was intro-
duced by the President and delivered an address of welcome as 
follows:

Mr. President and Members of the American Medico-Psycho-
logical Association:

I bid you welcome to Pennsylvania. I am sure that in 
doing so I express the sentiment of all the people of Penn-
sylvania. An organization such as yours, which has for more 
than half a century given its very best thought to the noblest 
interests of mankind, is certainly deserving of the highest com-
mandation. I note with pleasure that the president of your 
Association is a distinguished citizen of Pennsylvania, that he 
during a half-century has given the best years of his life and the 
most thoughtful study to that which more than anything else 
closely concerns humanity. While the title to your Association 
will suggest thoughts concerning the treatment of the human soul 
or the mind generally, yet more specifically, I conclude, it refers 
to those who have been so unfortunate as to be deprived of reason. 
The half-century of your organization, representing half of the 
nineteenth century, has been more marked in the development of 
the treatment of the insane than any other period in the history 
of the world. Indeed, I doubt whether at any time much 
thought, except possibly by the individual philosopher, or the 
thoughtful and considerate and merciful citizen, was ever given to 
such unfortunate beings. It has remained, therefore, for the 
latter half of the nineteenth century to accomplish whatever has 
been done in the treatment of the insane, and I rejoice to be able 
to say to you as a citizen of Pennsylvania, that in no locality upon 
the face of the earth has more consideration or attention been 
given to this subject than in this great old Commonwealth of 
Pennsylvania. We had no State hospital in 1844 when your 
society was organized. The indigent insane, so far as their 
treatment was concerned, were largely confined to the private in-
stitutions and the local poorhouses. Since 1854, beginning with 
the hospital in Dauphin county known as the Harrisburg Insane
Asylum, organized through the efforts of Miss Dix, we have built five additional institutions. We have the institution at Harrisburg where to-day are, I think, more than 800 insane, or certainly between 700 and 800, which is largely in excess of the capacity of that institution. We have constructed an institution at Danville, with a like capacity—to-day overcrowded. We have an institution at Norristown with over 2,000 inmates—overcrowded. We have our institution at Warren with possibly between 800 and 900 patients—overcrowded. Then there is the institution at Dixmont whose capacity is fully tested to-day. Within the care of the Commonwealth of Pennsylvania there are between 5,000 and 6,000 indigent insane. The very best treatment possible within the knowledge of man, day in and day out, is given to these people. In addition to these institutions, I have noted with a considerable degree of gratification that it has been determined, and legislative effort has followed the determination, to construct a chronic insane institution at Wernersville. We will open that institution on the first, or certainly by the middle of June. That institution will have a capacity of 1,000 inmates. It is, to my mind, a step in advance of the treatment heretofore given to the insane. I refer to its classification. Now, if you will permit me as a layman, who has gone in and out among these institutions, to speak, I will say that the State of Pennsylvania may go on building institutions and may provide the most comfortable surroundings, yet something else is wanted besides constantly building asylums. The magnificent stride which has been made in the treatment of the insane is yet to have its climax, in my judgment, in the discovery and the treatment of the causes, so that we may be able through skilled treatment to reduce the number of the insane instead of providing further accommodation. I look forward to such an Association as this and the men who are enlisted in the interest which it covers, for the solution of this problem. I look forward to the time when in Pennsylvania we shall conclude that a nurse in the ward of an insane asylum, ought to be the equal in skill of the nurse in a surgical hospital ward. When the time comes that our people will conclude that these unfortunate creatures should have the same skilled attention given to them, through the nurses in the wards in the hospital, as is given to the patient in our general hospitals, then we may hope for that classification which will ultimately lead to the discovery of causes
we know nothing about to-day. I believe it would compensate the State of Pennsylvania, though the increased expense was a hundred fold over and above that now paid for nursing and attendance, to obtain skilled nurses, trained in schools, trained under the best intelligence, for the wards of the hospitals for the insane.

I have a thought, it may be crude, as it is simply the observation of a layman little familiar with many of the things which directly concern, from a medical standpoint, the treatment of the insane; I believe, next to the separation of the chronic from what you may call the curable insane, will come another separation upon nervous conditions. Nay, more, I believe that the time will come when there will be a separation based upon the temperature of the individual body taken from time to time, with the characteristics of individuals and the notes made up from hours of observation by skilled nurses in the wards of the hospital. Then, possibly, by analysis, we can ascertain the causes which we are endeavoring now to discover in order to better treat the unfortunate creatures who are subject to this horrible affliction. Then, verily, we will have reached a point in the history of the treatment of insanity surpassing that in all the history of the world. I believe that will come. I think, indeed, we are getting to the dawn of it. This is what we are looking for in Pennsylvania and we believe that Pennsylvania is simply an illustration of every other State in the Union upon this line. They are all pressing to the front moved by that spirit of humanity which is particularly characteristic of our age.

Let me in conclusion congratulate you upon this assembly on your fiftieth anniversary and I do bespeak for you a pleasant time. I wish it were possible, Mr. President, to take this Association to each of our institutions and let them see the method of our treatment and discover for themselves that we have reached the climax of physical treatment. I trust that the wisdom which has characterized the deliberations of this body from its organization will continue not only to benefit those who are present here and those who shall read the literature which shall go out from this society but shall contribute to the doing away of that dreadful shadow which stalks abroad in our midst and help us in our day and generation to treat the insane as we are treating other diseases and by treatment cause insanity to disappear from our midst.
President Curwen responded as follows: We thank you, Governor, for your kind words and for the suggestions which you have made. They are just in the line of what this Association should attempt to do and therefore they come with more force to us, coming as they do from you, to urge us onward in the line in which we should proceed. This Association in the last fifty years has been striving with all its efforts and all the influence it had for advance in the care and treatment of the insane. That is its past record. Now we propose to start on the other line, the prevention of disease as well as the cure of existing disease, and for that we pledge ourselves and we hope to be aided and directed by gentlemen who have as high views and as strong views as yours. We thank you for your suggestions.

The President then appointed the following committee to nominate officers of the Association for the ensuing year: Dr. Stearns, of Connecticut; Dr. Woodson, of Missouri, and Dr. Powell, of Georgia.

Upon motion of Dr. Chapin, of Philadelphia, the programme, which had been printed under the direction of the Committee of Arrangements, was adopted as the order of business to be followed during the sessions.

Upon motion of Dr. Chapin, an invitation was extended by the Association to the resident physicians of the city, to all officers of institutions for the insane, to members of boards of trustees and boards of State charities, and also to professors in the medical colleges and members of the State Medical Society now in session in Philadelphia, to sit with us and participate in the discussions.

Upon motion of Dr. Chapin an opportunity was given for the introduction of members of boards of trustees of the different hospitals, that they might be registered and take part in the deliberations.

The following gentlemen were then introduced: Judge F. O. Mason of Geneva, New York, trustee of Willard State Hospital; Judge Alfred J. Mills of Kalamazoo, Mich., trustee of the Michigan Asylum for the Insane; Dr. J. L. Cleary of Wisconsin, member of the State Board of Control.

A recess of fifteen minutes was taken for registration.

The following members were present:
Adams, Geo. S., M. D., Medical Superintendent Westborough Insane Hospital, Westborough, Mass.
Allison, Henry E., M. D., Medical Superintendent Matteawan State Hospital, Fishkill Landing, N. Y.
Babcock, J. W., M. D., Medical Superintendent Lunatic Asylum, Columbia, S. C.
Bancroft, Charles P., M. D., Medical Superintendent New Hampshire Asylum for the Insane, Concord, N. H.
Berkeley, Henry J., M. D., Attending Physician City Insane Asylum, Baltimore, Md.
Blackford, Benjamin, M. D., Medical Superintendent Western State Hospital, Staunton, Va.
Blumer, G. Alder, M. D., Medical Superintendent Utica State Hospital, Utica, N. Y.
Brush, Edward N., M. D., Medical Superintendent Sheppard Asylum, Towsontown, Md.
Burrell, Dwight R., M. D., Resident Physician Brigham Hall, Canandaigua, N. Y.
Burr, Colonel B., M. D., Medical Superintendent Eastern Michigan Asylum, Pontiac, Mich.
Chapin, John B., M. D., Physician and Superintendent Penna. Hospital for the Insane, Philadelphia, Penna.
Chase, Robert H., M. D., Medical Superintendent Friends' Asylum, Frankford, Penna.
Clarke, Frank H., M. D., Medical Superintendent Eastern Kentucky Lunatic Asylum, Lexington, Kentucky.
Cook, George F., M. D., Oxford Retreat, Oxford, Ohio.
Cowles, Edward, M. D., Medical Superintendent McLean Hospital, Somerville, Mass.
Crumbacker, W. P., M. D., Medical Superintendent West Virginia Hospital for the Insane, Weston, W. Va.
Curwen, John, M. D., Medical Superintendent State Hospital for the Insane, Warren, Penna.
Douglas, John P., M. D., Medical Superintendent Western Hospital for the Insane, Bolivar, Tenn.
Edgerly, J. Frank, M. D., Assistant Physician Friends' Asylum, Frankford, Penna.
Edwards, John B., M. D., Medical Superintendent Wisconsin State Hospital, Mendota, Wis.
Evans, B. D., M. D., Medical Director New Jersey State Hospital, at Morris Plains, N. J.
Everts, Orpheus, M. D., Medical Superintendent Cincinnati Sanitarium, College Hill, Ohio.
Eyman, H. C., M. D., Medical Superintendent Cleveland State Hospital, Cleveland, Ohio.
Field, Matthew D., M. D., 115 E. 40th Street, New York, N. Y.
Fisher, Theodore W., M. D., Medical Superintendent Boston Lunatic Hospital, Boston, Mass.
Fitz Gerald, John F., M. D., Medical Superintendant State Custodial Asylum, Rome, N. Y.
Fuller, F. T., M. D., Assistant Physician North Carolina Insane Asylum, Raleigh, N. C.
Gapen, Clarke, M. D., Medical Superintendent Illinois Eastern State Hospital, Kankakee, Illinois.
Gilman, H. A., M. D., Medical Superintendent Iowa State Hospital for the Insane, Mt. Pleasant, Iowa.
Goddin, W. W., M. D., Medical Superintendent Government Hospital for the Insane, Washington, D. C.
Granger, William D., M. D., Vernon House, Bronxville, N. Y.
Hallock, Winthrop B., M. D., Cromwell Hall, Cromwell, Conn.
Hancker, W. H., M. D., Medical Superintendent Delaware State Hospital, Farnhurst, Del.
Harmon, F. W., M. D., Medical Superintendent Longview Hospital, Carthage, Ohio.
Hay, J. T., M. D., Medical Superintendent Nebraska Hospital for the Insane, Asylum, Nebraska.
Hill, Charles G., M. D., Attending Physician Mount Hope Retreat, Baltimore, Md.
Hill, Gershom H., M. D., Medical Superintendent Iowa Hospital for the Insane, Independence, Iowa.
Hinckley, L. S., M. D., Medical Superintendent Essex County Hospital, Newark, N. J.
Howard, Eugene H., M. D., Medical Superintendent Rochester State Hospital, Rochester, N. Y.
Hoyt, B. H., M. D., Medical Superintendent Second Hospital for the Insane, Spencer, W. Va.
Hoyt, Frank C., Medical Superintendent Iowa Hospital for the Insane, Clarinda, Iowa.
Hughes, D. E., M. D., Chief Resident Physician Philadelphia Hospital, Philadelphia, Penna.
Hurd, Arthur W., M. D., Assistant Physician Buffalo State Hospital, Buffalo, N. Y.
Hurd, Henry M., M. D., The Johns Hopkins Hospital, Baltimore, Md.
Hutchinson, Henry A., M. D., Medical Superintendent Western Penna. Hospital for the Insane, Dixmont, Penna.
Josselyn, Eli, M. D., Assistant Physician Penna. Hospital for the Insane, Philadelphia, Penna.
Kellogg, Theo. H., M. D., Medical Superintendent Willard State Hospital, Willard, N. Y.
Kilbourne, Arthur F., M. D., Medical Superintendent Rochester State Hospital, Rochester, Minn.
Lane, Edward B., M. D., Assistant Physician Boston Lunatic Hospital, Austin Farm, Mass.
Lawton, Shailer E., M. D., Medical Superintendent Brattleboro Retreat, Brattleboro, Vermont.
Long, Oscar R., M. D., Medical Superintendent Asylum for Dangerous and Criminal Insane, Ionia, Mich.
Lyon, Samuel B., M. D., Medical Superintendent Bloomingdale Asylum, White Plains, N. Y.
MacDonald, Carlos F., M. D., President State Commission in Lunacy, 334 Fifth Avenue, New York.
McKenzie, J. F., M. D., Medical Superintendent Illinois Central Hospital, Jacksonville, Ill.
Mead, Leonard C., M. D., Medical Superintendent South Dakota Hospital for the Insane, Yankton, S. D.
Meredith, Hugh B., M. D., Medical Superintendent State Hospital for the Insane, Danville, Penna.
Mills, Charles K., M. D., 1909 Walnut Street, Philadelphia, Penna.
Moulton, A. R., M. D., Assistant Physician Penna. Hospital for the Insane, Philadelphia, Penna.
Murphy, P. L., M. D., Medical Superintendent State Hospital, Morganton, N. C.
Nunemaker, Henry B., M. D., Assistant Physician Pennsylvania Hospital for the Insane, Philadelphia, Penna.
Orth, H. L., M. D., Medical Superintendent Pennsylvania State Lunatic Hospital, Harrisburg, Penna.
Parsons, Ralph L., M. D., Greenmount, Near Sing Sing, New York.
Pilgrim, Charles W., M. D., Medical Superintendent Hudson River State Hospital, Poughkeepsie, N. Y.
Powell, Theophilus O., M. D., Medical Superintendent State Lunatic Asylum, Milledgeville, Ga.
Pusey, H. K., M. D., Medical Superintendent Central Kentucky Lunatic Asylum, Lakeland, Ky.
Richardson, A. B., M. D., Medical Superintendent Columbus State Hospital, Columbus, Ohio.
Richardson, D. D., M. D., Resident Physician Male Department State Hospital for the Insane, Norristown, Pa.
Robinson, J. F., M. D., Medical Superintendent Asylum No. 3, Nevada, Mo.
Rogers, Joseph G., M. D., Medical Superintendent Northern Indiana Hospital for the Insane, Logansport, Ind.
Russell, James, M. D., Medical Superintendent Asylum for the Insane, Hamilton, Ontario.
Sanborn, Bigelow T., M. D., Medical Superintendent Maine Insane Hospital, Augusta, Maine.
Searcy, James T., M. D., Medical Superintendent Alabama Bryce Hospital, Tuscaloosa, Alabama.
Sinclair, George L., M. D., Medical Superintendent Nova Scotia Hospital for the Insane, Halifax, N. S.
Smith, S. E., M. D., Medical Superintendent Eastern Indiana Hospital for the Insane, Richmond, Ind.
Stearns, Henry P., M. D., Superintendent and Physician Retreat for the Insane, Hartford, Conn.
Steeves, James T., M. D., Medical Superintendent Provincial Lunatic Asylum, St. John, N. B.
Stewart, Nolan, M. D., Assistant Physician Mississippi State Lunatic Asylum, Jackson, Miss.
Sylvester, W. E., M. D., Medical Superintendent Kings County Lunatic Asylum, Flatbush, L. I.
Taber, Susan J., M. D., Assistant Physician State Hospital for the Insane, Norristown, Pa.
Talcott, Selden H., M. D., Medical Superintendent State Homeopathic Hospital, Middletown, N. Y.
Tomlinson, H. A., M. D., Medical Superintendent St. Peter State Hospital, St. Peter, Minn.
Wagner, Charles G., M. D., Medical Superintendent Binghamton State Hospital, Binghamton, N. Y.
Ward, John W., M. D., Medical Superintendent New Jersey State Hospital, Trenton, N. J.
Waughop, John W., M. D., Medical Superintendent Western Washington Hospital for the Insane, Fort Steilacoom, Washington.
Wegge, William F., M. D., Medical Superintendent Northern Hospital for the Insane, Winnebago, Wis.
Welch, G. O., M. D., Medical Superintendent Fergus Falls State Hospital, Fergus Falls, Minn.
Wentworth, Lowell F., M. D., Medical Superintendent Kansas Insane Asylum, Osawatomie, Kansas.
White, M. J., M. D., Medical Superintendent Milwaukee Hospital for the Insane, Wauwatosa, Wis.
Wiley, O. J., M. D., Long Island Home, Amityville, N. Y.
Wilson, R. S., M. D., Medical Superintendent State Lunatic Asylum, No. 1, Fulton, Mo.
Wise, Peter M., M. D., Medical Superintendent St. Lawrence State Hospital, Ogdensburg, N. Y.
Woodson, C. K., M. D., Medical Superintendent State Lunatic Asylum No. 2, St. Joseph, Mo.

The Secretary read a report of the Council, recommending candidates for membership as follows:

Candidates for Associate Membership.—Dr. Charles H. Latimer, Washington, D. C.; Dr. Nathan M. Baker, Jr., St. Peter, Minn.; Dr. Wallace M. Knowlton, Brookline, Mass.; Dr. E. L. Wilson, Howard, R. I.; Dr. John A. Houston, Northampton, Mass.; Dr. A. B. Howard, Cleveland, Ohio.; Dr. H. W. Page, Worcester, Mass.; Dr. L. Gibbons Smart, Towson, Md.; Dr. William Searl, Cleveland, Ohio; Dr. Geo. P. Sprague, Boston, Mass.

Candidates for Active Membership.—Dr. Charles G. Chaddock, St. Louis, Mo.; Dr. Anne C. Burnet, Manitowoc, Wis.; Dr. J. F. Edgerly, Frank-
ford, Pa.; Dr. William Mabon, Utica, N. Y.; Dr. M. S. Guth, Warren, Pa.;
Dr. Ira O. Tracy, Flatbush, L. I.; Dr. James H. McBride, Wauwatosa,
Wis.; Dr. Clarke Gapen, Kankakee, Ill.; Dr. Alice Bennet, Norristown,
Pa.; Dr. B. Sachs, New York; Dr. E. D. Fisher, New York.

Candidate for Corresponding Membership.—Dr. Victor Parant, Toulouse,
France.

Candidate for Honorary Membership.—Dr. James Rutherford, Dumfries,
Scotland.

President Curwen then delivered his address.* [See p. 32.]

Upon motion of Dr. Blackford the thanks of the Association were extended to the President for his exceedingly able and interesting address.

The Auditors then reported as follows:

**Report of Auditors.**

**Philadelphia, May 14, 1894.**

We, the undersigned, auditors of the American Medico-Psychological Association, would respectfully report that we have examined the financial statement, the accounts and the vouchers of the Treasurer and find the same to be correct.

We adopt the report of the Treasurer, submitted herewith, and recommend that the same be approved by the Association.

We recommend the usual assessment upon active and associate members.

Signed,

Richard Dewey,
A. R. Moulton.

This report was unanimously adopted.

The Secretary read a cable message from York Retreat, a telegram from Dr. J. B. Andrews, and letters from Dr. J. H. Callender and Dr. H. A. Buttolph, as follows:

**York, May 14, 1894.**

Medico-Psychological Association, Continental Hotel, Philadelphia:

York Retreat committee sends hearty congratulations.

**Utica, N. Y., May 15, 1894.**

Secretary Association, Continental Hotel, Philadelphia:

My congratulations to the members of the Association on its Semi-Centennial Anniversary. Regret my inability to be present on account of ill health.

J. B. Andrews.

*The remainder of the papers read before the Association will be found printed in order following the President's Address.
To the President and members of the American Medico-Psychological Association:

Gentlemen:—Though deprived of the opportunity of meeting with you on the occurrence of the Semi-Centennial year of the Association, yet I desire to extend most cordial greetings to all who may enjoy such privilege; also, to express the hope that the next half century may witness a progress in the several departments of inquiry connected with the care and treatment of the insane, in all its forms and phases, in keeping with the anticipated advancement of science in general, during that period.

It is also earnestly to be hoped that the benevolent interest in all ranks of society will continue to increase, for this truly afflicted class of citizens.

I recall, most vividly, the occurrence of the first meeting in 1844, of the medical officers of the few hospital and asylums for the insane then existing in the country—being at the time a medical assistant to Dr. Amariah Brigham, medical superintendent of the State Lunatic Asylum at Utica, N. Y., which was opened for the admission of patients on the 16th of January, 1843.

As is well known, the title of the organization then effected, and which was continued until a recent period, was The Association of Medical Superintendents of American Hospitals and Asylums for the Insane in the United States and Canada.

Whether this title was fully suggestive of the objects to be attained and the methods then pursued in carrying out the great purpose intended, it is not now and here important to consider. Suffice it to say, that in adopting at a late period, the title of the American Medico-Psychological Association now in use, reference was had to the importance of making it expressive of the fact that the investigations made by the Association embraced not only the subject of insanity and the hospital provision made for the care and treatment of the insane, but also inquiries made in regard to the physiology of the brain and of the physiology of the mind, in its normal state, as well.

Having these objects in view and with the increased facilities of the period, the Association is fairly under obligation to give careful and enlightened attention to everything relating to the etiology, diagnosis, prognosis and treatment of insanity, and it is to be hoped and expected that efforts thus made in future, will be crowned with signal success.

It should be understood and stated, however, that while much has been said and written in reference to the science of psychology as connected with mental phenomena and improvement, it has not, to any great extent, revealed a practical philosophy of mind and this, mainly, because little is taught by it of the character and uses of the several classes and of individual facilities and their relation to each other; and last though not least, in their dependence on the brain for their strength and manifestation in this life.

In this aspect of the question, it is at once apparent that any discussion in reference to insanity or the disordered condition and action of the mental faculties, should be based upon a correct view of the philosophy of mind, and, further, that this can only be established by the admission that the mental faculties, collectively and individually, as above stated, are evolved
and manifested alike in health and disease, or in the sane and insane, through the agency of the brain. This being true our first duty, most obviously, is, by any and all means in our power, to ascertain in whole or in part, as may be found possible, the mental function of the brain, aside from other and relatively inferior offices, as that of furnishing the seat of various nervous and muscular centers.

How is this to be accomplished? By patient and careful observation of the heads of living subjects, as to form, size and quality of brain, (judged by the temperament), with developments of the mental faculties as they appear in individuals and as when one individual is compared with another, or with many others. This is the method prescribed and followed by Gall and Spurzheim, who gave the most and best parts of their lives to this investigation and who were justly regarded as men of the greatest eminence in the kindred sciences of Anatomy, Physiology and Pathology, especially as related to the brain and its belongings.

As stated by myself, in another place, this is in fact the method by which physiologists have in nearly all instances ascertained the uses or functions of other organs and parts of the body. This was specially true in regard to the discovery of the function, of the heart or the circulation of the blood by Harvey in 1619, and long after its anatomical structure was known.

As an instance of the conservative tendencies of professional men in the adoption of new and important truths in physiology, it may be stated that this great discovery was for a long time contested on all sides with the greatest acrimony, and its was remarked by Hume as "evidence of obstinate adherence to preconceived opinions, that no physician in Europe who had reached forty years of age ever to the end of his life adopted it."

In view of the acknowledged limitation of human powers aided only by scientific processes, in divining the true physiology of organized parts, both in the animal and vegetable kingdom, this would appear to be the natural, if not, indeed, the only possible method of arriving at the truth in regard to them.

In closing my remarks upon the subject, perhaps already too much extended, I will express the earnest hope that great and continued efforts be made to understand and explain the intricate subject of insanity or mental derangement, also that it is my settled belief that it can only be successfully accomplished through the assistance of well conceived views of the philosophy of mind, based, as far as practicable, upon definite and comprehensive ideas of the mental functions of the brain as a whole and of all its parts.

Very respectfully and cordially yours,

H. A. BUTTOLPH.

SHORT HILLS, N. J., May 12, 1894.

CENTRAL HOSPITAL FOR THE INSANE,
NEAR NASHVILLE, Tenn., May 10, 1894.

Secretary American Medico-Psychological Association:

Dear Doctor:—I had cherished the hope until to-day that I would be able to attend the meeting of the Association next week, but a combination of circumstances will detain me at home.
I will thank you to express to the Association my sincere regret that it should be so, and my undiminished interest in its work, and in its prosperity. I have been, I hope, a faithful member for one-half of the period of its half-century existence, and look back at my attendance on its meetings—only one of which I have missed—as annual oases in my life, and I desired especially to be present at this semi-centennial meeting, and deeply regretted that I was unable to perform the duty assigned me, of reviewing a portion of the roll of honored dead and living of the membership from the South and West.

I trust the meeting may be a pleasant and profitable communion, worthy of the special occasion, and of the great branch of medical science to which we are devoted. Though absent in the flesh, I am cordially with you in the spirit. If proxies are allowed in the membership of the Council, I herewith commission you to represent me therein.

Fraternally yours,

Jno. H. Callender.

At 12.25 the Association adjourned.

SECOND SESSION.

The Association was called to order by the President at 3 p. m.

Dr. Edward Cowles of Somerville, Mass., read a paper on the "Progress in the Care and Treatment of the Insane During the Half-Century."

Dr. W. W. Godding of Washington then read a paper entitled, "Evolution of the Present Hospital for the Insane."

Dr. G. Alder Blumer of Utica read a paper: "A Half-Century of American Psychological Literature."

The Association then adjourned.

THIRD SESSION.

The Association met again at 8.30 p. m.

President Curwen announced that he still had a number of copies of the History of the Original Thirteen Members, with photographs, which he could furnish to members on application.

Dr. T. W. Fisher of Boston, and Dr. Henry M. Hurd of Baltimore, read papers on: "American Alienists of the Past Half-Century."

The address of Dr. Daniel Clark of Toronto on: "Psychiatry During the Coming Half-Century," was read by Dr. Chapin of Philadelphia in the absence of the author.

The Association then adjourned.
Wednesday, May 16, 1894.

First session.

The Association was called to order by the President at 10 A.M.

Mr. C. C. Vaughn, member of the Board of Trustees of the Michigan Asylum for Dangerous and Criminal Insane was introduced by Dr. Oscar R. Long. Mr. James A. Remick, Trustee of the Michigan Asylum was introduced by Dr. C. B. Burr.

The Association then proceeded to ballot for new members and all the candidates who had been recommended by the Council on Tuesday were elected.

Dr. Hughes of the Philadelphia Hospital: "A number of members of the Association have expressed a desire to visit the insane department of the Philadelphia hospital. Of course we should be delighted to have the Association visit us in a body or separately as may seem best. As this afternoon the Association will visit in a body the Pennsylvania Hospital for the Insane and that visit will probably be over by four o'clock, the members could come to Blockley as it is on their way back to the city. This visit would not take up any of the hours set aside for the regular work of the Association. We have supper at five o'clock for the patients. We have an associate dining-room that will probably accommodate 2,000 insane patients. Probably some of the members of the Association have not seen an associate dining-room. Ours is probably the largest in the country and this will be a good opportunity for seeing the patients eating their supper."

The Nominating Committee reported as follows:

The Committee on the nomination of officers and councillors for the ensuing year beg leave to report that they nominate, for President, Dr. Edward Cowles; Vice-President, Dr. Richard Dewey; Secretary and Treasurer, Dr. H. M. Hurd; Auditors, Drs. A. R. Moulton and H. A. Gilman; Councillors for three years, Drs. J. B. Chapin, P. M. Wise, F. H. Clarke and A. F. Kilbourne.

This report was adopted.

Dr. J. W. Babcock then read a paper entitled "The Prevention of Tuberculosis in Hospitals for the Insane."
A paper on "Varieties in General Paresis" by Dr. R. M. Phelps, Rochester, Minnesota, was read by Dr. A. F. Kilbourne.

Dr. N. S. Hepburn, of New York, read a paper entitled "Eye Symptoms in Early Paresis."

Dr. F. C. Hoyt of Clarinda, Iowa, read a paper on "The Tropho-Neuroses of Paretic Demetia."

Dr. C. B. Burr offered the following resolution, which was unanimously adopted:

Whereas, The library of the Surgeon General's office is of great service to the medical profession of the United States, therefore

Resolved, That the American Medico-Psychological Association respectfully requests that the annual appropriation for the library be increased from seven to ten thousand dollars, experience having shown that the former amount is inadequate to efficiently maintain it.

At 8.00 p. m., Dr. S. Weir Mitchell addressed the Association at the New Century Club.

Thursday, May 17th, 1894.

First session.

The Association was opened at 10 a. m., President Curwen in the chair.

The Secretary reported that the Council recommended the following candidates for membership:

Candidates for Active Membership.—Dr. Landon Carter Gray, New York City; Dr. Charles Henry Brown, New York; Dr. H. Ernst Schmid, White Plains, N. Y.; Dr. William E. Sylvester, Brooklyn, N. Y.; Dr. Marcello Hutchinson, Foxboro, Mass.; Dr. John T. Hay, Lincoln, Neb.; Dr. C. O. Dunlap, Athens, Ohio; Dr. Alfred J. Noble, Worcester, Mass.; Dr. W. Brown Ewing, Dixmont, Pa.; Dr. R. M. Phelps, Rochester, Minn.; Dr. Susan J. Taber, Norristown, Pa.; Dr. Edmund A. Christian, Pontiac, Mich.; Dr. Herbert B. Howard, Tewksbury, Mass.; Dr. J. F. Robinson, Nevada, Mo.; Dr. Frederick C. Winslow, Jacksonville, Ills.; Dr. John F. FitzGerald, Rome, N. Y.; Dr. John B. Edwards, Mendota, Wis.; Dr. J. F. McKenzie, Jacksonville, Ills.; Dr. George L. Kirby, Raleigh, N. C.

Candidates for Associate Membership.—Dr. William H. Hattie, Halifax, N. S.; Dr. Charles A. Drew, Clarinda, Iowa; Dr. Eliot Gorton, Morris Plains, N. J.; Dr. Marcus B. Heyman, Columbia, S. C.; Dr. R. Harvey
The Association proceeded to ballot for new members, and all were declared elected.

Dr. H. P. Stearns of Hartford, Connecticut, and Dr. E. N. Brush of Baltimore, Maryland, read papers upon "Lunacy Commissions."

Dr. W. L. Worcester of Arkansas read a paper on "Confusional Insanity."

Dr. T. H. Kellogg of New York, read a paper entitled "Frequent Disorder of Pneumogastric Function in Insanity."

Adjourned.

SECOND SESSION.

The evening session was called to order at 8 p. m. by President Curwen.

Doctors John B. Chapin, Wm. W. Godding and E. N. Brush read papers upon—"A New Departure in Medical Jurisprudence."

Dr. Richard Dewey of Chicago, read a paper entitled "Observations on the Case of Prendergast, the slayer of Mayor Harrison."

Dr. H. E. Allison read a paper on "Insanity in Criminals."

Upon motion of Dr. Hurd the paper of Dr. Edmund A. Christian, of Pontiac, Michigan, entitled "The Unity of Mania and Melancholia," was read by title and referred to the Committee on Publication.

Dr. Eli Joselyn read a paper entitled "Administration of Food to the Curable Insane."

Dr. A. R. Moulton of Philadelphia read a paper on "Body Weight and Mental Improvement."

Dr. C. B. Burr made the following report in behalf of the Committee on Statistical Tables:

To the American Medico-Psychological Association:

Your Committee to whom was referred the matter of preparing statistical tables tending to show the duration of life in the insane
and the permanency of recoveries from the various forms of mental disease would respectfully report that the magnitude of this task has constantly grown upon the Committee, and the conclusion has at times seemed unavoidable that the difficulties in the way of successfully treating the subject were insurmountable. Some months ago the Committee sent out to the various members of the Association a circular of which the following is a copy:

To Dr. ———

Dear Sir:

At the 49th Annual Meeting of the American Medico-Psychological Association, held at Chicago, the following resolutions were adopted:

"Resolved, I. That the members of the American Medico-Psychological Association who are identified with institutions for the insane from which reports are issued be requested to incorporate in the statistical tables of their respective institutions tabulations designed to set forth—

1. The duration of life in the insane.
2. The permanency of recoveries from the various forms of mental disease.
3. Length of interval of mental health between attacks of mental disease in patients discharged recovered.

"Resolved, II. That a committee of three members of this Association be appointed to prepare forms of statistical tables which shall embody these recommendations, to report to the Association at its next meeting."

Pursuant to this action, the undersigned were appointed a Committee on Statistical Tables.

The Committee would be very much indebted for any suggestions in the matter which occur to you. If practicable, will you favor the Committee with a form of table embodying your ideas?

Very truly yours,

C. B. Burr,
Henry M. Hurd,
P. M. Wise,
Committee.

To this circular but few replies were received, those to whom it was addressed evidently sharing with the Committee a fear that the information sought would be difficult to secure and its tabulation prove impracticable. Those who were so kind as to make suggestions expressed, in almost every instance, regret that the Association had not, to start with, a classification of mental disease which would place its members upon common ground, and further, that there was not a more general harmony in views as to what conditions may be regarded curable and what incurable. One super-
intendent expressed the difficulty which would be encountered in determining the permanency of recoveries from various forms of mental disease, very happily, as follows: "One man will see cases of acute curable paranoia; another, like myself, will see in paranoia a disease essentially incurable, and never report a case of recovery from it. Another will report cases of recurrent mania, where the fourth will insist that the nosological termination is in itself incompatible with any true recovery. Another will tabulate an epileptic suffering from a maniacal episode as 'discharged recovered' as soon as the mania subsides; while the next reporter will tabulate such a case as unimproved." He further writes that he has known cases of typical folie circulaire to be classified as recurrent mania on one admission, recurrent melancholia on another, and in both instances the patient was regarded as having recovered when discharged.

The above somewhat discouraging opinion is quite generally expressive of the sentiments of the members of the Association who have given assistance in the matter. This has forced the Committee to the conclusion that without a more generally accepted standard of recoveries and curability of insane conditions, the problem presented will be impossible of solution. It is at best extremely difficult, and the Committee is satisfied that from the most careful tabulation nothing better than a close approximation can be realized.

The Committee therefore, in reporting its conclusions, asks pardon for possibly exceeding its natural limitations and starting out with two assumptions, which, accepted as true, will permit a degree of progress in the direction of uniformity in the reporting of recoveries, will tend toward establishing a standard of recovery, and be expressive of the opinion of the Association as to what constitutes a curable condition.

Assumption No. 1.

That there are three curable types of mental disease:

1. Mania in its acute forms; this including acute mania, acute exhaustive mania, hystero-mania, and dementia after mania (that temporary mental impairment observed in patients convalescing from maniacal excitement).

2. Melancholia in its acute forms; including simple melancholia, melancholia with stupor, melancholia attonita, melancholia with
frenzy, hystero-melancholia, hypochondriacal melancholia, and dementia, after melancholia.

3. Acute alcoholism; including delirium tremens.

As to the last group: this is introduced into the table and separately considered, because of the fact that it so often impairs the value of asylum statistics of recoveries.

Assumption No. 2.

That no case should be discharged "recovered" from any institution more than twice, and readmitted as suffering from an acute form of disease.

The Committee recognizes the arbitrary character of this assumption, but it has been the bane of asylum statistics, and a fruitful source of criticism, that relapsing cases, like cases of recurrent mania, appear again and again in tables of recoveries, and that through the practice of thus reporting, asylum statistics have been vitiated and rendered useless.

Based upon these two assumptions, the Committee has prepared a form of table which it herewith presents. The table provides for the reporting of curable conditions on their first, second and third admissions. It is quite likely that objection will be offered to it on the score of the amount of labor which will be involved in its preparation, and the belief that the end will not justify the expenditure of time.

In view of the very natural protest which would go up against retabulation of old matter, the Committee recommends that, if adopted, this table and others to be presented be begun with an analysis of cases on hand at the close of the next fiscal year after its adoption.

Table No. 1, above alluded to, has columns for those present at the beginning of the year, those admitted during the year, and those transferred from other groups during the year,—this latter being a loophole for escape from previous errors in diagnosis.

Columns are also supplied for figures tending to show the period of complete immunity from mental symptoms in cases previously discharged "recovered," but now re-admitted; for discharged recovered during the year; for the average length of treatment of recovered patients (that is, the average length of treatment during the last admission); for the number who have died; and for the average duration of insane life in those who die—this to be com-
### Table No. 1

#### Mental Conditions

<table>
<thead>
<tr>
<th>Mental Condition</th>
<th>Men Admitted</th>
<th>Women Admitted</th>
<th>Men Discharged</th>
<th>Women Discharged</th>
<th>Total Discharged</th>
<th>Days of Treatment</th>
<th>Average Length of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paralysis</td>
<td>20</td>
<td>10</td>
<td>21</td>
<td>14</td>
<td>35</td>
<td>210</td>
<td>7</td>
</tr>
<tr>
<td>Dementia</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>30</td>
<td>7.5</td>
</tr>
<tr>
<td>Melancholia</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>21</td>
<td>10.5</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>30</td>
<td>7.5</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>30</td>
<td>7.5</td>
</tr>
<tr>
<td>Insanity</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>21</td>
<td>10.5</td>
</tr>
</tbody>
</table>

*Acute Alcoholism: treat as above.

#### Table No. 2

#### Form of Disease

<table>
<thead>
<tr>
<th>Form of Disease</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
<th>Men Discharged</th>
<th>Women Discharged</th>
<th>Total Discharged</th>
<th>Days of Treatment</th>
<th>Average Length of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mania, Acute</td>
<td>20</td>
<td>10</td>
<td>30</td>
<td>21</td>
<td>14</td>
<td>35</td>
<td>210</td>
<td>7</td>
</tr>
<tr>
<td>Mania, Recurrent</td>
<td>4</td>
<td>4</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>30</td>
<td>7.5</td>
</tr>
<tr>
<td>Dementia, Chronic</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>21</td>
<td>10.5</td>
</tr>
<tr>
<td>Dementia, Mania</td>
<td>6</td>
<td>4</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>30</td>
<td>7.5</td>
</tr>
<tr>
<td>Dementia, Melancholia</td>
<td>5</td>
<td>4</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>30</td>
<td>7.5</td>
</tr>
<tr>
<td>Dementia, Epilepsy</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>21</td>
<td>10.5</td>
</tr>
<tr>
<td>Alcoholism, Chronic</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>21</td>
<td>10.5</td>
</tr>
</tbody>
</table>

#### Table No. 3

#### Mortality Table

Duration of Life in Insane After Attack Which Led to Asylum Treatment

<table>
<thead>
<tr>
<th>Duration</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
<th>Men Discharged</th>
<th>Women Discharged</th>
<th>Total Discharged</th>
<th>Days of Treatment</th>
<th>Average Length of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 3 Months</td>
<td>20</td>
<td>10</td>
<td>30</td>
<td>21</td>
<td>14</td>
<td>35</td>
<td>210</td>
<td>7</td>
</tr>
<tr>
<td>3 to 6 Months</td>
<td>4</td>
<td>4</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>30</td>
<td>7.5</td>
</tr>
<tr>
<td>6 to 9 Months</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>21</td>
<td>10.5</td>
</tr>
<tr>
<td>9 Months to One Year</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>30</td>
<td>7.5</td>
</tr>
<tr>
<td>1 to 2 Years</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>30</td>
<td>7.5</td>
</tr>
<tr>
<td>2 to 5 Years</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>30</td>
<td>7.5</td>
</tr>
<tr>
<td>5 to 10 Years</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>30</td>
<td>7.5</td>
</tr>
<tr>
<td>10 to 15 Years</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>21</td>
<td>10.5</td>
</tr>
<tr>
<td>15 to 20 Years</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>30</td>
<td>7.5</td>
</tr>
<tr>
<td>20 to 25 Years</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>21</td>
<td>10.5</td>
</tr>
<tr>
<td>25 to 30 Years</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>21</td>
<td>10.5</td>
</tr>
<tr>
<td>30 to 35 Years</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>21</td>
<td>10.5</td>
</tr>
<tr>
<td>35 to 40 Years</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>21</td>
<td>10.5</td>
</tr>
<tr>
<td>Over 40 Years</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>21</td>
<td>10.5</td>
</tr>
</tbody>
</table>

| Total             | 20  | 10    | 30    | 21             | 14               | 35               | 210               | 7                           |

*To Paralytic Dementia.

**To Chronic Dementia.
puted from the time of the occurrence of the first attack of insanity.

There is also a column for the transfer to other groups after the occurrence of chronicity, and one for the number remaining in each group at the close of the fiscal year.

So much for the acute curable cases which have to do with statistics of recoveries.

Table No. 2 is divided into two parts; the first part dealing with curable conditions; the second with those that are incurable. Columns in this table are arranged to show transfer to other groups from acute curable groups and to carry the statistics along from period to period. As wide a latitude is allowed in the construction of this table as the individual inclination of the tabulator favors, provided the essential prerequisite is not departed from: to consider in the first group, as curable conditions, only those forms of disease heretofore alluded to.

Table 3 is a mortality table, and, like Table 2, divided into two parts. The first part deals at length with the acute cases which are epitomized in Table 1; the second part, with chronic cases.

In conclusion, your Committee would request that copies of these tables be furnished to each member of the Association, and that final action upon them be deferred until the next meeting, during which interval they can be considered by the members of the Association. It probably is unnecessary to add that the preparation of these tables will in no way necessitate the discarding of others already in use in the different institutions.

Very respectfully,

C. B. Burr,
P. M. Wise,
Henry M. Hurd.

The following resolution was adopted:

Resolved, That the report and illustrative tables be accepted and that the whole be printed and circulated among the members of the Association for consideration and criticism and further that the Committee be instructed to offer at the next annual meeting a definite plan whereby the statistics of the various institutions may be collated and presented in a condensed form.

The Secretary reported the annexed resolution from the Council relative to conducting a publication.
Resolved, That the Council make application to the Association for permission to make such arrangements, during the coming year, as it may deem proper in its discretion, for conducting and publishing a journal, according to the provisions of Art. IX. of the constitution; provided that after due investigation it is deemed wise and practicable to undertake such publication.

Resolved that permission be granted.

Adjourned.

Friday, May 18th, 1894.

First Session.

The meeting was called to order by President Curwen at 10 A. M.

The Secretary reported in behalf of the Council that Dr. S. Weir Mitchell had been recommended for honorary membership. Also that the next meeting of the Association would be held June 11th, 1895, in Denver, Colorado, and the following were named as members of the Committee of Arrangements: Drs. F. C. Hoyt, P. R. Thombs, C. K. Woodson and the President and Secretary ex-officio.

Dr. Mitchell was elected an honorary member by ballot.

Dr. Cowles, in behalf of the Committee on Training Schools, reported progress and said that the Committee required a longer time before it could submit a complete report, and continued as follows: An essential point for success in the training of nurses for the insane, is in my judgment, training in general nursing just as much as the asylums can give them. The large institutions having infirmary and hospital wards, practically have as good hospital facilities as most of the smaller general hospitals, always having some surgical and some acute medical cases. The nurses should be taught all they can be taught of general nursing, and then the special nursing of the insane should be added to that. The nurse will then be what we want her to be. Our graduates should have a good standing with the graduates of general hospital schools throughout the country; therefore we have to consider what the standard of the general hospital schools is. One difficulty we meet with this very year is, that the standard of these schools is changing. After about 20 years' experience in the work of general hospitals, the schools are becoming discontented. The public is becoming discontented with the differences in quali-
fication given to nurses by the different schools in large and small hospitals, and the movement is being made this year, by an organization of training school representatives, to establish for that class of schools a more uniform standard. There is an opinion that the length of the course in the training schools should be greater, that the two years should be made two and one-half, or three years. We can at once see the advantage of that. We must consider whether we would require our nurses to stay in the service. I do not think that would be a difficult matter, but we must consider the younger schools, and the hospitals for the insane, that seek to establish schools, and ascertain if there is to be any special difficulty encountered on that account. These are the questions that present themselves to us, so far; and the purpose of the Committee is to get, as far as we can, a consensus of opinion from all the gentlemen who have begun the work, and we purpose to have something to show for it, a year from now. The feeling among us so far, is, that we will not undertake to prepare a manual in the form of that of the British Medico-Psychological Association; such a manual may be said to be either too much, or too little. I doubt if our schools are ready for the Association to formulate a set manual. In all matters of general nursing the text-books of the general hospital schools are ample for us; we really only want something that covers mental nursing, so to speak, and whether it is wise for us, in the name of the Association, to publish a manual of that kind, I doubt very much. But what we can do, obviously, is to prepare a manual for hospital superintendents and teachers; a course of study, showing what it should be and how to conduct it; the recommendation of text-books; the manner of conducting classes; the manner of examinations; and the general standard to which classes shall be brought in order to come some where near uniformity. That can be done and we will undertake next year, to present to the Association the "copy" for the publication of such a small manual.

Dr. J. W. Babcock: It was for several years my good fortune to witness the growth of Dr. Cowles' training school system and to study his methods. Upon my taking charge of the South Carolina Asylum, the Board of Managers insisted that a similar work should be begun in that institution. The school is now in its third year. It comprises 19 female and 16 male pupil nurses
and three graduates. In one of his early papers on asylum training schools, Dr. Cowles suggested that by sending out well-trained nurses these institutions would make an indirect return to the communities that supported them. As bearing upon this point, I should like to report that from the South Carolina Asylum Training School, 45 nurses have been sent to different parts of the State within the past year to nurse private cases of bodily illness. A small general hospital recently established in Columbia, about half a mile from the Asylum, now admits the best of our female nurses for four months of their two years' course. Here they get additional experience in surgical nursing.

Another important function of training schools was briefly touched upon by Dr. Billings at the International Congress in Chicago last year, namely, their obligation to promote the public health by increasing and diffusing knowledge as to the causes, nature and best methods of prevention or treatment of disease. To the same Congress Miss Nightingale sent a notable paper on the subject of health nursing as distinct from sick nursing. It seems to me that in this direction lies one of the important duties of asylums. Some asylum physicians have felt called upon to apologize for the narrow field of sick nursing offered by hospitals for the insane and to lament the absence of the brilliant and inspiring results of surgery. It seems to me that the achievements of preventive medicine are not without inspiration and where can so good a field be found for the practical training of men and women in hygiene and sanitary science as is afforded by our large State institutions?

One of the most encouraging features about asylum training schools is the improvement in the class of attendants who apply as the years pass on and the usefulness of the schools is recognized. Younger, more energetic and more intelligent men and women make application for positions in the schools. The failures-in-life, middle-aged men of alcoholic habits, and broken down or disappointed women—do not come to the hospital as a last resort, with the idea of doing as little work as possible for their pay. The educational requirement drives them away. In their place we get younger applicants with ambition for the future instead of a past of disappointment. One drawback, however, I must admit is that these applicants are often too young, even if 21 years of age. I think that from 25 to 35 years would be a better age for probationers.
I question the propriety of establishing a uniform curriculum in all asylum training schools. Make the length of the period the same if you like, two or three years, each comprising nine months' didactic instruction, but leave the choice of text-books and number and subject of lectures open and thereby I am sure the ambition and originality of the teachers will be enhanced. In time we may evolve a text-book of mental nursing that will be suited to many asylums; that time, in my opinion, has not yet arrived. Meanwhile, I am convinced by careful investigation that as a basis for recitations nothing is better than the admirable Text-Book of Nursing of Clara Weeks-Shaw for the junior year and Miss Hampton's Nursing: Its Principles and Practice for the senior class. These books, especially the latter, foster the real spirit of the "hospital idea" which we are all striving to introduce into asylum work.

Dr. Cowles: I wish to make a request of the Association in the matter of the constitution of the Committee. It seems to me that it would be desirable to add to it some of the men who have been doing active work and who are representatives of the various classes of hospitals.

Upon motion the Committee was continued for another year and three members were added to it, viz.: Drs. C. P. Bancroft, C. B. Burr and J. W. Babcock.

Dr. Gilman read the report of the committee on the Relation of State institutions and Politics.

Dr. E. N. Brush: I am heartily in favor of every paragraph in this report except that which states that the Trustees should be appointed from the two political parties. The paragraph preceding it I think, suggests the adoption of a thorough and complete civil service for asylum appointments which in spirit should extend to the trustees as well as to asylum officers, attendants, etc., and there is no more propriety in saying that two or three political parties should be included in the trustees than that they should say that the superintendent should be one year a Republican and the next a Democrat, so as to keep on both sides of the fence.

I move as an amendment to the resolution that it be adopted with the exception of that portion recommending the appointment of trustees from two political parties. I think we would better ignore political parties in these matters.
Dr. Kilbourne: The Committee recommends that any vacancy in the Board of Trustees be filled by one of the same political party. In our State we have a board of five and the law states that not more than three members shall belong to the party in power. It is a point to be discussed whether a vacancy should be filled as the Committee recommends.

Dr. Carlos F. MacDonald: I am heartily in accord with the spirit and substantially with the letter of the resolutions contained in the report just read by Dr. Gilman. I also fully agree with Dr. Brush's objection to the use of the term "politics" as embodied in the resolution, that is, to the proposition that in the selection of boards of managers appointments should be equally allotted to political parties. This I regard as an objectionable feature and I would second the amendment offered by Dr. Brush to strike it out. The practice of selecting boards of managers in the manner proposed is a pernicious one and when followed, has never resulted in keeping the institutions governed by them out of politics. In fact, it has usually tended in the opposite direction, as I can testify from personal experience with, and observation of, such boards. I am clearly of the opinion, in common with both my associates in the New York State Commission in Lunacy, that managers should be selected without reference to their political faith and that partizan influences should have no place in the government of hospitals for the insane. Furthermore, we believe that no institution for the care and treatment of the insane can be successfully conducted where such influences obtain. I am pleased to be able to state that in the matter of appointment and retention of their resident officers and subordinate employees the New York State hospitals are practically no longer subject to political favoritism; also, that the element of "politics" in the boards of managers and trustees is rapidly being eliminated, through the agency of a healthy public sentiment in our State, which regards the care and treatment of the dependent insane as something which should be sacredly kept above partizanship, and I feel safe in saying that under the operation of the Civil Service law our State hospitals have now reached a point of safety, in this matter, beyond the danger of a relapse. At the request of the State Commission in Lunacy, the Civil Service commission of our State, with the approval of Governor Hill, adopted a rule in 1890 providing in substance for open competitive examinations for the positions of the
various resident officers of our State hospitals, and raising the standard of eligibility to such examinations so as practically to bar out incompetent and inexperienced persons. Under this rule applicants for examination for the position of superintendent must have had at least five years' actual experience in a hospital for the insane, while those for the position of first assistant must have had three years of similar experience, and junior assistants must have had one year's experience in a general hospital, or one year's continuous service as medical intern in a hospital for the insane. Each must pass a competitive examination, be a graduate of a legally chartered medical college, a resident of the State and possessed of good moral character. Selections for appointment from each class must be made from the three highest on the list of that class. Promotions from the position of junior to intermediate grades, below first assistant, may be without examination.

The effect of this rule, which has now been in operation since 1890, has been to materially raise the standard of the medical service by securing a much better class of men in the lower ranks and paving the way for promotion to the higher ranks of experienced and worthy men who merit promotion; but who seldom obtained it under former methods, unless they happened to have a "pull" with their board or with those who controlled their board.

Under the new system four assistant physicians have already become superintendents, and there are several others on the eligible list from which future selections will be made. By thus doing away with the element of favoritism which obtained under the old system one great source of dissatisfaction among assistant physicians in our hospitals has been removed. When the new civil service rule was first proposed, some of our superintendents were opposed to it, but the result has shown that it was a decided step in advance, as I believe all of them are now agreed. We also hope to be able, in the near future, to remove another source of discontent,—a relic of the old system,—by rectifying the marked inequality of salaries and wages now paid to the officers and employees of similar grade in our State hospitals. Another new feature of our State hospitals, of which mention might be made, is a civil service rule adopted at the request of the Lunacy Commission, and of several of our superintendents; providing for the appointment, after non-competitive examination, of medical internes, two in each hospital, at the moderate salary of six hundred dollars per
annum to be selected from recent graduates in medicine of not more than two years' standing. This provision is designed to provide a training school for medical officers from which promotions to the regular staff may be made. These medical interns are required to come up for examination for the position of junior assistant physician at the examination next ensuing after one year's service as intern, and if successful, they may remain in the service of the hospital pending promotion; but if unsuccessful they must be dropped.

There is another feature of the resolution to which I decidedly object and which I would move to strike out. I refer to the provision that the appointment and removal of employees by the superintendent shall be subject to approval by the trustees. In my opinion every superintendent should have the absolute right of selecting and discharging his subordinates independently of the trustees.

The superintendent is the responsible head of the hospital and his authority should be commensurate with that responsibility. If given this power superintendents would be spared much embarrassment which lack of it now causes them. I know this to be the case in my own State and I have no doubt the same is true of other States.

Superintendents not infrequently are debarred from making selections with reference to the highest grade of qualifications and the best interests of the hospital, because they fear that their nominations would be rejected by the board or, at least, be displeasing to certain members of that body. Superintendents are also frequently prevented from dismissing incompetent or unworthy subordinates because to do so would not meet the approval of their boards. Were it necessary I could cite numerous instances of managers and trustees successfully using their influence to secure the appointment and retention in the service, of incompetent, dissolute or unworthy relatives or friends, or to advance the same in rank and pay out of their order or beyond their merits, not to speak of schemes to divert the trade of the hospital to certain quarters, favoring contractors in the matter of proposals for supplies, buildings, etc. I therefore second Dr. Brush's amendment respecting the selection of trustees with reference to their political faith, and move to further amend by striking out the clause which provides that appointments and dismissals by the superintendent shall be subject to approval by the trustees.
Dr. Gilman: I accept the amendments offered by Drs. Brush and MacDonald.

The resolutions reported by the committee, with the above amendments, were then put to vote and carried.

The report as adopted reads as follows:

Report of Committee on "The Relations of State Institutions to Politics."

Gentlemen of the Association:

Your Committee appointed at the annual meeting of our Association in 1893 at Chicago on that portion of the President's address referring to "The Relations of State Institutions to Politics" begs leave to submit the following report, and requests its adoption:

Whereas, The history of hospitals for the insane in several States represented in our Association has for years shown scenes of turmoil, unrest, constantly recurring changes, and as a result; unsatisfactory efforts to increase the efficiency of such institutions, from the fact that positions have been regarded as legitimate spoils for successful political parties, and

Whereas, More recently other States have become overwhelmed in this maelstrom, ruinous to the prosperity of the institutions, to the reputation of the most able, devoted, and self-sacrificing men engaged in the work of alienists in our land, but above and beyond all, perversive of the best interests of the insane committed to the care of such hospitals with their rapidly changing administrations; therefore

Resolved, That this Association should give no uncertain sound in denouncing the corrupting and disastrous lack of principle which involves our State institutions in the whirlpool of any political party contest, or that in any way points to the position of trustees, superintendent or subordinate officers as a reward for party service.

Resolved, That we favor a Civil Service Policy in the organization and management of our State institutions; that the trustees or managers should be selected, and appointed in accordance with such policy.

Resolved, That these officers should be selected for their devotion to the cause of humanity and a benevolent spirit, as well as business sagacity and broadminded ability, rather than because of a political "pull" which they are supposed to control.

Resolved, That the superintendent should be selected by such board solely on professional grounds; ripe in experience, with reputation for scientific attainments, love of humanity and executive ability. He should have the appointment of his subordinate officers and his tenure of office should be during good behavior or competency.

Resolved, That each State should, so far as practicable, establish a system of examinations for assistant physicians, and other subordinates, under Civil Service Rules, and vacancies occurring in any of the State hospitals should be filled by the successful competitors after such examinations.

H. A. Gilman,
P. M. Wise,
Daniel Clark.
Dr. Cowles, of Massachusetts, gave notice that he would offer the following amendments to Article V of the Constitution of the American Medico-Psychological Association at the next annual meeting: (Article V, page 4.)

After "President," line 16, insert "at least two months prior to the annual meeting of the Association," and after "membership," line 20, insert "The application of every candidate for active or associate membership shall be accompanied by an original contribution, submitted as thesis for admission, for the scrutiny and approval of the Council."

The Secretary read a communication from the Women's Christian Temperance Union, which upon motion was referred to the Council.

Dr. R. M. Bucke read a paper on "Cosmic Consciousness."

Dr. Hurd read a memorial of Dr. J. C. Hall which had been prepared by Dr. R. H. Chase of Philadelphia.

Dr. Chapin moved that this memorial be referred to the Committee on Publication, and that the memorials of Dr. Nellis, Dr. Workman and Dr. Fisher be read by title and referred to the same Committee.

Dr. Richard F. Gundry stated that Dr. George H. Rohé, Superintendent of the Maryland Hospital for the Insane was traveling in Europe and moved that he be made a delegate from this Association to the British Medico-Psychological Association.

Dr. Chapin stated that President Dr. Curwen was about to visit England and had accepted an invitation to be present at the next session of the British Medico-Psychological Association, and moved that he also be made a delegate of the Association.

These motions were adopted.

The Secretary announced that the Council, last night, in accordance with authority granted by the Association, decided to publish a volume of Transactions to represent the Semi-Centennial work of the Association.

President Curwen in resigning the chair spoke as follows:

The duties of this meeting have been performed. In returning to you the office your kindness and partiality have bestowed on me, I thank you most sincerely for the patience and forbearance you have shown to me in the discharge of my duties. My mem-
bership in the Association extends to forty-three years and in that time I have been absent from only two meetings. I was Secretary for thirty-four years, and two years in the other offices you have so generously conferred on me. The preparatory work of construction of hospitals, and instruction in the great principles which underlie the true and just treatment of the insane, have in a great measure passed, though much remains to be done in the way of enlightening the community in their duty to the insane.

The Association enters on a new era in its progress toward more literary and scientific work, and that scientific work from this day forward will be so done as to startle those who have given little credit to the Association for such work.

You have shown your desire for that advance in your selection of a President for the ensuing year, in the person of Dr. Edward Cowles, whose attainments in mental science have placed him in the front rank. May each member of the Association have wisdom and strength given him to discharge his duties zealously and faithfully.

I now introduce to you the President-elect Dr. Edward Cowles.

Dr. Cowles in taking the chair thanked the Association for the honor which had been bestowed upon him. He thought that the Association had honored itself for years in having had for its Secretary the retiring President.

The Association adjourned at 12.45 p. m. to meet in Denver, Tuesday, June 11th, 1895.

HENRY M. HURD,
Secretary.
The retrospect of fifty years is crowded with pleasing memories and delightful reminiscences of those who have been members of the Association of Medical Superintendents of American Institutions for the Insane, sombered with the shadows of those who, at varying intervals, have passed from the seen to the unseen.

Assembled within a short distance of the place where that Association, to which this Association is the legitimate successor, was originally organized on October 16, 1844, it seems a fitting occasion to recall some traits of the character of the men who gave themselves with whole-hearted devotion to the promotion of the welfare of the insane.

Actuated by motives and principles of the highest philanthropy, they initiated movements which have steadily advanced and are still advancing, with a force and momentum which will gradually overcome all obstacles and give a consistence and permanence to all matters pertaining to the care of the insane, which will eventually issue in the most enduring and beneficent modes of relief.

Personal acquaintance with nearly all, and an intimate association with many of those who stood in the front rank, afford the opportunity of such notices of them and their noble, untiring efforts, as may serve to stimulate those now in the ranks to more earnest, persistent and whole-hearted devotion to the cause to which they gave their lives with singular fidelity, consistency and self-forgetfulness.

On the third day of June, 1844, a young man who had received his degree of Doctor of Medicine on the fourth day of April, 1844, entered on his duties as Assistant Physician of the Pennsylvania Hospital for the Insane, in Philadelphia, in which position he remained until the first day of October, 1849. Elected Physician-in-Chief and Superintendent of the Pennsylvania State Lunatic Hospital at Harrisburg, on February 14th, 1851, he became a member of the Association of Medical Superintendents of American Institutions for the Insane, of which he was elected Secretary
at the meeting of the Association held in Quebec, Canada, on June 8th, 1858, and continued in that office until May 5th, 1892.

On the sixteenth day of October, 1844, thirteen gentlemen, who were superintendents of hospitals for the insane, met in Philadelphia and organized the Association of Medical Superintendents of American Institutions for the Insane by the election of Dr. Samuel B. Woodward, of the Massachusetts State Lunatic Hospital at Worcester, Mass., as President; Dr. Samuel White, of the Hudson Lunatic Asylum, Hudson, N. Y., as Vice President; and Dr. Thomas S. Kirkbride, of the Pennsylvania Hospital for the Insane in Philadelphia, Penna., as Secretary and Treasurer.

The names of the other gentlemen were Dr. Isaac Ray, of the Maine Insane Hospital, Augusta, Maine; Dr. Luther V. Bell, of the McLean Asylum for the Insane, Somerville, Mass.; Dr. C. H. Stedman, of the Boston Lunatic Hospital, Boston, Mass.; Dr. John S. Butler, of the Connecticut Retreat for the Insane, Hartford, Conn.; Dr. Amariah Brigham, of the New York State Lunatic Asylum, Utica, N. Y.; Dr. Pliny Earle, of the Bloomingdale Asylum for the Insane, New York, N. Y.; Dr. William M. Awl, of the Ohio Lunatic Asylum, Columbus, Ohio; Dr. Francis T. Stribling, of the Western Lunatic Asylum, Staunton, Va.; Dr. John M. Galt, of the Eastern Lunatic Asylum, Williamsburg, Va.; Dr. Nehe-miah Cutter, of the Pepperell Private Asylum, Pepperell, Mass. Several other gentlemen, who had expressed their intention of being present, were detained by unavoidable causes.

Having met all these gentlemen at that first meeting, an acquaintance began which was strengthened by subsequent intercourse at the meetings of the Association, and in many cases by frequent social communion, which left a deep impression of the zeal, the energy, the learning and high personal character of each of the thirteen, though the death of a few, within a few years, removed them from the sphere of personal association.

A sketch of each of these gentlemen drawn from this personal acquaintance, together with a notice of others who have been prominent members of the Association, may be of interest to those who have not enjoyed the same opportunity of learning their earnest devotion to the care and welfare of the insane.

Samuel Bayard Woodward was the son of a physician, and a native of Connecticut, born on June 10th, 1787, and licensed to practice medicine at the age of twenty-one. His attention was called to this special department
of the profession by the occurrence of several cases of insanity in his own practice and in that of his professional brethren, whose adviser he was. The difficulty of managing these cases in their private practice led Dr. Woodward and his particular friend, Dr. Eli Todd, to take the first step towards the establishment of the Retreat for the Insane at Hartford, and he took credit to himself in having secured for it its present delightful location. He was appointed Superintendent of the State Lunatic Hospital at Worcester, Mass., in September, 1832, went to Worcester in December following, and moved into the Hospital as soon as rooms could be finished and furnished for the reception of his family. He retired on June 30th, 1846, on account of failing health, and moved to Northampton, Mass., where he died quite suddenly on the evening of January 3d, 1850.

His personal appearance was commanding and his carriage truly majestic. His hair was almost white, and with a bright, animated expression of countenance and large, handsome features, he made a strong impression by his earnest manner. His stature was six feet, two and a half inches, and without the deformity of obesity, his weight was about two hundred and sixty pounds. He was erect, and though full in figure, his motions were quick and graceful. Although very civil and accessible to all, he seemed born to command. Dignity and ever-enduring cheerfulness sat upon his countenance and betokened the serenity and happy state of the feeling within. Of an ardent, enthusiastic temperament, he exerted by his conversation and writings a wonderful influence on the community in which he lived, and he employed his full powers for many years, for the benefit of the insane, by endeavoring to interest all within the reach of his influence to labor for them.

Samuel White was born in Connecticut on Feb. 23, 1777. He commenced his professional career at Hudson, N. Y., in 1797.

Owing to the occurrence of insanity in his own family, by which his domestic enjoyment was interrupted, he was led to pay much attention to mental disorders, and in 1830 he established a private institution at Hudson, N. Y., which he successfully conducted. In 1849 he was elected President of the New York Medical Society, and delivered an address on insanity which presented one of the best synopses of our knowledge of insanity, especially of its treatment, which has ever been published. His health began to fail shortly after the meeting of the Association, and he died at Hudson, N. Y., on February 10, 1845.

He was tall, though slender, his countenance grave and dignified, yet he was of a social disposition and a man of pleasing address. Within a more limited sphere he discharged the various duties of a long and active professional life with ability, and in a truly Christian spirit. With iron gray hair and a sober, calm and thoughtful expression, he gave the impression of a man of earnest character, and of thoughtful, studious habits.

Thomas Story Kirkbride, a native of Pennsylvania, of the old stock which came over with William Penn, was born July 31, 1800, and received an education in the schools of his native county of Bucks, and in the schools of Trenton, N. J. He graduated from the Medical Department of the University of Pennsylvania in the spring of 1832, and soon after was elected Resident
BY JOHN CURWEN, M. D.

Physician of the Friends' Asylum for the Insane at Frankford, Philadelphia, where he remained one year, and then served two years as Resident Physician of the Pennsylvania Hospital in Philadelphia, where he had renewed opportunities of studying the treatment of the insane.

After being in private practice a few years in Philadelphia, he was elected Superintendent and Physician-in-Chief of the Department for the Insane of the Pennsylvania Hospital in October, 1840, and opened that institution for the reception of patients on January 1, 1841, and all the insane in the Pennsylvania Hospital in the city were transferred to the new institution in the course of the month of January. Having accepted the position with the expectation of "developing new forms of management, in fact giving a new character to the care of the insane," he gave himself, mind and heart, to the duties of his position, and his zeal and enthusiasm for the welfare of the insane never slackened so long as life endured.

If the earlier years of the institution, great attention was given to laying out, adorning, and the careful improvement of the grounds within the enclosure, embracing forty-one acres of land, so that ample walks for exercise, pleasant drives and cheerful views and surroundings might divert from morbid fancies to more healthful ideas.

The attention given to these matters was the relaxation from more exacting and imperative duties, and gave that degree of out-door exercise which one, in the delicate physical condition and feeble digestion which troubled him at that time, so much required to give tone and vigor to his whole system.

Great as was the interest he took in directing the building and improvements of the place and great as was his ability in these respects, it was within the wards that he found his chief delight, and there also that the strength and the graces of his nature showed themselves more clearly. To trace out and understand the wonderful influence which he had over his patients, and how he induced them to adopt most readily the plans which he believed would surely advance their restoration and add to their comfort, can best be done by considering his wonderful patience and his devotion to everything which had a bearing on their welfare, and the sincerity which they felt sure directed every thought and movement. His thoughtful nature was always looking forward to what could be made most steadily and certainly available for their pleasure, and for the promotion of their mental and physical health. Until the erection of the Department for Males, he made it a rule to see all the patients under his charge in the morning, and if anything prevented that visit, he was sure to take an opportunity in the course of the after part of the day, to attend to what he considered a most imperative duty. That visit was not a mere perfunctory duty, but he always took occasion to inquire particularly into the wants and feelings of the individual, hear all he had to say, give advice, soothe, cheer or so impress the person with his interest in him, and his earnest desire to benefit him, that he felt in every respect, for the time, relieved, and looked longingly for the return of the same kindly attention. His manner, his address, his patient listening to all complaints and grievances, the gentle tone of his voice and the sympathy which manifested itself in every tone and action, had a wonderful effect on those who were depressed and greatly cast down, as well as on those of an opposite character.
On the organization of the Association of Medical Superintendents of American Institutions for the Insane, in October, 1844, he was elected Secretary, serving in that capacity for seven years. He was Vice President for seven years and President for eight years. The advancement of the Association in every honorable manner, and the enunciation by it of sound principles on every subject connected with the welfare of the insane was always prominently before his mind, and his zeal in its cause was characterized by a warmth of feeling which found expression whenever its interests were considered, and he never failed to attend its meetings whenever his health would permit: he was absent but eight times from the formation of the Association until his last sickness, and from those meetings he was kept by sickness in his family, his own ill health, or by duties which could not be postponed: and the last message sent by him to the Association, only six months before his death, showed the earnestness and enthusiasm with which he watched all its proceedings: "Present my kindest regards to all the members and express to them my great regret that I cannot be with them in body as I will be in spirit, and my great interest in all their deliberations;" and to the messenger he added this. "Let me hear from you all about the meeting."

He early entertained the idea of the separation of the sexes in buildings under the same general management, and this plan was fully developed in the report for 1854. He labored with the greatest assiduity to collect, by private subscription, the money needed for the erection of such a building on the part of the property west of the Hospital then in operation, and so faithfully did he give himself to this work and so zealously was he supported by the Managers of the Hospital that the greater part of the money was subscribed, and the first stone of the new building was laid, on July 7th, 1856, and the formal laying of the corner-stone took place on October 1, 1856.

No uncertain sound attended his utterances on all matters pertaining to the welfare, care and treatment of the insane, and the mild and pleasant manner in which his opinions were expressed served to carry conviction to many minds which would have resisted a more dogmatic expression, and added force was given by the evident sincerity and devotion to truth and duty which dictated them. No more positive indication of the confidence reposed in his judgment, and earnestness and the sincerity with which he urged his views, can be looked for, than in the collection of the large amount for the erection of the Department for Males of the Pennsylvania Hospital for the insane; by far the larger portion of that amount having been obtained by his personal efforts in direct application to individuals; and any one who will examine that long list will see the uncommon tact and energy displayed by him in his appeals to all classes and conditions of men.

The building was formally opened for the reception of patients on the twenty-seventh day of October, 1859,

When the Board of Trustees of the Pennsylvania State Lunatic Hospital at Harrisburg was appointed by Governor William F. Johnston, in 1859, Dr. Kirkbride became one of the Board, and continued in service until 1862. He took an active and energetic part in the organization of that Hospital, and his long experience and thorough knowledge gave him an influence with
his colleagues which he exerted to place that institution in the best possible condition for the promotion of the welfare of its inmates.

His connection with the Pennsylvania Institution for the Instruction of the Blind, for more than forty years, and the great interest manifested in the design and successful operation of that institution, and the great faithfulness displayed in the very constant attendance at all the meetings of the Managers, from few of which he was absent during the long period of his service, made clear to every one, that next to the Hospital of which he was superintendent, no institution held a higher place in his regard and affection.

Any one wishing to be thoroughly conversant with all the details of construction of hospitals for the insane should read, attentively, his work on the construction and organization of hospitals for the insane. The work will be found most admirable for the clearness of its statements on the different points; most thorough in its elaboration of details; and bearing in every line the impress of a clear head, sound judgment and most intimate acquaintance with everything which can have a bearing on the promotion of the restoration, comfort and welfare of the insane, directed and guided by that earnest conscientiousness which was such a prominent trait in his character.

A careful examination of the forty-five reports prepared by him during the long period of his superintendency, will make clear the thoroughness and fidelity with which he considered all matters pertaining to the care of the insane. Those reports will be found to contain discussions on every matter which was current at the time they were written, and the calm and judicial manner in which each was treated as it arose will impress the reader with the thought that the truth of what was stated was self-evident to the writer’s mind, and influenced all his plans and thoughts.

At a very early day he took the position that every institution for the insane should be called a Hospital, and it is gratifying to show that at this date that idea is securing an earnest recognition in the minds of the profession and the community.

Deeply imbued with the religious principles of the Society of Friends, in which he had been educated, while placing little value on various externals of the Society, he endeavored, consistently, to carry out the principles laid down by them in all his intercourse with his fellow-men. To a disposition, genial, gentle and kind-hearted, he united great decision and determination of character, and, convinced after careful examination that he was right, he kept steadily on in the course he believed to be correct, not deviating in the least from what he believed to be the true line of duty. Generous and liberal-minded, strong in his attachments and friendships, he cherished no feelings of enmity against any, but strove to live in peace and harmony with all; and when others refused to act harmoniously, going on in the line of duty, avoiding contention while adhering strictly to what he believed to be truth and justice. His generous mind revolted at all pretences and attempts to make the worse appear the better reason, and he scorned all deception.

He possessed a wonderful tact in his intercourse with the insane, which, combined with unfailing good nature and honesty of purpose, gave him great power, which he always used to advance their interests in the fullest manner.
Calm and self-possessed in scenes where others were agitated and alarmed, he exercised the happy faculty thus enjoyed with great judgment and discretion, thus evincing in the clearest manner his power to direct and control. No trait of his character was more prominent than his single-hearted devotion to every good word and work, and in this, and in the earnestness and conscientiousness with which his work was performed, he strove to follow the example of Him who always went about doing good.

*Dr. Isaac Ray*, then in his prime, active, vigorous and earnest in every thought and movement, stood then, as he did through all the remainder of his life, among the first of those who there met. With iron gray hair, and the student stoop of his shoulders, he delighted to gather a small group around him and discuss the different questions which concerned the welfare of the insane, sitting in that peculiar posture so natural to him, with his head bent forward, his legs crossed and his hands crossed or folded together on his lap before him. No one who ever enjoyed these opportunities of hearing him pour forth the richness of a mind well stored with the treasures of literature in general, and of insanity in particular, either as one of a group, or when seated with him in his own parlor, will ever forget the instruction which he then received, and the kindly, fatherly tone and manner he always evinced towards those younger in years and in experience. In whatever position in life he was called to act, his sound judgment and well-matured views always gave him a commanding influence, which he invariably used to promote the welfare of the insane and other afflicted classes.

Dr. Ray was a native of Massachusetts. Born of highly respectable parents, in the town of Beverly, on the sixteenth of January, 1807, he there commenced his earliest education, subsequently entering Phillips Academy at Andover, and afterwards Bowdoin college, where he remained till compelled by ill health to leave his studies, which he had been prosecuting with great assiduity. As soon as his health was sufficiently restored, he began the study of medicine in the office of Dr. Hart, of Beverly, completing his studies under Dr. Shattuck, a distinguished physician in Boston, and ultimately graduating at the medical department of Harvard University, in 1827. In that year he began the practice of medicine at Portland, Maine, and about two years after, inducements were offered him to leave that city and settle in Eastport, in the same State. It was at this time, while living in Eastport, that Dr. Ray first had his interest excited on the subject of insanity and the treatment of the insane, and especially in reference to matters connected with the branch of medical jurisprudence relating to it. The prevalent views on all these subjects were then far behind what are common at the present day, and led Dr. Ray to prepare a work, "The Jurisprudence of Insanity," since generally recognized as one of the highest authorities in this department of medico-legal knowledge, and quoted alike by alienists, lawyers, and all others interested in the subject, at home and abroad.

No better evidence of its being generally appreciated need be given, than the fact that six editions have been exhausted in this country, while it was a source of grief to Dr. Ray that his condition of health rendered it impossible for him to prepare a seventh, which had been called for by his
publishers, and for which he had on hand interesting and important materials.

Dr. Ray was appointed Medical Superintendent of the State Hospital for the Insane at Augusta, Maine, in the year of 1841, and immediately assumed the duties of this position, residing in the institution, till he was invited by the Board of Trustees of the Butler Hospital at Providence, Rhode Island,—which was then about to be organized—to become its superintendent.

Dr. Ray sailed for Europe, soon after his appointment, to visit many of the more prominent institutions for the insane in Great Britain and on the Continent, and in this manner passed the summer months of 1845. He spent the next two years in superintending the erection of the Butler Hospital, which was open for the reception of patients in 1847. Then, taking up his residence in the Hospital, he remained there, superintending its affairs with great ability, and to the satisfaction of all who were in any way connected with it, till January, 1867, when his impaired health compelled him to resign his position, to which he was so much attached and in which he had done so much to elevate the standard of Hospital treatment for the insane. He spent most of the year in visiting his professional brethren in different parts of the country, and in selecting a place for his permanent residence finally accepting the city of Philadelphia.

The change from a New England climate to that of Philadelphia, and the rest from constant labor which was permitted him, made a great improvement in Dr. Ray's health. He increased his literary work, enjoyed engaging in matters of public interest and found himself able to take an amount of physical exercise to which of late he had been a stranger. His regained health enabled him also to accept calls in consultation from his professional brethren, and especially as an expert in legal and criminal cases, in which his services were frequently solicited. Dr. Ray was a member of many professional and scientific associations. Wherever he was thus associated he was noted for his active interest, and for the part he took in the preparation of papers and his participation in any discussions that might take place.

Dr. Ray was one of the founders of the Social Science Association, and was always an intelligent student of every subject which came under its consideration. His papers read before it, and his views in all matters that received its attention, were distinguished for practical good sense and advanced conclusions in regard to the welfare of the community.

Dr. Ray was about the medium stature, but did not possess a very robust constitution. His features were marked and his general expression grave. His manner was dignified, his language clear and distinct, and in speaking and writing he always used a pure English and attracted attention no less by his personal appearance than by his manner of delivery and the matter of his remarks.

Dr. Ray, for many years, had been troubled with a chronic cough which seemed to be bronchial in its character. Although annoying, this cough did not appear materially to affect his general health, and after taking counsel from the most able of his medical brethren, he seemed to have concluded that his malady was one not likely to be removed by treatment.

The great change in Dr. Ray's health which occurred in the latter part of
1879, was evidently more the result of a great and unexpected family affliction than of his previous condition. It was not wonderful that the sudden death of his son, at the meridian of life, should have left results of no ordinary character. This sad event, so unlooked for was a shock to the father, which did more to prostrate his health and strength than would have been done by years of customary labor. With his intimate friends he was still the same genial character, still interested in whatever concerned his profession or his fellow man; but he ceased to write, complained of what had formerly been a pleasure now becoming a toil to him; found his flesh wasting and his strength diminishing, and frequently showed a sadness quite unnatural to him. From the early part of December, 1880, he remained in his house, still seeing his friends, interested in his books and in what was going on in the world and in his specialty; but steadily losing weight and strength. From his daily increasing weakness his friends realized that the end must be near. On the evening of the 31st of March, 1881, he retired at about the usual hour. After being in bed he had one troublesome spell of coughing, but then slept quietly, only once in the early morning, inquiring the hour. So peacefully did he rest, and so calm was his sleep that he made no sound of any kind, nor moved a muscle, as far as could be heard; and when approached somewhat later, there had been no change in his position, but life had departed, and only what was mortal remained of this noble and useful man.

Dr. Ray was a man of great versatility of talent. His ability as a writer is well known and his conversational powers were remarkable. He had a great facility in adapting himself to any society in which he might be placed, and was equally agreeable to the grave, professional man, or to the specialist, as to those of tenderest age, with whom he was usually a great favorite.

A list of Dr. Ray's writings, which has been preserved, shows how industrious an author he was, and how multifarious were the subjects in which he took an interest. From 1828, when his first publication of which any record has been kept, was made, down to the 1880, during which year he published his last contributions to the press, it will be seen that but a single year passed in which something original was not noted.

Dr. Ray was Vice President of the Association from 1851 to 1855, and President from 1855 to 1859.

Dr. Luther V. Bell was born in Chester, New Hampshire, Dec. 30, 1806. He entered Bowdoin College at twelve years of age and graduated in 1823. He received his medical degree from Dartmouth College in 1826 and subsequently pursued his medical studies in Europe. He commenced and pursued the practice of medicine and surgery in the towns of Brunswick and Derry, New Hampshire, with success in both departments, and interested himself largely in sanitary and philanthropic measures, tending to the elevation of his profession and the general welfare of the people.

He labored earnestly in the establishment of the New Hampshire Asylum for the Insane, was elected to the General Court with the special object of urging forward this measure, and made a very able report on the number and condition of the insane of that State, and the means of providing for
them. While attending a second session of the Legislature and pressing this object, he received, very unexpectedly, the intelligence of his having been appointed Physician 'and Superintendent of the McLean Asylum for the Insane.

He was appointed during the latter part of 1836, and entered upon his official duties at the beginning of the next year. He was an early and earnest advocate for the introduction of steam and hot water, and mechanical power, as the proper and only suitable mode of warming and ventilating hospitals, and the McLean Asylum, over which he presided, was the first institution in which a circulation of hot water was successfully employed for warming a large, inflowing current of air. In 1845, on the solicitation of the Trustees of the Butler Hospital for the Insane, at Providence, Rhode Island, then in contemplation, the Trustees of the Massachusetts General Hospital, of which the McLean Asylum is a branch, gave Dr. Bell leave of absence to visit Europe, that he might, after a comparison of the institutions of the old world, be enabled to devise a plan of hospital embodying all that was excellent and desirable, then known to the profession. After his return he presented the plan of that establishment, which so fully met the highest hopes of its friends.

He was, for two years, President of the Massachusetts Medical Society, and his inaugural address was on ventilation. He subsequently published a small volume entitled, "The practical method of ventilating buildings, with an appendix on heating by steam and hot water." He held the post of Executive Councillor in the administration of Governor Briggs, in 1850, and was a member of the Committee of Pardons, to which was referred two cases, famous in the annals of crime in Massachusetts; that of Daniel Pearsons, convicted of the murder of his wife and infant twin children, and that of Prof. J. W. Webster, for the murder of Dr. George Parkman. He resigned his position as Superintendent of the McLean Asylum, in the fall of 1856, the state of his health urging this step. In addition to impaired health from pulmonary disease he had lost children, one after another, at the most interesting epochs of parental attachment, and under the highest hopes.

The death of his estimable wife filled the measure of his domestic sorrow.

From the McLean Asylum he removed to his private residence in Monument Square, Charlestown. Here his life was not a retirement, as he was constantly consulted in cases of insanity and other cerebral and nervous affections, and on questions of a medico-legal character. At the breaking out of the rebellion, he was among the first to offer his services to the Government. He went as Surgeon of the Eleventh Regiment of Massachusetts Volunteers, but was soon promoted to the position of Brigade Surgeon to Gen. Hooker's Division, on the Lower Potomac. He died in camp, quite suddenly, from endocarditis, on February 11, 1862.

Dr. Bell was tall and commanding in appearance, with a large, high forehead, and an abundance of dark, bushy hair, and his whole countenance gave the impress of a fine and active intellect, which placed him in so prominent a position among his fellow-men in whatever situation he might be, either in urging the claims of the insane or in State and National politics, for
which he had a strong predilection. His social qualities were of a high order and he charmed all who came within the sound of his voice, or met him in familiar intercourse, with the well-matured views he so ably and eloquently advanced on all subjects. He was known to the older members of the Association as the able alienist physician, by his great skill in the detection of disordered mental manifestations, by his elaborate description of that form of acute mania so often described as Bell’s disease, by his genial qualities and his earnest, persevering efforts to advance the specialty to the highest rank.

He was Vice President of the Association from 1850 to 1851, and President from 1851 to 1855.

Dr. Charles Harrison Steadman was born in Lancaster, Mass., June 17, 1805. He entered Yale College whence he did not graduate, but received subsequently an honorary degree of A. M. He took the degree of M. D. at Harvard, in 1828. In 1830, he was appointed Resident Surgeon of the United States Marine Hospital, at Chelsea. In 1840, he removed to Boston and entered into practice there. In 1842, he was appointed Superintendent of the Boston Lunatic Hospital, and Physician and Surgeon to the numerous correctional, industrial and reformatory institutions of Boston, in the same enclosure which contained the Lunatic Hospital. In 1851, he resumed private practice in Boston. He was the first Medical Coroner appointed in the State. In 1851, he was elected to the Massachusetts Senate. In 1853, he became one of the Governor’s Council. At the opening of the Boston City Hospital in 1854, he was appointed Visiting Surgeon of that Institution, and died June 7, 1866, Senior Surgeon of that Institution.

Few men had greater opportunities of observing disease than he, and he improved them with great earnestness. He was averse to writing, although he was clear and perspicuous in style, so that much of his observation has been lost. He educated many students before the days of medical schools in Boston, many of whom have attained high positions in the medical world; and all of them remember him with warm respect and affection for his lucid way of teaching, his quick diagnosis, his wonderful resources in therapeutics and his manly, decided and easy methods of conveying his instructions. His manner was polished, his disposition humane and sense of the ludicrous and love of a joke very keen.

Dr. John S. Butler was born at Northampton, Mass., in 1803. He graduated at Yale College in 1825, and after beginning the study of medicine in the office of Drs. Hunt and Barrett, of Northampton, he attended a course of lectures at the Harvard Medical School, continuing his professional education at the Jefferson Medical College; he took his degree there in 1828. From 1829, he was engaged for ten years in general practice in Worcester, Mass., where he was a frequent visitor at the Lunatic Asylum, and gained from Dr. Samuel B. Woodward his interest in the care of the insane.

Dr. Butler was appointed Superintendent of the Boston Lunatic Hospital, September 16, 1839, and resigned October 10, 1842.

He was appointed Superintendent of the Retreat for the Insane at Hartford, Conn., on May 13, 1843, and resigned October 20, 1873.
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On his resignation he was engaged in expert and consultation practice, and in 1878 was made the first President of the Connecticut State Board of Health, which published his first annual address on State Preventive Medicine. He resigned that office after ten years, but retained his membership in the Board until his death.

Thirty-three years of Dr. Butler's active life were given to the responsible care of the insane, as the superintendent of two institutions although his service did not begin till he was thirty-six years of age.

His distinguished personal traits were large-hearted charity and cheerful optimism; these never deserted him even in his last days. He never grew to be an old man in spirit. He was strong on the practical side; a shrewd observer, he had a rare insight into human nature and he used it wisely and kindly. His interests were always enthusiasms; he was genial and courteous, earnest and sincere. He had a pleasant humor and was always ready with a merry conceit, a quaint saying or an apt anecdote.

Dr. Butler was of the medium height, rather stoutly built, with a large well-formed head and high forehead, sandy hair and a merry twinkle of his eye which showed his fondness for humor.

Dr. Butler died at Hartford, Conn., on the 21st of May, 1890, in the eighty-seventh year of his age. He was Vice President of the Association from 1862 to 1870, and President from 1870 to 1873.

Dr. Amariah Brigham was born at New Marlboro, Berkshire County, Massachusetts, on December 26, 1798. He commenced practice, a youth somewhat short of his majority, in the town of Enfield, Mass., where he remained two years and then removed to Greenfield, where he continued seven years.

He visited Europe in 1828, and remained abroad about a year, visiting hospitals in all the countries in which he traveled, and on his return resumed practice in Greenfield, and in 1831 removed to Hartford, Conn. In 1837 he was elected Professor of Anatomy and Surgery in the College of Physicians and Surgeons, in New York city, where he remained a year and a half. He was elected Superintendent and Physician of the Retreat for the Insane, Hartford, Connecticut, in 1840, and in the fall of 1842 to a similar appointment in connection with the State Lunatic Asylum, Utica, New York. He commenced publishing the "Journal of Insanity," July, 1844. His health began to fail in the summer of 1847 (though he had been feeble for two years previous), and though benefited by a trip to the South, in the spring of 1848, he never fully regained it and died September 8, 1849. He labored industriously with his pen to advance the cause of the insane.

In person, Dr. Brigham was tall, somewhat less than six feet in height, and very slender; his weight in health, probably not exceeding one hundred and thirty pounds. His features were well proportioned, though rather small than otherwise, eyes of a soft, dark blue, expressing more than usual, the varying emotions of his mind. His hair was thin, of a brown color, and slightly, if at all, gray at the time of his death. His gait was naturally slow. His voice was soft, low and quite melodious. As a whole, his appearance and manner indicated to the observer, a superior and cultivated intellect,
a firm will, perfect self-possession, a social disposition and a kind and generous heart. He was Vice President of the Association from 1848 to the time of his death.

Dr. Pliny Earle was born in Leicester, Mass., Dec. 31, 1809. His early education was secured at the Leicester Academy, then and for many years afterwards, a very famous school. He afterwards went to the Friends' School at Providence, R. I. His medical studies were pursued mainly at the University of Pennsylvania, where he graduated in medicine in 1837. He then visited Europe and visited many of the asylums for the insane in the different countries of Europe. In 1840, he became Resident Physician of the Friends' Asylum at Frankford, Pennsylvania. This position he held during two years, and in 1844 received the appointment of Medical Superintendent of the Bloomingdale Asylum, in New York. This position he relinquished after five years of service, and went to Europe the second time for further observation and study relating to the treatment of the insane. After his return from his second visit to Europe he was appointed Visiting Physician to the New York Asylum, in 1853, and during this year he delivered his first course of lectures on mental diseases, at the College of Physicians and Surgeons. At a later period he was appointed as a Professor of Materia Medica and Psychology in the Berkshire Medical Institute, at Pittsfield, Mass. He appears to have delivered but one course of lectures, and his connection with this institution was terminated by his acceptance of the position of Superintendent of the Lunatic Hospital at Northampton, Mass. This position he held during twenty-two years. This period, which closed in his seventy-sixth year, was filled with some of Dr. Earle's most important work.

Dr. Earle was a man of large individuality, active mind, retentive memory and good judgment. He was able, therefore, to exert a very decided influence upon those who came under his care and those with whom he was associated in his specialty. He was positive in his convictions, and held tenaciously to any course of action he may have once entered upon. He was thoroughly conscientious, and while never aggressive and fond of discussions, yet was always ready to state and defend his views upon all subjects relating to that specialty of medicine to which he had devoted his life. While he was much interested in the general affairs which pertained to the conduct of his hospital, yet he was a diligent reader, and probably during a longer period than any other superintendent in the country, continued to contribute to the literature of insanity. He was diligent, pains-taking and thorough in all his work as a superintendent and physician. Dr. Earle retired from the duties of superintendent at the age of seventy-six, though he continued to occupy apartments in the Hospital, where he died on May 17, 1882.

His deep interest in its welfare and, indeed, in all that pertained to medicine, remained to the last. He was a member of many literary and scientific societies, Vice-President of the Association from 1883 to 1884, and President from 1884 to 1885.
Dr. William M. Awl was born in Harrisburg, Penn., on May 24, 1799, his mother having been a lineal descendant of John Harris, who founded Harrisburg, and the daughter of William Maclay, the first United States Senator from Pennsylvania; and while quite young, the family removed to a farm at a short distance from Sunbury, Penn. When fifteen years of age, he was sent to the academy in Northumberland, kept by Rev. Isaac Grier, and after his death by his son, Robert C. Grier, afterwards Judge of the Supreme Court of the United States; and there he acquired all his preliminary education. He studied medicine with Dr. Samuel Agnew, of Harrisburg, and attended one course of lectures in the session of 1819-20, in the University of Pennsylvania.

In the spring of 1826 he started on foot for Ohio, and settled first at Lancaster, and an important surgical operation there performed gave him his first introduction into practice. After moving several times from place to place, he finally settled in Columbus, Ohio, in 1833. His attention was first called to the care of the insane by a case of violent acute mania, which he was called to treat in Somerset, Ohio.

On January 5, 1835, he attended a convention of medical men of Ohio, which had been called by himself and several others, to take some measures towards the care of the insane and the education of the blind. A memorial was presented to the Legislature on these subjects, and an appropriation was obtained towards the erection of a hospital for the insane, and Dr. Awl was appointed one of the trustees to build it. He, in company with two others, visited the Eastern and Middle States, to gain information on the subject. The building was completed in 1838, and Dr. Awl resigned as trustee and was appointed superintendent.

He was one of the originators of the Ohio Institution for the Blind, and was always deeply interested in that institution, and was physician of it at the time of his death. He continued in charge of the Lunatic Asylum until 1850, when he was displaced by that system of political appointment which has so unfortunately prevailed in Ohio from that day to this.

He attended the meeting of the Association in Philadelphia, in 1876, and quietly passed away on November 19, 1876, having been a sufferer from a complication of diseases for several years. He was Vice-President of the Association from 1846 to 1848, and President from 1848 to 1851.

Dr. Awl was of a cheerful, lively disposition, with a great fund of natural, genial humor, which made him a very pleasant companion, and united with great tact and sound common sense, served him admirably in dealing with the insane.

Dr. Francis T. Stribling was born January 20, 1810, in the town of Staunton, Virginia, where he received his elementary education, and soon entered the office of his father, who was then clerk of the County of Augusta, in which he remained several years. Having determined to adopt the medical profession, after some preparatory reading under the advice of a distinguished physician of Staunton, he spent a session at the University of Virginia, and in the following year took his degree of doctor of medicine from the University of Pennsylvania.
In 1836, at the early age of twenty-six years, he was elected by the distinguished gentlemen who then composed the Board of Directors, Physician to the Western Lunatic Asylum. Within a few days after his election, Dr. Stribling went on a tour of observation through the Middle and Northern States, to inspect the best regulated institutions for the insane, and to gather by observation and intercourse with those in charge all the information necessary to guide him in the discharge of his responsible duties. The law regulating the institutions for the insane in Virginia, passed by the Legislature in 1840-41, was really prepared by him. From that time to the commencement of his last illness, he devoted himself assiduously to the enlargement of the capacities of the institution for usefulness. He died July 23, 1874.

Dr. Stribling was of the medium height, with a full, fair face and fine forehead, a cordial, genial manner and a generous, open-hearted expression, which won on those with whom he came into constant association. Never very robust in build or in health, he yet managed, by care and discretion, to accomplish a large amount of work for the insane. To talents of high order, he united unblemished integrity and warm and generous feelings, while in the discharge of his responsible duties, he exhibited inflexible firmness, and such grace and serenity of manner as to win the confidence and affection of all who were brought into association with him.

Dr. John M. Galt was born in Williamsburg, Virginia, on March 19, 1819. He evinced, at a very early age, an ardent love of reading and study, and was remarkable, not only for his acquirements in his studies but also for his ability in all athletic exercises. He eagerly read all the principal authors within his reach, in English, Latin, Greek or French, and was also enthusiastically fond of botany. He graduated in 1838 at William and Mary College and received his medical degree from the University of Pennsylvania in 1841.

In July, 1841, he was appointed Medical Superintendent of the Eastern Lunatic Asylum at Williamsburg.

Dr. Galt contributed largely during his whole life to magazines on general subjects, in addition to many articles on the subject of insanity. In 1816 he published a work entitled "Treatment of Insanity." He was a great linguist, for with the exception of the Russian and Turkish languages, he required no one to translate for him the tongues of the other nations of Europe. It was his daily habit to read a certain number of pages of Xenophon, Thucydides, or some other standard Greek author. In addition he had turned his attention to the languages of the East and was so good an Oriental that he read the Koran in the original Arabic.

Though singularly temperate in all things, his digestive organization became very much undermined and he was for several years subject to attacks of indigestion, occasionally of great violence, the last of which occurred in May, 1862, and terminated in his death on the 18th of that month, after an illness of four days, and he was buried among his forefathers in the Bruton Parish Church, Williamsburg, Virginia.

Dr. Galt had the most youthful expression of any of the members, with a
very full face, medium forehead, large head and pleasant countenance. He was of the medium height, rather stoutly built, with a pleasant manner, easy expression and a full flow of words and was the third member of his family who, in regular succession, had had charge of the institution which he then represented.

**Dr. Nehemiah Cutter** was born in Jaffrey, N. H., on March 30, 1787. He graduated at Middlebury College in 1814 and received the degree of M. D. from Yale College in 1817. He commenced practice in Pepperell, Mass., in 1818. He had charge of an insane person in that year, and about 1822 received insane persons into his family. The number of patients increased so rapidly that he was obliged to make additions to his house and, about 1834, built a new and larger building in addition to those already erected. He associated with him at different times several gentlemen, who continued with him for varying periods, until his institution was burned down in May, 1853.

As a patron of education, he contributed largely of his own means for the founding and support of an academy in Pepperell. Self-possessed on all trying occasions, even in temper, social and affable to distinction, he acquired a powerful salutary influence over the minds of his patients. His interest in the public welfare rendered him greatly beloved and his loss was sincerely regretted. He died March 15, 1859.

Dr. Cutter was of the medium height, rather under than above, stoutly built, with a pleasant, benevolent expression of countenance and a mild manner of speaking. Endowed with great energy and determination, when the institution which he had built with great labor and expense was burned, and the work of years swept away in a few hours, he returned to the practice of the branch of medicine he had so steadily and earnestly pursued, with all the ardor and energy of his youth.

**Miss D. L. Dix.** In the latter part of October, 1844, a lady, Miss D. L. Dix, came to Philadelphia on the mission which had occupied her time and thoughts in other States: to investigate the condition of the insane. After a careful examination of the condition of the insane in the poorhouses of Pennsylvania, she presented a memorial to the Legislature containing a touching appeal for the establishment of a hospital for the insane and her labors were rewarded by the passage of a bill for the construction of a hospital at Harrisburg.

This was, however, only one of a large number which she was instrumental in urging on the legislatures and people of other States to erect for the care and treatment of the insane.

To use the term applied to her by the Scotch, as "The American Invader," she was also instrumental in doing great good to the insane in Scotland and in other parts of Europe.

To enumerate all her efforts for the insane, the prisoners, the feeble-minded and the afflicted of every degree, would require a larger volume than her biographer has given to her whole life.

An acquaintance of more than forty years, and a friendship, almost mater-
nal on her part, gave an opportunity to know the plans and projects, the kind disposition, the ardent longing to relieve all who were distressed, troubled or diseased, which actuated her whole life and was the inspiring element in all her work.

Educated in the best schools of her native New England, imbued with deep religious feeling, tenderly alive to all the kindliest sympathies for the afflicted and suffering of every class and condition, animated by a high sense of right and duty, controlled by strong common sense, Miss Dix was admirably endowed for the noble work in which she spent her life. Endued with great moral and physical courage, she was calm and self-possessed in scenes and circumstances where many a sturdier nature would have been startled. Resolute in purpose and in her convictions of truth and justice, she persevered in the face of difficulties and obstacles at which others would have recoiled, and rarely failed in what she undertook, for the reason that right and justice guided her aim and actions.

For more than forty years of the latter part of her life, the greater portion of her time, her thoughts and energies were given to the amelioration of the condition of the insane. In the prosecution of this work she traveled over a number of the States, in whatever mode of conveyance she could find, visiting the poorhouses in every section, looking carefully into the manner in which the insane were treated, and wrote memorials to the legislatures of several States, detailing what she had seen, and urging them to adopt the proper mode of relief by the erection of hospitals for their care and treatment. She spent weeks, and often months, at the seat of the government of the State, seeking by personal converse with the members and with the committees specially charged with the appropriation of money, to influence them to take action which she deemed so necessary for the welfare of the insane. The number of hospitals which she was thus instrumental in establishing cannot now be certainly known, from her reluctance to state matters bearing directly on her own labors, but it must have been about fifteen. After the institutions were established her interest did not abate, but her visits were frequent and she advised and counseled with the superintendents, encouraging them and aiding them in every way in her power; correcting false impressions in the minds of persons she met in the community, and in every way striving to interest all in the care and treatment of the insane.

Her efforts were not confined to the United States alone, but the following extract from a notice by Dr. D. Hack Tuke will show what she did in Scotland:

"Miss Dix's philanthropic labors were not confined to the States. She was interested in the asylums in Canada, and at one period was painfully impressed with their bad condition. Again, every one who knows the history of the reform in lunacy in Scotland, knows that her visit to that country in 1855, her exposure of the dreadful state of things she discovered and her vigorous onslaught on the authorities who supported them, led to a complete revolution in the care and treatment of pauper lunatics. Those who heard from her own lips the stirring incidents of that raid upon Scotland after her return to England, and her interview with the Home Secretary only a few
hours before the Provost of Edinburgh arrived in hot haste on the scene, in
order to anticipate and nullify the good woman's appeal—but just too late—
are not likely ever to forget her graphic story. Her clear statement of facts,
herself dignified presence, her obvious sincerity and her dogged perseverance
triumphed. She could afford to smile at the epithet bestowed mockingly
upon her, 'The American Invader.'

Though her efforts were directed mainly to the relief of the insane, she
never omitted an opportunity to do what lay in her power for those confined
in prisons of different kinds, and among those of varying degrees of crime;
and she never failed to use her influence with all with whom she was associated
in favor of the blind, the deaf and dumb, and for the advancement of the
efforts made in behalf of the imbecile children, to the end that every appliance
practicable should be given for their education and advancement to higher
and better conditions of mind and body. She was careful to inform herself
in all matters pertaining to the condition and mode of relief of the defective
classes, and the calmness of her judgment and sound practical sense made
her a valuable counselor to all those striving to advance the welfare of those
classes.

Standing at one time on the shore of the Island of Newfoundland, she saw
a large vessel go ashore without relief or means of assistance to crew or
cargo. The sight distressed her, and her sympathies were keenly enlisted
in behalf of the sailor, so much exposed on that coast, on one part of which
so many vessels have been lost. The enlistment of her sympathies soon took
a practical direction in her efforts to obtain from the British Government the
establishment of life-saving stations, which have been the means of saving
many sailors from a watery grave on that desolate coast.

Nothing was more striking in her whole life and conduct than the grace,
the womanly dignity and modesty (in the highest and best sense of that much
abused word), which characterized her in all her intercourse with those
with whom she was called to act; and this was one great secret of the
power and influence which she was enabled to exercise, not only over those
with whom she was obliged to act in the effort to secure for the insane and
others, those measures of relief which seemed the best adapted to the purpose,
but also with all those who, by reason of mental or moral obliquity, were in-
clined to be rude in manner and forgetful of the proprieties of language. The
manner in which she exercised her influence over public men and legislators
was strikingly characteristic of the traits mentioned. She never could be
induced to make a public address before a promiscuous audience, but she
would meet an individual member of a committee or all the members, state
her views plainly, distinctly and forcibly, answer objections and argue dis-
puted points, with calmness and dignity, so as to leave the impress of her
great sincerity and earnestness.

She was very present in everything she undertook, and spared no labor
or effort to impress the truth, as it was before her own mind, on the minds
of those with whom, in a measure, rested the success of her efforts, no
matter what their position in the social or political sphere. She very rarely
failed in her efforts to secure the attainment of the measure she had under-
taken. In her plan to secure Congressional aid for the relief of the insane in
the different States, she was defeated by the executive veto, and the course pursued in after years by the member of the cabinet who wrote that veto, intensified to the highest degree the dislike which she entertained towards him for the course which he pursued. Her intense love of country and patriotic devotion to its highest interests were strikingly manifest in the efforts which she made during the late war, for the relief of the sick and wounded. She was deceived in regard to many who offered their services to her, with strong recommendations from persons in prominent positions; but while these inefficient persons impeded her work and placed her in a false and unpleasant position, it did not take away the ardent love of country which animated her in all her efforts, and which was more distinguished and earnest in contrast with the selfishness and greed of those who so hampered her work.

Dr. William H. Rockwell was born in East Windsor, Connecticut, on Feb. 15, 1800. He graduated at Yale College in 1824, and from the medical department of the same institution in 1831. In 1827, while a student of Dr. Hubbard, of Pomfret, Conn., he received the appointment of assistant to Dr. Todd, of the Retreat for the Insane, at Hartford, Conn. He remained connected with that institution for the greater part of the time until his appointment to the Vermont Asylum, June 28, 1833. During the illness of Dr. Todd and after his death, he had charge of the Retreat until the appointment of Dr. Fuller, and wrote the report for the year 1834.

Dr. Rockwell was prevented from attending the first meeting of the Association by reason of a bill at that time pending in the legislature of Vermont, which demanded his attention in behalf of the interests of the insane who might be committed to his care. Tall, robust and vigorous in appearance, of a kind, gentle and pleasant disposition, he was eminently a practical man, giving special care to the occupation of his patients and laboring earnestly for their benefit in every way in his power.

Few men possessed such qualifications for surmounting difficulties as he, and the history of the institution at Brattleboro gives tangible evidence of his indefatigable energy. He was pre-eminently self-reliant, and though he differed from some of his colleagues in the matter of policy in practical management, he was scrupulously faithful to his convictions and to his trusts.

For a year and a half preceding his death he was confined to his bed, suffering most from his fractured limb, gradually wearing away, and sinking to his final rest; and then it was that the strong points of his character shone out with the most striking brilliancy. Realizing that his work was done, and that he had done it faithfully, he expressed his willingness to be judged by it; undisturbed by the shafts of malevolence and indiscriminate censure, he calmly observed, "that his work would be better appreciated and his motives better understood after he had gone." He died on the 30th day of November, 1873.

Dr. William H. Stokes was born at Havre-de-Grace, Maryland, on Jan. 18, 1812. His parents, who were representatives of an old Maryland family, removed from Havre-de-Grace to Baltimore in 1818. Receiving his elementary
education in the schools of Baltimore, he graduated from Yale College in 1831, and received his degree of M.D. from the University of Maryland in 1834, and was soon afterwards appointed resident physician to the Maryland Hospital, the State institution for the treatment of the insane. This position he only occupied for one year, but his attention was then directed to the care and treatment of the insane, and for half a century he devoted his mental and physical energies to the relief of this unfortunate class.

He engaged in private practice in Mobile, Alabama, from 1835 to 1840, and visited Europe in 1841, and spent that year in professional study in the hospitals of Dublin, and became the special protege of the celebrated Dr. Stokes of that city, then one of the leading medical men of the day, and was greatly assisted by his warm friendship. Returning to Baltimore in 1842 he established himself in that city, and in the same year he accepted the position of attending physician to the institution for the insane which, then known as St. Vincent’s Asylum, subsequently became Mount Hope Retreat.

During his long and eventful professional career, Dr. Stokes filled many positions of honor and responsibility. His death, in May, 1893, was caused by measles.

Dr. Stokes was a type of the old school Maryland gentleman; his manners courtly and his bearing always dignified. He was so reserved as to be almost stilted in his dignity, but beneath this there was a warm heart that always won the admiration of his friends, and the love and attachment of his patients. His great life work was Mt. Hope Retreat, which he followed from its humble beginning with a handful of patients, to a position, both in regard to numbers and appointments, second to no private asylum in the country.

He was impelled by the infirmities of age to sever an active connection with the institution in 1887, leaving a memory of faithful devotion to the care of the insane, and of an able, conscientious physician and devoted friend of the unfortunate.

Dr. Nathan D. Benedict was born in Otsego County, New York, on April 7, 1815. He fully graduated with honor in 1837, at Rutgers College, New Brunswick, New Jersey, and commenced the study of medicine immediately after he graduated at the University of Pennsylvania in the spring of 1841, and at once engaged in practice in Philadelphia, where he was successfully pursuing his profession when he was appointed medical superintendent of the Philadelphia Almshouse in 1846. He gave himself with earnest devotion to the care of the insane, and to the heating and ventilation of that department of the institution. He was chosen superintendent of the State Lunatic Asylum at Utica, New York, in the fall of 1849. While engaged in directing the necessary alterations for the heating and ventilation of that building, on a plan which he had originated and urged upon the managers, he was attacked with pneumonia, attended by profuse hemorrhage, and when able to be about after months of confinement, he was recommended to spend the winter of 1853-4 in Florida. Returning in the spring of 1854, with the expectation of engaging in his work at the Asylum, he was required to resign, which he did with the greatest reluctance for his
heart was in the work. He removed to Florida in the fall of 1855, and opened an institution for invalids at Magnolia. In this he succeeded well until the breaking out of the rebellion which virtually compelled him to give up his intentions, as the Government took charge of his buildings for hospital purposes, and he removed to St. Augustine, where he continued to reside, and filled several offices of honor and trust.

He died on April 30, 1871. Calm, genial, self-possessed, he had a special adaptability to the care of the insane, and entered on and carried forward his work with a force and energy, springing from deep convictions and beneficent impulses, which were greater than his physical constitution could bear.

Dr. Chauncey Booth died on Jan. 12, 1858, at the age of forty-one years. He had been assistant physician at Brattleboro, Augusta and at Somerville. He did not leave much for the literature of our specialty. Beginning our work at twenty years of age, he labored without intermission with us to the close, and he never, until the last two years when every moment was crowded with duties, would have consented to put himself forward as an instructor of others; and this modesty was perfectly sincere. In 1847, he drew up, and that only by request, an account of an epidemic dysentery of some eighty cases, at the asylum, which commanded the highest encomium of the late Dr. Fisher, the best pathologist of his time and place. Dr. Booth's only hospital report will stand as a bright memorial of what the man was, while, as the trustees in their report indicate, his papers in their files demonstrate what he would have been as chief of a great hospital for the insane.

Dr. Booth had suffered under marked pulmonary disease ever since the winter of 1850–1851. Cavities in one lung were distinctly diagnosed as far back as that date, and the evidence of slow but continuous progress was manifest until the scene closed. If there were ever an unequivocal example of will power, in suspending and retarding the certain march of phthisis, it was in this case. Looking his symptoms daily in the face, he seemed to feel that he had an enemy to be met, and that every foot of the ground was to be contested with him. As brave as any hero who ever faced the cannon's mouth, he never allowed his stern and unrelenting foe to gain upon him by intimidation. He kept coolly at work, subverting the approach of the enemy by every strategic means which science and experience furnished to his aid; but no panic, no disheartening yielding, ever lost him an inch in the contest, and as if to determine a victory in favor of the unintimidated contestant, phthisis did not run its usually easy and certain triumph. Two months before Dr. Booth's decease, when the consumptive symptoms had scarcely a more prominent place than they had had for six or eight years Bright's disease set in with its distinct features. The noble victim recognized the fatal weight of this unexpected ally, and calmly yielded to the overwhelming forces of the combined enemy.

The immediate approach of death was met in the same spirit which had marked the entire onward march of the enemy. There was neither bravado, nor boast, nor affected indifference. He set his house in order as deliberately as one arranges for a distant journey, and when the last moments were ap-
proaching, he desired that his only child, a boy of some seven or eight summers, weeping at the scene, should be removed so as to escape the lasting impression of the physical effects of the struggle in articulo mortis.

A striking feature of his personal character was his eminent, social, genial wit; an instinctive power of seizing and grouping together the most unexpected and incongruous images, all most telling and illustrative of the subject matter in point; yet unlike the almost inseparable incident of the ordinary possession of this dangerous gift, never leaving behind one sting, nor a single allusion which any party could repeat. He went on through life, not merely "without an enemy," giving the idea in its stale and well-worn phrase, but absolutely without a suspicion of what an enemy might be.

A remarkable feature of Dr. Booth's character was, that while he had never been "in the world," he had as complete and sagacious an idea of its entire system, as if he had plunged into the perplexities of trade, the struggles of ambition, and the debasement of the passions. He passed from the pure circle of the family of a Connecticut clergyman, the father as marked for a holy simplicity as the mother was for the traits which characterized the son, into the wards of a great lunatic hospital, thence to another, thence to a third, and thence to his reward. No man of the age of forty, in this community, can be found who ever passed so few days away from the immediate fields of his daily duty.

Like all other men devoted to one absorbing pursuit, he had his own pet pleasures, his peculiar side avocations, to which he loved to steal after every call of duty was over, in the stillness of the household fireside. Yet few men of that great company of those who knew him in the same pursuit as themselves, could probably ever have conjectured wherein that specific taste would have shown itself. It was in the study of the ecclesiastical history of New England. The strong point of Dr. Booth's professional character was an absolute identification with the insane. If not born within hospital walls, he had passed his whole actual life within them, and never seemed to dream of being anywhere else. No man seemed so perfectly to enter into the insane nature of those around him.

Buried with him in the quiet shades of Mount Auburn, was no common measure of that mighty talent of dealing with the insane mind, which, as was well observed by one of the great masters of our art, "can be acquired, but never can be communicated. It must die with its possessor."

**Dr. John E. Tyler** was born in Boston, December 9, 1819. He was born to an inheritance of good quality from both parents. On the death of his father, when he was only fifteen months old, his mother with her children, left Boston to reside with her father, who was a merchant in extensive business in Westborough. Tyler's childhood and first school days were spent there. Later he was sent to Leicester Academy and to Hopkinton. At first he was destined for a mercantile life, and much of his boyhood and early manhood was spent in business. He first served in the store of his uncle and grandfather, doing a large miscellaneous country business. This was well calculated to develop the versatility of talent which he possessed, and which was of such signal service to him in the administrative positions
to which he was called in his later professional life. From this he was removed to a position in a wholesale store in Boston. In both these places he exhibited the same sterling traits of character which we shall find, in a constantly increasing degree, all through his subsequent career. Leaving this position, he entered upon study preparatory for college, with the intention of entering the ministry, under the instruction of a Rev. Mr. Kittridge, and afterwards at Phillips Academy, Andover. He entered Dartmouth College in 1838 with the largest class which has ever entered that college. It graduated eighty-five members. Tyler's fine mental endowments and genial nature soon placed him in the front rank in his class, for influence and popularity. Such were his traits that he could not help being a leader. He was a quick and accurate scholar; not a man made up of perception and memory, but *with* those; of genuine, robust common sense, which taught him at a glance the most happy way to do or say a thing, and, withal, of the most attractive bearing among his fellows. Besides he was brim full of humor and good cheer, with a sincerity and frankness which at once disarmed any jealousy which might have arisen in less ingenuous minds.

At this early period he displayed the same mental qualities for which he was distinguished later in life, in the capacity of professional expert: namely, rare power to hold in mind a mass of facts and arguments, survey and compare them, separate the essential from the accidental, and proceed with logical clearness to the legitimate deduction.

On graduating from college he opened a private school in Newport, R. I., which he greatly enjoyed, and the memory of which was very dear to him through life. While in Newport, Dr. Tyler commenced the study of medicine, under the instruction of the late Theophilus C. Dunn, of that city. After this period of private study he attended a course of lectures at the Dartmouth Medical College, and then completed his course of medical studies in Philadelphia, attending two sessions of lectures at the medical department of the University of Pennsylvania. He graduated at that institution in the spring of 1846.

Dr. Tyler, after his graduation, while spending a few days with friends in Westborough, started to prospect for a field of practice in Connecticut, but on his way received a letter from his friend and classmate, Rev. S. J. Spalding, calling his attention to the new village of Salmon Falls, N. H., and thither he turned his steps. He soon secured a large practice in the town and surrounding county, and placed himself in the front rank of his profession, in that section of the State. The same qualities of mind and heart, already noticed, soon brought to him a patronage quite equal to his time and strength to serve. He was a cordial supporter of every public improvement, and took a leading place as a mover and strong promoter of enterprise in every form calculated to advance the public interest and give efficiency to local institutions.

Before the expiration of the six years of his residence in Salmon Falls, he had already been twice elected to represent the town in the legislature. In the legislature he took a commanding position and exerted positive influence. An acute judge of men, who knew him long and well, says he pos-
sessed uncommon power of winning men to his views, and when he enlisted in behalf of an object it was very apt to succeed.

He was elected superintendent of the New Hampshire Asylum for the Insane on October 5, 1852, and entered upon the discharge of his duties on the first of November following. After five years of uninterrupted work of the most laborious character he offered his resignation, which was not accepted until the following year. Dr. Tyler was fully aware of the inroad made upon his health by these active years of uninterrupted work and after leaving the asylum he devoted a few months to rest and recreation. During the time he traveled in the Western States and there contracted malaria, which laid him up the next winter and the influence of which continued in his system, in a degree, through life.

In the winter of 1858 he was elected by the Trustees of the McLean Asylum, superintendent of that institution, the office having been made vacant by the death of Dr. Chauncey Booth.

It had been his intention to resume the general practice of medicine, but his call to the McLean Asylum turned him from this purpose, secured to that institution, fortunately, his eminent services, and retained in the specialty one of its most accomplished members.

He commenced on February 22, 1858, a term which continued till March 3, 1871, a period of a little over thirteen years.

During part of these years he was lecturer on Mental Disorders at the Harvard Medical School, and these lectures were rich in the fruits of his observation and close study.

He knew that his life, in later years, hung upon a thread; but he was up and about his work, his lectures, his consultations and professional visits, till the afternoon of the day when disease fell upon him in a form and with a severity which he knew to be fatal. But he had no preparations to make and no doubts or regrets, so far as he himself was concerned. He died as he had lived, a brave, noble Christian, cheerful and happy to the last. Starting with a mind well prepared by a college training, and a faithful study of his profession, he obtained in due season the merited reward of such preparation. While engaged in a general practice, embracing to a large extent the most respectable and cultivated part of the community, he was selected by the trustees of the State Asylum of New Hampshire to become its superintendent. So well did he discharge this trust that, under his charge, the institution notably prospered while he established his own reputation in his peculiar calling. At the McLean Asylum the best qualities of his nature were brought into action, as they had never been before, and his remarkable fitness for the kind of duty he had assumed was admirably displayed. In no other similar institution in the country are larger drafts made on the patience, the temper, the industry, the zeal, in short, on all the moral and intellectual resources of the superintendent. For thirteen years he stood the trial, steadily gaining the approbation of his trustees, the confidence and esteem of his patients, and the respect of his medical brethren. He came to the work with a correct appreciation of its responsibilities, and an earnest endeavor to achieve the highest measure of success; thenceforth it became the all-absorbing interest of his life. Surrounded by memorials of his prede-
cessors, he needed no other incentive to make himself worthy a place by the side of a Booth, a Bell, a Lee and a Wyman. It was a purpose worthy of the noblest ambition. How worthily he achieved it, we learn from the abundant testimony both of his patients and his employers. He cared little for popular applause and was well satisfied with the approbation of those, who alone, were the proper judges of his merits.

It cannot surprise any one acquainted with the ceaseless demand on him, that inroads were at last made upon his health. Admonished of this, after nine years of unremitted application of mind and body, he sought rest in a trip to Europe in February, 1867, and devoted seven months to travel and observation, returning in September of the same year. During this journey he inspected foreign institutions, made the acquaintance of leading men in his specialty abroad, and was received by them with marked courtesy and attention. Temporarily rested, he again worked on with his wonted assiduity till the spring of 1870, when he again took a respite in a journey to Florida. While on his way home he was seized with an alarming fever and remained, for several weeks, desperately sick in the city of Savannah. Many times his life was despaired of, and it was only after long and tender care that he was able to reach home. His vital powers had now received a shock from which it took years to recover. As fast as he gained strength, however, he gave it to the duties of his office, till March, 1871, when it appeared certain that absolute freedom from official responsibility was essential to his complete restoration. Recognizing the necessity he resigned his position of Superintendent of the McLean Asylum.

In April, he sailed again for Europe, this time free from professional care and responsibility, attended by his wife and select personal friends. Although a close observer and a man to enjoy what he saw as a traveler, still he longed for home and his much loved activities, and was thus drawn back from rest sooner than he ought to have been, after only seven months' absence.

He returned much improved in health and vigor. His indomitable love of active life would not allow him to rest without definite employment, and so he at once opened an office in Boston for professional consultation. Immediately then commenced the demand for his services and professional opinions which he constantly and rapidly increased to the end of his life. This period embraced between seven and eight years.

His practice and consultations were confined to diseases involving the mind, and his services were in much demand, not only in his own city and State, but over New England and in New York.

His desire to come to the close of life with the harness on and in working order was allowed to be gratified. He died April 7, 1878.

Dr. Clement A. Walker was born in Fryeburg, Maine, July 3, 1820. He died suddenly, after several years' serious illness, April 26, 1883, being 62 years and 9 months of age. His boyhood was passed near the White Mountains of New Hampshire, almost in the shadow of Mt. Kearsage. He fitted for college at the Fryeburg Academy, a school once honored by the instructions of Daniel Webster, and still flourishing. He graduated at Dartmouth College in the somewhat remarkable class of 1842, of which he was not the
least distinguished. His intimacy with Dr. Tyler began in college and continued with more than brotherly affection until the death of the latter. His power of making and keeping friends was one of the strong points of his character.

During his college career his health gave way and he traveled in the South, teaching school in Virginia and making some valuable acquaintances there. He had suffered from hemorrhage from the lungs, which led his friends to fear a fatal result. He afterwards acquired an apparently vigorous physique which was severely tested by his thirty years of active hospital life. He was a little above the medium height and became stout in middle life. His eyes were dark and piercing, his lip expressive of firmness, the nose large and his hair straight and jet black in youth, but turning at thirty-five to white with his snowy beard gave him the aspect of a vigorous old age in early manhood. He graduated in medicine at Harvard University in 1850, and began practice in South Boston under Dr. Charles H Stedman, who was then physician to all the city institutions located there, including the Boston Lunatic Hospital. In 1847-9, when cholera and ship-fever were prevalent among the poor emigrants at the quarantine station at Deer Island, he volunteered with his classmate, Dr. Upham, to assist in the fever sheds and rude hospitals erected there for temporary use. He entered on the work of managing these unfamiliar and dreaded diseases with characteristic promptness, courage and skill. Dr. Upham’s reputation was speedily established by an able monograph on ship-fever; and Dr. Walker’s no less by his success in dealing with the intractable diseases above mentioned. July 1, 1851, Dr. Walker was appointed superintendent of the Boston Lunatic Hospital, which position he held until his resignation on account of ill-health, January 1, 1881, a period of nearly thirty years.

This hospital, built in 1839, had been in charge of Dr. Butler, its first superintendent, and Dr. Stedman, whom Dr. Walker succeeded, a period of twelve years. In its rear was a semi-detached building known as the “Cottage,” fitted up with cells like those of a police station, for the violent insane. Such cells were supposed to be a necessary adjunct to a hospital for the insane in those days. Dr. Walker at once advised their disuse, and in a short time succeeded in having them abandoned, by gradually placing their occupants in the wards of the main building. He thus became the pioneer in the discontinuance of cells in the treatment of the insane in this country. He was remarkable for bringing things to pass. Whatever he took in hand he gave his whole mind to; and his clear intelligence, strong will and skilful management accomplished many things seemingly impossible. In the care of the insane, these qualities gave him a great advantage over obstacles, and exerted a powerful moral influence upon patients and their friends. He never knew when to give up a case. With death at the very door he persisted in active and sometimes successful treatment. While not neglecting judicious alimentation he had more faith in medicine than is fashionable at present. While life lasted there was not only hope but active help for all his patients. In many ways he improved his hospital, elevated the standard of treatment, diminished restraint and brought about needed changes and reforms. For many years his advice was implicitly relied on by successive boards of visitors and directors.
He early recognized the necessity for better accommodations for the city's insane, and for years labored earnestly for this object, until success nearly crowned his efforts. A site for the new hospital was purchased, plans made and adopted, and an appropriation passed only to be vetoed by the mayor, who opposed the project. This veto was a severe blow to his hopes, and he had only the satisfaction of seeing the city's plan of construction adopted at Danvers, and of having the medical supervision of the work in behalf of the Commission who had it in charge.

As an expert in mental disease, Dr. Walker was frequently called in court in his own and other States. His opinions being deliberately formed and clearly expressed, carried weight in consequence. His written opinions, reports and medical papers were always carefully prepared, condensed in expression and logical in method. His handwriting even expressed his character in its peculiar squareness and solidity. In dealing with men, a rare combination of strength of mind, sound judgment, tact and well-chosen language, gave him great influence and made him a safe adviser, a useful advocate and friend. He made the most humble, whose cause he espoused, feel that his chief desire for the moment was to serve his interests. The patience with which he entered into the details of another's troubles, or listened to the tedious recital of symptoms, was only equaled by the persistency with which he devoted himself to their relief. He left no stone unturned to accomplish his benevolent purposes. He was large-hearted, sympathetic and generous to a fault, and now and then was made the prey of ingenious schemers, through an excess of misdirected sympathy. His social feelings were strong and his acquaintance grew in many directions. He was prominent in the Masonic order, reaching the highest degree attainable in a very short period, and devoting much time and energy to the subject while his interest lasted. He was an active member of the Association from 1851 until a short time before his death, and was President for three years. When in good health he was usually present, and took a leading part in the deliberations. During the war he was appointed inspector of hospitals, and made a tour of service in the west. In 1872, he made a brief visit to Europe. A few years since, by the influence of the German Consul, he was presented with the decoration of an order of nobility for his humane treatment of an insane German citizen in Boston. He was a member of numerous medical societies.

Dr. Walker was buried with Masonic honors and his funeral was attended by many of those whose physician, friend, or benefactor he had been. Many a depressed and despairing sufferer whose burden he had lightened or removed has reason to bless his memory and to mourn his loss.

Dr. Jesse P. Bancroft was born in Gardener, Mass., April 17, 1815. Like many New England farmers' sons of that day, he felt the yearning for a higher education, and not possessing the requisite means, was obliged to earn for himself by teaching and other methods, the necessary funds for a collegiate and professional education. As is often the case, the earnestness of purpose and character developed by this early struggle were reflected through all his latter life. He fitted for college at Andover, Mass., entered Dartmouth College in 1837, and graduated from that institution in 1841. He
studied medicine with the late Prof. E. R. Peaslee, of New York, and graduated from the Dartmouth Medical School in 1844. During the period prior to his medical graduation, he was demonstrator of anatomy in Brunswick Medical School. In 1845, he commenced the practice of medicine in St. Johnsbury, Vermont. He soon developed a large general and consultation practice, and during the twelve years he remained there acquired an extensive reputation as a practitioner, and a high character in the community.

A growing interest in psychological study led him to look with favor upon a call made to him by the trustees of the New Hampshire Asylum, to become superintendent and treasurer of that institution. On July 15, 1857, after much reflection and against the importunities of his numerous friends and patients in St. Johnsbury, he gave up general practice, and accepting the position offered him, entered upon the special study and practice of psychological medicine.

Dr. Bancroft's subsequent life is practically identified with the history of the New Hampshire Asylum, with its early struggles and final success, and with the advancement of better methods in the care and treatment of insanity. In this latter particular he acquired not only local, but national reputation. When Dr. Bancroft came to New Hampshire he found a general indifference to the cause of the insane, as well as a woful lack of funds with which to develop the institution and supply proper remedial treatment for the patients committed to his care. He recognized that each case of insanity must be studied by itself, and in order that every measure of treatment, medicinal and moral, might have its full effect, the environment of the patient must be so modified as to contribute to its recovery. All the interesting problems of mind, with its innumerable demands in disease, confronted him at this very time, while surrounded with perpendicular walls of stone and brick and with limited means at his disposal. To the task of alteration of old construction, Dr. Bancroft bent himself with untiring energy. By avoiding anything like useless expenditure, skilful financiering and judicious appeals to legislative committees, together with generous donations from individuals who recognized the urgent needs of the institution, he entered upon a successful plan of development and new construction that began, soon after he assumed charge of the institution, and terminated only with his resignation.

Dr. Bancroft was an eminently practical man, richly endowed with that greatest of all Nature's blessings—good common sense. For this reason he made an admirable asylum superintendent. He carried all the innumerable needs of a large institution in his mind, and never allowed one interest to preponderate over another, but persistently labored until the ends that were of greatest practical benefit to his patients were fulfilled.

Dr. Bancroft was a close observer and a diligent student. For this reason his opinion was frequently sought in his own and adjoining States, both in consultation and in medico-legal cases. He gave to every case fair and impartial study, and never expressed an opinion until he had thoroughly surveyed the case in every aspect and demonstrated, satisfactorily to himself, the correctness of his position. He was most conscientious in the study of criminal cases where a plea of insanity had been raised. It early became a
rule with him never to accept a position upon a case which he could not conscientiously maintain. He regarded the preservation of his own reputation and a strict adherence to a truthful presentation of the medical aspect of a case, of far more account than the acceptance of an expert's fee.

"For three years I was with him as his chief assistant, and I came to know him thoroughly as a man of breadth of judgment and untiring industry, and most eminently successful in the management of his hospital." (Godding.)

"He was especially clear and comprehensive in his grasp of principles which underlie the care of the insane, and particularly conscientious, efficient and successful in applying them to the work in hand." (Eastman.)

"Dr. Bancroft was a man who averaged well all round. He was a good physician, an able manager of an asylum, and was rather, it seemed to me, exceptional in his ability to provide for the individual wants of his patients. He was greatly interested in and excelled in hospital architecture." (J. P. Brown.)

"Every good and generous work had his sympathy and, as far as practicable, his support. He labored long and earnestly that the pauper insane of New Hampshire might become the wards of the State. Few things ever gratified him more than the enactment by the Legislature of the law which made them such. Affability and delicacy, integrity, patience and sweetness were so interwoven with every feature of his mental composition that they became parts of it." (Report of the Trustees.)

On the 30th day of April, 1891, Dr. Bancroft peacefully passed away. His last illness dated from an attack a year and a half before his death, while presiding at a meeting of the New England Psychological Society. Although stricken with what he knew must be a serious if not fatal sickness, with heroic calmness and a characteristic presence of mind he put the motion for the meeting to adjourn, and was carried to his hotel by tender hands. He gradually rallied and, though unable to enter into active work, never for a moment, until the day of his death, lost his interest in passing events or whatever transpired in the specialty he loved so well.

Dr. Charles H. Nichols was born in Maine in 1820. He received his education at the Friends' School at Providence, R. I., and graduated from the medical department of the University of Pennsylvania in 1843. He was appointed assistant physician of the State Lunatic Asylum at Utica, N. Y., in 1848, and received the appointment of superintendent of the Bloomingdale Asylum in 1849, which he resigned in 1852 to accept the superintendency of the Government Hospital for the Insane, at Washington. He prepared the plan and superintended the construction of that hospital, and directed its affairs with great ability and satisfaction to the Government until his resignation in August, 1877, when he received the appointment of superintendent of the Bloomingdale Asylum.

It may be mentioned as an interesting fact in connection with his position as superintendent of the Government Hospital for the Insane, that a strong effort was made in 1853 to remove him from that position. The Association met that year in Baltimore, visited Washington to examine the site
chosen for the hospital and called on President Pierce, who had for several years been one of the trustees of the Asylum for the Insane at Concord, N. H. The President received the members in the most courteous manner and showed them through the White House and grounds. As the members were leaving the President requested Dr. L. V. Bell to remain and take dinner with him. The members believed that that visit and the interview of Dr. Bell were the means of preventing the execution of the plot which had been laid for the removal of Dr. Nichols.

On assuming charge of Bloomingdale Asylum, Dr. Nichols devoted himself with his accustomed energy and assiduity to the erection of new buildings and the improvement of the whole institution, and when it was determined to build a new institution at White Plains, he was requested by the managers of the Asylum to visit Europe and examine the different institutions there with the view of adopting the best plans which could be devised for the new Bloomingdale. He sailed from New York on July 7, 1889, and visited and took careful notes of various institutions in Great Britain and on the continent, returning to Bloomingdale on November 1, 1889. He died December 16, 1889.

"He was interested in all that concerns the advancement of civilization and the highest interests in society in general, and also, and especially, the weaker members of the body politic.

"He had a happy faculty of meeting men and numbers of men, and though not fluent in the use of language, yet he was fortunate in the selection of what was largely appropriate to the occasion; it expressed accurately the thought of his own mind and was generally to the point. His method of viewing questions which came for consideration extended to their different relations and bearings, and he presented what he had to say in such a manner that when he had finished it appeared very reasonable. His very presence, his bearing, his open and frank countenance, his self-poise, all gave emphasis and added interest to what he might have to say. Another element of this all-roundness of character consisted in the thoroughness with which he did what he undertook. He was not willing to trust to mere impressions, or to the reports of others. It was necessary for him to examine for himself and be satisfied that things were done in the best way, as he understood that way.

"We have a remarkable expression of this quality of thoroughness in his character, in his notes on hospitals which have now been submitted to us and which we may regard as a sort of legacy by will from him to us. What excellence of self-sacrificing character do they indicate, when we recall under what bodily conditions of suffering they were made. In his seventieth year, with an organic disease of such a nature that he was scarcely, if at all, ever without a large degree of pain, and an attendant weakness so great as to preclude his walking except what was absolutely necessary while passing through the different institutions he so laborously visited and studied; and yet with a will so strong and a desire so great to do the work which had been given him to do for the institution over which he presided, and for the class of unfortunates with whose misfortunes he had so closely linked his life, that he never for a moment faltered. He struggled on in pain and weariness at times so great as to produce prostration, through labors sufficient to fatigue the
strongest man, till he again rested in his home with the work he had undertaken finished.

"He was frank, sincere, open-handed, open-hearted, high-minded and a thoroughly manly man. A personality appreciative of truth, honor, virtue, and all that makes for righteousness in one's self and others, enshrined in such physical endowments, it seems to me fairly represents that of our late associate, Dr. Charles H. Nichols." (H. P. Stearns.)

"His personal presence not inaptly prefigured his mind; he was a large man every way. He spoke with deliberation, but when his sentence was rounded to its close it was found that his deliberation meant something, that his point was made and that he had gone over the whole ground. His views were broad, his judgment remarkably sound; his mind handled topics exhaustively and being unusually well informed in very much outside of his profession his opinions were of value on whatever subject expressed. When his mind was made up on anything, he had an opinion and was ready to state it when asked. In this he was not aggressive, but his convictions were strong and when aroused there was no question but what he had the courage of those convictions. His mind, while healthily conservative, was always in advance and the farthest from fossilization. His life, a most active one, was devoted to the interests and the care of the insane, and there are fitting monuments to that life which are better than marble and that will remain." (W. W. Godding.)

Dr. Edward Jarvis was born in Concord, Massachusetts, on January 9, 1802. He graduated at Harvard College in 1826 and took his degree in medicine in 1830. He practiced medicine two years in Northfield, Mass., five in Concord, Mass., and five in Louisville, Kentucky, with but moderate success. His tastes inclined to the study of mental science and anthropology and he lacked confidence in the effects of his remedies. He was early interested in the cause of education and started public libraries in Concord and Louisville. In 1836, while at Concord, he received an insane young man from Cambridge into his house for treatment. Several other patients were afterwards received and he then became interested in the treatment of insanity, which specialty he resumed at his home in Dorchester and continued for many years successfully. Dr. Jarvis was disappointed several times in obtaining the superintendency of certain hospitals for the insane in Massachusetts, for which position he brought the highest recommendations and for which his tastes strongly inclined him. He felt these disappointments keenly but was not deterred from pursuing his favorite studies, as far as possible, in the community at large.

In 1840 his attention had been directed to the apparently excessive amount of insanity among the free colored population of the North. This excess had been used by Southern statesmen in Congress to show the probable effect of emancipation upon the negro. Dr. Jarvis showed that the census of 1840 was grossly in error in this respect. His aid was solicited in preparation for the census of 1850, and, without official authority, he gave one-third of his time for three years to perfecting the reports. In 1874 the government acknowledged his claim by paying for his services. He was
again employed on the census of 1860 and 1870 and became the leading authority on vital statistics, and was recognized as such at home and abroad.

In 1854 the Legislature of Massachusetts appointed a commission consisting of Messrs. Levi Lincoln, Increase Sumner and Dr. Jarvis, to inquire into the number and condition of the insane and idiots in Massachusetts, and the report of that committee, prepared by Dr. Jarvis, is a monument of his laborious zeal and patient, pains-taking investigation into the number of insane and idiots in Massachusetts. The Hospital at Northampton was erected in consequence of their recommendation.

In 1849, he became a member of the corporation of the School for Idiots in Boston, and in 1849, was appointed physician to the Institution for the Blind. He continued to be associated with Dr. S. G. Howe, in the supervision and care of these two institutions for many years, his services being largely gratuitous.

In 1860, Dr. Jarvis visited Europe, where he traveled extensively to look after an insane patient of wealth, who was accompanied by his family. He was commissioned a delegate to the International Statistical Congress in London, where he made the acquaintance of many distinguished foreign physicians and alienists. He was chosen one of the two vice-presidents on that occasion. In 1874, his labors were suddenly arrested by a stroke of paralysis. He remained in comfortable health, however, till October 20, 1884, when a second attack occurred which terminated fatally on October 31, 1884. His wife died the second day after, and they were both buried on the same day, in their native town of Concord.

Dr. Jarvis' writings were voluminous and embraced a wide range of subjects. His papers on vital statistics, hygiene and insanity, number over one hundred and fifty. He wrote, also, a school physiology, which was translated into Japanese and is in use in Japan.

He was a member of many learned scientific societies. Of a kind, genial, social disposition, he was always ready to impart of the treasures of a mind well stored with various knowledge to those who met him. He had the manner of a scholar, absorbed in the consideration of important and beneficial schemes, and while constantly seeking information from others he was equally ready to impart what he possessed to them.

*Dr. George Chandler* died May 17, 1893, at the age of 87 years. Nothing definite is known of his history except that he was superintendent of the Insane Asylum at Concord, N. H., from March 6, 1842, the date of his appointment, until his resignation in 1845. He was appointed superintendent of the State Lunatic Hospital at Worcester, Mass., on the resignation of Dr. S. B. Woodward, on July 1, 1846, and resigned on April 1, 1856. He spent his time after his resignation in travel and biographical work.

He was social and pleasant, quiet and undemonstrative in his manner, cheerful and agreeable among his patients.

*Dr. R. J. Patterson* was born in Mt. Washington, Massachusetts, Sept. 8, 1818. After an academic education he graduated from the Berkshire Medi-
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cal Institution at Pittsfield, Mass., in 1842. He began his professional life as an assistant physician in the Insane Asylum at Columbus, Ohio. On July 1, 1848, he was appointed superintendent of the Indiana Hospital for the Insane, resigning that position on June 1, 1853; and on July 6, 1860, was appointed superintendent of the Hospital for the Insane at Mt. Pleasant, Iowa, and resigned on October 1, 1865, and in 1866 he established Bellevue Place at Batavia, Illinois. He was for seven years Professor of Medical Jurisprudence in the Chicago Medical College. He died on April 27, 1893.

The profession had great confidence in the ability and faithfulness of Dr. Patterson; the community in which he dwelt for so many years always looked upon him as a man of power and character, and the unfortunates under his charge at once recognized the force which kindliness and understanding combined to produce.

Dr. Horace A. Buttolph was born in the township of Northeast, Dutchess County, New York, on April 6, 1815. When he was but a youth, the family moved to Pennsylvania, but after a few years they returned to Dutchess County, where the son attended school till the age of fourteen, when he became an inmate of the family of a maternal uncle, Dr. Charles McAllister, of South Lee, Berkshire County, Mass. During his residence there he became a pupil in the Stockbridge Academy, where his early education was completed. Later he devoted his time in part to the study of medicine under the direction of his uncle, to teaching school, and in the advanced stage of medical studies to assisting his uncle in his professional duties. He graduated at the Berkshire Medical Institution at Pittsfield, Mass., Dec. 15, 1835, after having attended three full courses of lectures. Early in the year 1837, he located for general practice in Sharon, Litchfield County, Conn., where he resided five years. Toward the close of that term, in 1841-2, as a means of further medical improvement he passed the winter in attending medical lectures in the University of New York.

"I entered upon the duties of an assistant physician, (Dr. Amariah Brigham, Medical Superintendent,) in the State Lunatic Asylum at Utica, New York, at the date of its opening for the admission of patients, on the 16th of January, 1843, where I remained, acting a portion of the time both as assistant and apothecary, until the spring of 1847. During the year 1846, with the view of enlarging my sphere of observation in reference to asylum architecture and management, I visited about twenty of the principal institutions for the insane in Great Britain, France and Germany.

"Having received the appointment of medical superintendent of the New Jersey State Lunatic Asylum, near Trenton, then in process of erection, I moved to that city in the spring of 1847 to engage in the duties of the office. The building, at the time, was but partially enclosed, and an entire year was required for its completion, and for the arrangement of the various fixtures and the supply of furniture prior to the admission of patients, who were received on the 15th of May, 1848.

"At that period more difficulty was experienced in procuring the best adapted fixtures than at a later date, though it is perhaps worthy of men-
tion that the Trenton Asylum was the first under State control to be warmed by indirect radiation from air chambers heated by steam. Prominent among the sources of embarrassment in this State at that period, and for several years later, was the stringent condition of the State finances, there having existed to date and for some years after a constitutional prohibition against the creation of a State debt exceeding one hundred thousand dollars, united with hesitation and delay in many instances, even in the appropriation of small sums as they were required by the institution at that stage of its existence.

"After some years this state of things was changed, when appropriations were made from the State Treasury to the amount of two and a quarter millions for the establishment of the second institution at Morris Plains.

"As is well known, the asylum buildings at Trenton were very plain with an original capacity for about one hundred and fifty patients. By two extensions, however, in the course of several years, it was made to accommodate six hundred patients and their attendants, while some hundreds more were crowded into it before room was provided for them elsewhere. The period of unbroken service rendered to the State in this institution was twenty-nine years, or from April 1, 1847 to April 1, 1876.

"Some time prior to the close of this engagement I was employed by the State as one of a commission to select a site for another asylum building, and by the aid of an architect, Samuel Sloan of Philadelphia, to prepare plans, estimate of costs, &c., for its erection. The completion of this work, however, was effected by a second commission a few years later, though the plans of building before made, with slight exception, were adopted.

"The capacity of the building as planned was for six hundred patients and their attendants. During the course of its erection, however, it was determined by the commissioners and others to finish a fourth or additional story for the use of patients, thus increasing its capacity to eight hundred. This structure was built of gneiss in broken range work, largely fire-proof and presented in its extent and outline a highly imposing appearance, while its outfit of the various working fixtures, machinery, &c., was equal to the best of those furnished at that period. As the time approached for its completion and use, I was solicited, indeed, urged to take the place of medical superintendent when it was opened, which occurred on the 17th of August, 1876.

"Having passed nearly nine years in charge of this institution, I left it on the last day of December, 1884, thus making the period of my service in the two States of New York and New Jersey, forty-two years less sixteen days."

It is only just to Dr. Buttolph to say what he has not said of himself, that his retirement from the superintendency of the Asylum at Morris Plains was an enforced one, caused by political intrigue.

Since leaving the asylum, he has been residing at Short Hills, Essex County, N. J., devoting himself to literary work and to whatever he can do for the welfare of the insane, in whom he still feels a lively interest.

Dr. John Fonerden was born in the city of Baltimore, in the year 1802. He commenced the practice of medicine in that city, and in the earlier portion of his professional life devoted himself especially to midwifery, and became in
his line one of the most popular and most reliable practitioners of the city. He was elected resident physician of the Maryland Hospital in June, 1846, and continued in that position until his death in April, 1869, greatly respected and esteemed by all who knew him.

Dr. D. Tilden Brown was born in Boston, Mass., in August, 1822. When six years of age his parents moved to New York city, which became his home for the greater part of his life. His academic education was acquired at a celebrated school in Poughkeepsie, and at the Washington Institute. He pursued the study of medicine in the office of Dr. Willard Parker, and graduated at the college of Physicians and Surgeons in 1844. When scarcely twenty-two years of age, he was the senior medical officer of the City Asylum on Blackwell's Island, under the general superintendency of Dr. McClelland who resided at Bellevue Hospital. For one year he was medical assistant in the Vermont Asylum and for a like period in the State Lunatic Asylum at Utica, which latter position he resigned to engage in practice with Dr. Parker.

The health of Dr. Brown compelled him to relinquish the general practice of medicine and induced him to become the agent of several business men who where endeavoring to open a way across Central America for the rush of emigration to California, in 1849. By reason of his familiarity with the Spanish language, he was brought into direct relations with the authorities with whom he had to treat. He explored the several routes which have since become well known, and ultimately negotiated the first treaty for transit across the Isthmus of Nicaragua. His efforts brought fortunes to others but not to himself.

In June, 1852, he assumed the charge of Bloomingdale Asylum, made vacant by the resignation of Dr. Nichols. Dr. Nichols was the successor of Dr. Brown at Utica, and his predecessor and successor at Bloomingdale.

Dr. Brown prepared the plan of the Shepard Asylum at Baltimore.

He resigned his position at Bloomingdale in January, 1877, and went abroad for his health. He died in 1890.

As a medico-legal expert he stood in the first ranks. His judicial mind made him an expert in the highest sense of that term. At the request of the court and the contending parties to a suit in which the question of insanity was involved, he examined most voluminous testimony, assured that his conclusion would be accepted. Upon taking the stand at the appointed time, he proceeded to sift and weigh the evidence with such clearness of judgment as to secure the willing assent of the entire audience. The judge, in complimenting the expert from the bench, said it was the most remarkable weighing of evidence he had ever witnessed, and in view of the fact that it was done in the exact order in which the testimony was given and without note to refresh the memory, was marvelous.

Dr. Henry M. Harlowe was born in Westminster, Vermont, April 19, 1821, and died in Augusta, Maine, on April 5, 1893. After pursuing his academic studies at several academies in Massachusetts and Vermont, and teaching for a time, he attended medical lectures at Harvard Medical School and at
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the Berkshire Medical Institution at Pittsfield, Mass., where he graduated. He entered the Vermont Asylum for the Insane, then under Dr. Wm. H. Rockwell, shortly after graduation. In the spring of 1845, upon the resignation of Dr. Isaac Ray, Dr. Harlow was appointed assistant physician of the Maine Insane Hospital, under Dr. James Bates. He ably filled the position of assistant physician until the conflagration which occurred during the winter of 1850, which resulted in destroying almost the entire hospital. Immediately after the fire, the superintendent was instructed by the trustees of the institution to visit the various hospitals in the New England and Middle States, for the purpose of devising improved methods of construction. This procedure left Dr. Harlow as acting superintendent, and, upon the resignation of Dr. Bates which took place a few months subsequently, Dr. Harlow was appointed his successor, which position he held uninterruptedly for thirty years.

For a long period the demands made upon his physical and mental strength were excessive, in devising means and methods in re-building and re-constructing the new institution from its former ashes. Although the labor to be performed was great, yet with unflinching courage, and in the face of many obstacles, he commenced his task. From this period until 1870, the doctor's energies were entirely engrossed in providing for the increased demands for the treatment and care of the insane, in the construction of additional wings, in the introduction of new methods of heating and ventilation, and in the building of rear centre structure and farm buildings. Imbued with indomitable energy, keen perception and a sympathetic nature, he was a man excellently well qualified to care for those bereft of their reason. He was a person possessed of great love for his specialty, was kind yet firm in his discipline, and impressed his patients with the belief that he was seeking their best good, and invariably held the respect and love of the many patients who came under his care.

Dr. John P. Gray was born on August 6, 1825, in Centre County, Penna. He was educated in the common school, in Bellefonte Academy and Dickinson College, and received his medical degree from the University of Pennsylvania, in 1848. After a period of two years' service in the Philadelphia Hospital he was chosen, on account of his qualifications and ability, assistant in the State Lunatic Asylum at Utica, N. Y., and in July, 1854, was elected superintendent.

Accepting unreservedly the view that insanity was a physical disease, the medical care of patients assumed the highest importance; to the strictly medical treatment of insanity he gave special consideration. The moral treatment, by employment, amusement and mental occupation, was early given a prominent place. His labors were always in the direction of progress, both in material improvement and administration, as well as in the treatment of patients.

In accordance with his steady and persistent urging, the Superintendents of the Poor, in 1856, passed resolutions that the State should make ample provision for all its insane, who were not in condition to reside in private families; that none should be cared for in any county poor and almshouse;
that the proper classification demanded for the care of the insane could only be secured in establishments constructed with special view to their treatment; and that the curable and incurable should not be cared for in separate institutions.

He also urged and succeeded in securing the removal of children from the poorhouses to the various orphan asylums, and their support in them at public expense. The separation of the convict and criminal insane from other patients and treatment in an institution constructed with special reference to their isolation and safe keeping, were largely due to Dr. Gray.

He was one of the Commission to locate both the Willard and Buffalo asylums, for the latter of which he furnished the plans, and was one of its board of managers until it was in full operation.

Dr. Gray regarded physical causes only as producing insanity. Insanity, a physical disease, due to strictly physical causes, was one of the distinctive features of his belief and teachings.

Dr. Gray was the first in this country to recognize the importance and to introduce special investigation into pathological conditions existing in insanity, and to the Utica Asylum belongs the credit of having the first special pathologist on its official staff.

However great the success and credit Dr. Gray deservedly gained for his labor in the directions already mentioned, it was in the field of medical jurisprudence, as an expert in insanity, that he attained the greatest triumphs of his life.

Dr. Gray also achieved success as a lecturer in insanity. For some years he occupied the chairs of Psychological Medicine and Medical Jurisprudence in the Albany and Bellevue Medical Colleges.

More than any other person, Dr. Gray shaped the lunacy legislation of the State of New York, and it is largely to his influence with the commission appointed to codify and revise the law, that we owe the present lunacy statutes, which surpass in many respects those of Great Britain, upon which they were in part modeled. In matters pertaining to other dependent classes his influence was also felt, as his advice was often sought by the boards of managers having charge of the various charities, reformatories and prisons, by legislators, judges and officials.

Dr. Gray died at Utica, New York, on the 29th day of November, 1886, at the age of sixty-one years. The initiatory cause of his final illness was the result of an attempt made by an insane man to assassinate him, in March, 1882, immediately upon his return from Washington, at the conclusion of the trial of Guiteau for the murder of President Garfield. The bullet passed through his face, under the floor of the nose, paralyzing some of the nerves of the face and mouth, and producing stenosis of the nasal passages, which seriously interfered with his breathing. It also caused a neuralgia from which he was, for a long time, an almost constant sufferer. This injury, with the nervous strain and responsibility of the protracted trial, combined with the continued performance of the duties of his position in the asylum, perceptibly impaired his health and were powerful factors in producing the fatal results. In January, 1886, the board of managers of the Asylum, gave him a leave of absence for six months. A portion of this period
was passed in the South, and the remainder in a foreign tour, undertaken in the hope of improving his health. He returned in October, seemingly benefited by the change, and again resumed his labors, but under peculiarly trying circumstances. Early in November business called him to Baltimore, whence he returned much prostrated, and suffering from a recurrence of the disease which was so soon to prove fatal. From this time it was evident that little hope could be entertained of his recovery. He slowly failed, from blood poisoning, induced by disease of the kidney, and died in uraemic coma.

In looking over his life-work, there is a richness of labor and a fullness of success that rarely fall to the lot of man. In all the fields of action in which he bore a part, as the head of a great charity, a medical jurist, a lecturer, as the editor of the Journal of Insanity, as a physician, a citizen and a friend, there were the evidences of great power, of strength of character, and generosity of disposition, which were the elements of his success, which made him beloved, and which made his death a serious calamity to the community, to the profession and to his friends.

Dr. Joseph Allison Reed was born in Washington, Penna., December 31, 1823. He graduated from Washington College, and received the degree of Doctor of Medicine from Jefferson Medical College in 1847.

He settled in Allegheny city and for three years was physician to the Western Pennsylvania House of Refuge, and for two years visiting physician of the Department for the Insane of the Western Pennsylvania Hospital, in Pittsburg.

In 1857, he was elected to take charge of the institution. He exerted himself with the managers and others to secure the establishment and erection of a separate institution for the insane, and the Western Pennsylvania Hospital for the Insane at Dixmont, Penna., was the result of their joint labors. This was opened for the reception of patients in 1862. Dr. Reed was elected Superintendent and continued in that position until his death on Nov. 6, 1884. He was consulted by the State authorities on all subjects relating to the care of the insane; was a member of the commission for the erection of the State Hospital for the Insane at Danville, and was appointed by Governor Hoyt, one of the commission to investigate and report upon the laws of the State relating to the insane, and assisted in framing the present law in relation to the care of the insane.

His chief characteristics were patient devotion and indomitable energy. He was controlled by high and unswerving principles, and let nothing influence him to step aside from the path of duty which he had marked out for himself.

Dr. John C. Hall was born March 12, 1843, near Harrisville, Ohio, and until he was twenty years of age, resided in his native State.

In 1863 he attended Westtown School in Pennsylvania, and leaving there in 1866, was engaged as clerk at the Friends' Asylum, Frankford, Philadelphia, and attended lectures at the Medical Department of the University of Pennsylvania, from which he graduated in 1868. Shortly after he received an appointment at the Philadelphia Hospital and, subsequently, acted as associate with Dr. Maris at the Philadelphia Dispensary.
In 1870 he commenced the practice of medicine, holding at the same time the position of visiting physician to the Jewish and Episcopal Hospitals. In April, 1876, he was appointed assistant physician of the Friends' Asylum, and in the fall of the year 1877, succeeded Dr. Worthington as superintendent and held this position until his death on July 4, 1893.

Dr. Hall was earnest and devoted in all his work for the cure and welfare of the insane, and labored earnestly to place the institution of which he had charge in the best possible condition to meet the wants of those who were committed to his charge, making many changes in the building to have it conform to the more recent views and adding many things in various ways to give amusement, occupation and diversion to those under his charge.

*Dr. Andrew McFarland* was born in Concord, N. H., on July 14, 1817. He gave great promise and was given every facility for improving his mind. He graduated at Dartmouth College in 1843, and graduated at Jefferson Medical College, in Philadelphia, in 1845.

He was appointed superintendent of the Insane Asylum at Concord, N. H., on August 26, 1845, and resigned July 30, 1852. He spent some time in Europe in the examination of hospitals, and on his return he engaged in general practice for a short time and was elected superintendent of the Central Illinois Hospital for the Insane on June 16, 1854, and resigned Dec. 8, 1869.

After his resignation he established Oak Lawn Retreat, at Jacksonville, Illinois, on May 10, 1872, and managed that very successfully until a short time before his death, when he transferred the charge to his son, Dr. Geo. C. McFarland.

He had charge of the insane of Wyoming and other Western States and had great confidence reposed in him. He died November 22, 1891.

He was very social and genial, with more than ordinary ability as a writer, and gave himself with whole-hearted devotion to the duties that devolved upon him.

*Dr. Richard Gundry* was born at Hampstead Heath, England, on the 14th day of October, 1830. At the age of fifteen or sixteen he removed with his father to Canada. He had been looking forward to the study of law previous to his removal to Canada and had shaped his studies with that in view. After his removal, he renewed the study of law at Simcoe, Ontario, and soon thereafter began the study of medicine with Dr. Coverton. Subsequently he entered the medical department of Harvard University, from which he graduated in 1851, at the age of 21. He commenced the practice of medicine at Rochester, N. Y., but soon receiving a legacy on condition that he would spend a certain time in traveling, he spent about two years in Europe, returning in 1853. He renewed his practice at Rochester, N. Y., and was engaged in that during the cholera epidemic of that year. He was prevailed upon by one of his cholera patients to remove to Columbus, Ohio, which he did, probably, in the fall of 1853. He was soon connected with a medical journal at that place and lectured on anatomy and clinical medicine in Starling Medical College. On August 4, 1855, he was appointed
assistant physician to the Columbus Insane Asylum. He accepted the
position at first, temporarily, to take the place of an assistant who had gone
for a few months' visit to Europe. By such seemingly slight accidents of
environment was his future professional course determined. The assistant
did not return and Dr. Gundry remained in the position, lecturing, mean-
while, at the Starling Medical College, until the year 1858, when he was
transferred to a similar position in the new insane asylum at Dayton. In 1861,
he was promoted to the medical superintendency of the institution at Dayton.
He continued in that position until the year 1872, when he was called to assume
charge of the completion and opening of the new insane asylum at Athens,
Ohio. This he successfully completed and opened in the spring of 1874, and
remained its superintendent until January, 1877, when he was again called
to the responsible task of opening the new insane asylum at Columbus,
Ohio. The old institution, in which his labors in the specialty were begun,
was destroyed by fire, and it had been reconstructed on an enlarged scale
and in a degree of magnificence at that time seldom seen in similar institu-
tions in this country or elsewhere. Here, as in the other institutions of
which he had had charge, he displayed the same skill in organization.
The growing spirit of partisanship did not permit him to remain long un-
disturbed in this position, however, and in May of the following year, 1878,
he was forced to retire.

No more disgraceful exhibition of partisan politics was ever made than in
the enforced retirement of Dr. Gundry from the superintendency of the
Insane Asylum at Columbus. The Trustees insisted on his retirement
while, at the very time, they passed a series of resolutions commending his
faithfulness in the discharge of his duties, his great ability as a superin-
tendent and his learning, coupled with the personal statement, humiliating
to them as men, that they were compelled to the course they took by the
dictates of partisan politics.

Immediately on his forced retirement from this institution, he was offered
and accepted the medical superintendency of the Maryland Hospital for the
Insane, at Catonsville, Maryland, near Baltimore. Here he remained in the
same position until his death, which occurred on the 28th of April, 1891. At
the latter institution, the same progressive spirit was manifested, and with
his coming the institution at once took on a new life in all its departments.
His kindly sympathy for the afflicted and his humane and progressive spirit
manifested themselves in the allowance to each patient of the utmost degree
of liberty that was consistent with safety. Dr. J. Pembroke Thom, presi-
dent of the board of trustees of the Maryland Hospital for the Insane, uses
the following language: "It always gives me pleasure to call to memory
Dr. Richard Gundry. For many years he and I were associated, he as
superintendent and I as a visitor. When I became President of the Board,
our intimacy became greater, and I am frank to say the more intimately I
knew him the more my admiration for his intellect, his wonderful memory,
his urbanity of manner, his kindness of heart and his earnest desire to help
the weak and afflicted of all sorts and kinds, impressed me. When he first
came to the Maryland Hospital, all the mechanical appliances known to the
inventive mind were in vogue for the control and improvement of the
lunatic. He at once began the work of reformation and in a very short time abolished all such methods."

In 1880 he was appointed lecturer on mental diseases in the College of Physicians and Surgeons, of Baltimore, and in 1881, was also chosen Professor of Materia Medica and Therapeutics, in the same institution. He was one of the gentlemen instrumental in establishing the Maryland school for feeble-minded children, and was one of the directors at the time of his death. Dr. Gundry was a man of strongly marked individuality. He was an original thinker, independent and self-reliant, and possessed of that self-confidence which is not offensive, but comes from a knowledge of inherent strength. He had a keen sense of honor. His most unfriendly criticism of any individual was made in his presence. While by nature and training fond of controversy, and an adversary worthy of any honorable antagonist, he combated ideas, not persons.

As a conversationalist, Dr. Gundry had few superiors. Possessed of a retentive memory, and thoroughly conversant with history and biography, he was most interesting and versatile in the social circle. On going to Baltimore, he at once took a high position in the educational circles of that city of culture and refinement, and was the honored and highly esteemed companion of the brightest and best spirits among her professional men.

He adorned every position he was called to fill, and discharged the duties with commendable fidelity and thoroughness, and gave to all who were privileged to enjoy his friendship, the lasting impression of a man of high mental attainments, great versatility of talent, and warm-hearted devotion to every good work; ingenuous and true in all his instincts to justice and right.

Dr. William S. Chipley was born at Lexington, Kentucky, Oct. 18, 1810. He inherited a firm and vigorous organization, including a large and well-balanced brain, with great intellectual potentialities.

He received an academical education and afterward the degree of Doctor of Medicine (1833) from the Transylvania University. Soon after graduating, he commenced the practice of medicine in Columbus, Georgia, but returned to Lexington, Kentucky, in 1844, and limited his activities to the cultivation and practice of his profession. Successful as a practitioner and reputable as a man of learning, he was elected to the chair of Theory and Practice of Medicine in the medical department of Transylvania University, in 1853, and delivered the lectures from that chair until called to the position of superintendent of the Eastern Lunatic Asylum of Kentucky, at Lexington, in 1855. This position he occupied continuously for fifteen years, discharging the incumbent duties with ability and marked devotion to the interests of the insane as well as the interests of the State.

Personal and political exigencies compelled Dr. Chipley to resign the superintendency in 1870,—soon after which he opened a private hospital for the insane at Lexington, which he conducted until 1875, when he accepted the superintendency of the Cincinnati Sanitarium. Here in the successful discharge of professional duties, February 11, 1880, he died of structural disease.
Dr. Chipley was a man of imposing presence and dignified address. His characteristics were loyalty to duty, principle and personal friendships. He was fond of society, especially of men; choosing by preference persons younger than himself.

He was an earnest, intelligent, sincere, practical man and physician—a high-toned, patriotic citizen, and under all circumstances, a gentleman, in the American acceptance of that designation.

**Dr. John Woodbury Sawyer** died after a brief illness, on Dec. 15, 1885, at the age of fifty-one years. He was born in Danvers, Mass., November 5, 1834, and received his medical education at Harvard University, where he graduated as Doctor of Medicine in 1858. He was immediately by the selection of Dr. Ray, appointed to the office of assistant physician of the Butler Hospital for the Insane, at Providence, R. I., where he spent the first two years of his professional life. He then entered upon the practice of his profession in Boston, and after the lapse of a little more than a year, he was appointed assistant superintendent of the State Hospital for the Insane at Madison, Wis. He had been engaged in discharging the duties of that position for nearly six years, when, on the resignation of the late Dr. Isaac Ray, he was chosen superintendent of the Butler Hospital, and entered upon the duties of the office in January, 1867.

"From the day of his election to the day of his death, a period of nearly nineteen years, he discharged the diversified duties of this office with unremitting assiduity, with rare wisdom and distinguished success. The trustees recall with unqualified satisfaction and grateful appreciation, the various and laborious services which he has performed and his watchful oversight of its interests. In each of the several spheres of official service he has shown the utmost fidelity to every trust, a breadth of capacity and a soundness of judgment equal to every emergency, and withal a kindness of heart and an elevation of character which, in an unusual degree, have secured the esteem and the highest respect of those with whom he was associated.

"His manners were gentle and winning; his character was marked by singular modesty, united with great firmness of purpose, by rare good judgment, by manly independence, by self-denying benevolence and by unfailing devotion to the duties he was called to perform."

His death was undoubtedly traceable to injuries received from an insane man, whom he had been called to visit, and occurred a few days after the visit.

**Dr. Solomon S. Schultz** was born in Washington Township, Berks County, Penna., on July 5, 1831. His paternal ancestor had settled in that part of Pennsylvania in 1734, having been driven from the province of Silesia by religious persecution. After a thorough preparatory education he entered Princeton College, and graduated from that institution in 1852, and in 1855 received the degree of A. M. After graduation he taught school for a short time and then commenced the study of medicine with Dr. D. D. Detwiler, of Montgomery County, Pennsylvania. In 1856, he graduated from the
medically department of the University of Pennsylvania, and shortly after, opened an office for the practice of medicine in Allentown, Penna. In 1857, he was appointed assistant physician of the Pennsylvania State Lunatic Hospital at Harrisburg, Penna., and discharged the duties of that office with exemplary fidelity until 1862, when he entered the army as assistant surgeon. He had made, while connected with the hospital, a trip to Europe, spending several months in visiting hospitals for the insane and other places of interest in different parts of the continent. The war broke out while he was in Europe. The news came as he was ascending Mont Blanc with some English tourists. They had partly ascended the famous mountain and had slept one night at the Grand Mules, when another party of travelers coming up in the morning brought the news of the commencement of the American war. Dr. Schultz continued upward and accomplished, what very few Americans could boast of, the ascent of Mont Blanc. He hastened home and entering the army as acting assistant surgeon, he was subsequently promoted to be assistant surgeon and surgeon of Pennsylvania Volunteers, and assistant surgeon and surgeon of U. S. Volunteers, and was in constant service in hospitals and in the field until the end of the war. He was attached, successively, to the 75th and 23d regiments of Pennsylvania Volunteers.

He acted as surgeon-in-charge and executive officer, successively, of the general hospitals at Harrisburg, Penna.; Covington, Kentucky; Madison, Indiana, and Columbus, Ohio; being also in the latter place, superintendent of the hospitals.

In 1865, he resigned his commission as surgeon in the army and commenced the practice of his profession in Harrisburg, and was building up a successful practice when, in August, 1868, he was elected by the commissioners for the erection of the hospital for the insane at Danville, superintendent. He entered on his duties with characteristic earnestness and fidelity, giving the most devoted attention to all matters connected with the construction of that institution, and urged forward the work in spite of delayed appropriations, so that part of the building was ready for occupancy in 1872, when the first patients were admitted. He conducted all the complicated matters of that hospital in its construction and management in every way with singular fidelity, thoughtfulness and care, not only in regard to the welfare, comfort, happiness and restoration of the patients intrusted to his care, but in those parts of his duty which pertained to the administration of the trust, in connection with the Commonwealth and the various communities from which the patients were sent to the hospital. He was a man of acute sensibilities, and, as such, was greatly annoyed and distressed by the reiterated attacks on his management of the hospital, by those who knew little of his devotion to his duties and earnest effort to promote in every way the comfort and happiness of those committed to his care.

These attacks, many of them malicious in every respect, added to the mental strain of conducting, as successfully as he did, a large hospital for the insane, undermined his health. He was preparing for a rest and relief in the hope of regaining his health, when an unusual accumulation of
troubles and attacks depressed him to such an extent that he failed and
died on the 27th day of September, 1891.

Kind, gentle, sympathetic, of few words, but a warm heart; always
ready to do what lay in his power for his friends and for all who needed any
help and counsel he was able to give.

Dr. Mark Ranney was born in Vermont, in 1827. Receiving an aca-
demical education, and graduating from the Vermont Medical College in
1849, he was very shortly afterwards appointed assistant physician of the
Butler Hospital for the Insane, Providence, R. I. Here, under the care
and direction of that very able and distinguished man, Dr. Isaac Ray, he
remained until 1854, profiting by the experience, learning and extensive
professional attainments of that eminent alienist. Accepting a position as
assistant physician of the McLean Asylum, at Somerville, Mass., he
remained in connection with that institution until 1865, when he received
the appointment of superintendent of the Hospital for the Insane at Mt.
Pleasant, Iowa, to the discharge of the duties of which position he brought
the training, attainments and professional ability acquired by his long con-
nection with those institutions.

He remained in charge of the hospital at Mt. Pleasant until 1872, when,
on account of a series of various troubles and annoyances he resigned,
intending to spend a year in travel in Europe, but was requested to take
charge of the State Hospital at Madison, Wisconsin; and after remaining
there a year, was invited by a unanimous vote of the trustees, again to
take charge of the hospital at Mt. Pleasant. He died Jan. 31, 1882, after a
brief illness.

As superintendent of the hospital for the insane, lecturer on insanity to
the Iowa University, and in every position requiring the exercise of sound
judgment and clear convictions, under the guidance of correct principles
and a discriminating mind, he was always enabled to decide promptly and
judiciously what was really for the best.

Dr. Joseph Draper was born at Warwick, Mass., February 11, 1834. His
early education was obtained in the common schools, and in the academies
at Brattleboro, Vt., and Deerfield, Mass. After he entered upon the study
of medicine, he attended lectures at one of the medical schools in New York,
and also at the Jefferson Medical College, Philadelphia, where he gradu-
ated in 1858. After a considerable period in general practice, he became
an assistant of Dr. Rockwell, in the Vermont Asylum, where he remained
until January, 1865. He left this position for one of an assistant sur-
geon in the United States General Hospital at Brattleboro, in which he re-
mained a few months, and in May became an assistant in the State Asylum
at Worcester, Mass. He was also acting superintendent of that institution
for one year. In 1870, he became an assistant to Dr. Buttolph, in the State
Asylum at Trenton, New Jersey, where he remained until February, 1873,
when he was appointed superintendent of the Vermont Asylum, where he
remained until his death. After Dr. Draper was appointed superinten-
dent, he devoted himself to the conduct of the Asylum with a singleness of
purpose rarely excelled by any of his associates in the country. His first
and last thought related to its improvement and provision for the best treat-
ment of those who sought its care. His theory in reference to the number of
patients in an institution was that it should not be so large that the super-
intendent could not have the general oversight of each case and study it
clinically. No efforts were too great and no expenditure too costly in his
view, if they conduced towards securing the grand result to be sought in all
curable cases, viz.: recovery.

After Dr. Draper visited Scotland and Switzerland, he conceived the idea
of converting the highland nearest the institution into a park for his patients.
He entered with his usual enthusiasm on the work, and covered the park
with walks and roads leading to the top, from which one of the most charm-
ing views can be had of the Connecticut River Valley, for several miles to
the north and south. He then began the erection of a stone tower, to which,
during each summer, he added several feet, the work being done chiefly by
his patients, under the direction of a practical mason and engineer. It now
stands incomplete, though lacking only its crown. Near this mountain park
Dr. Draper secured two large farm houses, which he fitted up for summer
homes for such of his patients as could be placed in them, for limited periods,
with safety and advantage to themselves. It was thought that if change from
home for short periods is beneficial for sane people, much more so must it be
for certain classes of insane, whose only home is an asylum. These
houses command extensive views of meadow land and distant mountains,
and are arranged as nearly as possible like ordinary homes. They were the
first of the kind connected with hospitals in this country, and Dr. Draper is
entitled to much credit for his move in this direction.

Dr. Draper endeared himself, not only to those immediately associated with
him in his asylum work, but also to the community in which he lived, as
few other superintendents of asylums have ever been able to do. He thor-
oughly identified himself with its growth and interests. He was the prime
mover in establishing a society, whose main object was beautifying the vil-
lage which lies on the banks of the Connecticut, nestled close between the
mountains. These mountains he loved not only to look upon, but to ascend
and look from.

His friendships were strong and enduring. He hated sham in every way
His face and physique indicated how strong in purpose, how inflexible in
resolution he was. One needed to know him well to be able to form a just
estimate of his character; this required time. His modesty was so great that
it overshadowed and partially obscured some of the other excellences of his
mind. But to those whom he knew well he was a most genial and delightful
companion.

Dr. Peter Bryce was born at Columbia, South Carolina, on March 5, 1834,
and received an academic education at the South Carolina Military Academy,
where he graduated with a high grade of scholarship. Upon completing
his academic studies, he lost no time in entering the medical profession.
In 1859, he graduated as Doctor of Medicine in the medical department
of the University of New York. After receiving his diploma in this
college, he pursued his studies in Europe and especially in the hospitals of Paris. Upon returning to America, he became connected with the State Lunatic Asylum of South Carolina, and afterwards, for a short time, was assistant physician of the State Lunatic Asylum at Trenton, N. J. From this latter position he was called, in the year 1860, by the unanimous voice of the first board of trustees of the Alabama Insane Hospital, to the position of medical superintendent.

At the meeting of the American Medico-Psychological Association, in 1892, he was elected President though he was known to be in feeble health, but the hope was cherished that he would be so far restored as to preside at the meeting in 1893. Dr. Bryce died on the 14th day of August, 1892.

Earnest and faithful in all his work, with more than the usual endowment of mind cultivated by careful study and accurate observation, with a genial and cordial manner, he was endeared to all who knew him by the gentleness, suavity and dignity of his address, and the high and generous tone which he manifested.

Dr. George Cook was born at Cayuga County, N. Y., on November 20, 1825. He graduated at the Geneva Medical College in 1846, and soon afterwards became an assistant to Dr. Brigham, of the State Asylum for the Insane at Utica, N. Y. After the death of Dr. Brigham, he spent some time abroad, and upon his return assumed the duties of first assistant physician at the Asylum at Utica.

In 1855, in company with several members of his family he established Brigham hall, at Canandaigua, N. Y., which was reorganized in 1859, under a charter secured by a special act of the Legislature, and Dr. John B. Chapin became associated with him.

The institution was conducted with great ability and success. On the morning of June 12, 1876, while making his regular visit through the hospital, Dr. Cook was stabbed in the neck by one of the patients, and died in a few hours after.

Calm, quiet and gentle, in his manner, he was admirably fitted for the duty of managing and directing the care of the insane. With sound judgment, he was clear and decided in his convictions, cautious in his deductions, and his well disciplined mind enabled him to grasp clearly all the problems he was called to solve. Generous and noble-hearted, he won the esteem of those who knew him, and his death so sudden and violent was a source of great regret to all.

Dr. Thomas F. Green was born in Beaufort, S. C., on the 25th of December, 1804, and died in Midway, Georgia, on the 13th of February, 1879, of apoplexy. He was past his majority when he studied medicine and began to practice. He located in Milledgeville, Georgia, and was doing well as a physician, when the current of his life was changed and turned into a direction which was to be full of blessings to his race. A northern philanthropist, who was interested in the welfare of the insane, visited Milledgeville to suggest and advocate the establishment of an asylum for the insane. He called a meeting of a few gentlemen of broad views and generous hearts, and laid
his plans before them. The warm heart of Dr. Green became much interested in the great question presented, and he gave it close attention. He was connected with the first effort to secure the grant from the legislature. In 1846, he succeeded Dr. Cooper as superintendent of the asylum. He continued in the office for thirty-three years. He was full of life; cheerful, merry, courteous, considerate. He was a sincere Christian, in his home life a model, one of the most benevolent and unselfish of men. He was devoted to the institution; he literally lived for the asylum.

Dr. John Waddell was born in Truro, Nova Scotia, on March 17, 1810. The early part of his education was received at the Grammar School in Truro; subsequently he attended the Pictou Academy, where he spent several years, completing a full course of liberal culture. He spent one year in business but not finding that congenial he commenced, in 1834, the study of medicine, which he pursued at Glasgow for some time, and on October 18, 1839, he received his degree in London. He attended medical lectures in Paris during the winter of 1839-40, and returning to Truro in the summer of 1840, entered on the practice of his profession. After practicing nine years he was, in 1849, appointed medical superintendent of the Provincial Lunatic Asylum at St. John, New Brunswick, and entered on his duties on December of that year. In a pre-eminent degree, he possessed the qualities of mind and heart to insure success in his chosen field. His administrative ability was of a high order; he was prudent, practical and economical in his management. His fine personnel, gentlemanly bearing, suave manners and cheerful disposition, gained for him at once the confidence and esteem of his associates and the public as well.

He continued in the discharge of his duties as superintendent until May 1, 1875; a period extending upwards of twenty-six years, and during all that time he labored with great assiduity, and with marked success, in the medical treatment of the patients, the general management of the house, and in all that pertained to the prosperity of the institution.

At no time had he had the medical assistance which should have been granted to him in the care of the patients, and the long continued strain wrought to such an extent on his nervous system that he never fully regained his health and strength, but died on August 29, 1878.

Dr. Wm. B. Goldsmith was born in Bellona, Yates County, N. Y., on January 11, 1854. The common school of the village and home instruction, including his father's library, were his only educational advantages until, at the age of fourteen, he entered the Academy in Canandaigua, where he fitted for college. At the age of sixteen he entered Amherst College, from which he graduated in 1874, at the age of twenty. After graduating from Amherst he entered the Willard Asylum as a medical student and dispensing clerk, where he remained until the fall of 1875, when he matriculated in the College of Physicians and Surgeons in New York. He also spent at Willard the interval between the two courses of lectures he attended, and in the spring of 1877, he received the degree of Doctor of Medicine.

After spending a few weeks as interne at the Presbyterian Hospital,
Dr. Goldsmith, on the first of May, 1877, received the appointment of second assistant physician of the Bloomingdale Asylum. He resigned his position at Bloomingdale in August, 1879, and in September, sailed for England, where he spent first, about six months as a volunteer assistant to Dr. Major, of the West Riding Asylum, in Yorkshire; then a few weeks in study, mostly in London, and in travel, and finally held a volunteer position on the staff of Dr. Clouston, of the Royal Edinburgh Asylum, when he was invited to return to Bloomingdale to take the place of first assistant physician. He accepted the position, and returning at once from abroad entered upon its duties on September 15, 1880.

A vacancy having occurred in the office of medical superintendent of the Danvers State Hospital, Dr. Goldsmith was appointed to it, upon the strong recommendation of his medical and other friends, both in this country and in Great Britain. After being in charge of the Danvers Hospital for about two and one-half years, he offered his resignation, but the trustees persuaded him to withdraw it and accept a year's leave of absence. He spent the year in the study of German and French; the examination of institutions for the insane, and professional study, under Westphal, Krafft-Ebing, Charcot and others.

Returning from abroad in July, 1884, Dr. Goldsmith resumed the charge of the Danvers Hospital and continued to superintend it with increasing ability and usefulness till he entered upon the duties of superintendent of the Butler Hospital for the Insane, to which he had been elected by the trustees of that institution to fill the vacancy created by the lamented death, a short time before, of their former superintendent, Dr. John W. Sawyer. He entered upon his duties on the first day of February, 1886, and at the time of his death had discharged them with rare professional skill, unremitting assiduity and singular success, for the period of two years and nearly two months.

He died after a brief illness on March 14, 1888, and was buried in his native hamlet, at his own request.

He was a man of great ability, high honor, great moral and physical courage, a diligent student, an admirable administrator and a genuine friend.

Dr. Joshua H. Worthington, whose name was connected with the Frankford Asylum for the Insane, in Philadelphia, for about thirty-five years, was among those earliest interested in the treatment and cure of the insane. He was a firm believer in the importance of mild and gentle treatment as a means of cure, with as much liberty as possible and freedom from unnecessary restraint. He was born at Darlington, Harford County, Maryland, a few miles from Baltimore, in 1817. His father, a physician of large practice in the neighborhood, was desirous that his eldest son should have an education to fit him for future usefulness. In the country school which he attended, within a few miles of his home, he gained a good knowledge of Latin and Greek.

On reaching early manhood he left home and entered Jefferson Medical
College in Philadelphia, from which he graduated in 1837, and being under age it was some time before he received his degree.

An interval followed in which, returning home, he helped his father in the duties of his practice and also perfected himself in one or more additional branches connected with the same. A vacancy occurring among the officers of the Frankford Asylum, he was chosen to fill the place. Here his faithful performance of duties belonging to his position being recognized, he was advanced from time to time till at last he was appointed medical superintendent, which place he honorably and faithfully filled until November 1, 1877, when he resigned. He realized that retirement to private life and freedom from all professional cares would be wisest, as his health had become much impaired.

Dr. Worthington made several visits abroad for health and recreation, at such times visiting institutions for the treatment of insanity and becoming acquainted with medical men interested in this special branch of the profession. The latter years of his life were passed in the peaceful retirement of his home near Baltimore, and later near Philadelphia. He died in 1885.

Judicious in all matters connected with the insane, earnest and eager to advance their interests in every practicable manner, he labored faithfully and steadily to attain what he deemed just and right for those entrusted to his care. He was always pleasant and cheerful in his manner; noble, generous and kind-hearted.

"Dr. Worthington was a member of the orthodox branch of the religious Society of Friends, and his deeply earnest and faithful Christian life bore honoring testimony to the saving and Divine power of that blessed Saviour in whom he so fully trusted."

Dr. Edward R. Chapin was born at Salisbury, Connecticut, in 1821. His mother was early left a widow and, subsequently, married Dr. W. H. Rockwell, for thirty-six years the superintendent of the Vermont Asylum. Young Chapin was a youth of fifteen when he went to Brattleboro at the opening of the asylum there, in 1836. In 1838, he entered the collegiate course at Yale, but was obliged to abandon this after one year, on account of a trouble of his eyes. He became a student of medicine and graduated at the medical department of Yale in 1842. He was appointed assistant physician, the same year, at the Maine Insane Hospital, then superintended by Dr. Ray, which position he held for one year. He was then, for two years, connected with Bellevue Hospital and subsequently, for four or five years, located in practice in New York.

In 1849 or 1850, he went to California as surgeon on a Panama steamer, and remained for two years or more in San Francisco, connected with a city hospital there, during which period he improvised, in connection with the city hospital, some accommodation for the insane, which constituted the first public provision made in that State for this class.

Returning from California he was for a year or two in service as surgeon on Atlantic steamships, and in 1855, entered the specialty again. He filled the position of assistant physician at the Vermont Asylum for three years,
when he was appointed resident physician at the Kings County Lunatic Asylum in 1858, which position he held until 1873, when he resigned, married, and henceforth retired from professional life.

He suffered an attack of pneumonia, in 1871, which he barely survived, convalescence was protracted, and the following winter was spent by him in Europe. After his retirement in 1873, the summer seasons were usually spent in New England, and the winters in the more genial climes of the Southern States or California. In the autumn of 1885, he went abroad with his wife to spend the winter in Torquay. She died in Paris, in June, 1886, after a brief illness when the doctor immediately returned to this country. He remained through the summer and autumn in Brattleboro, but almost immediately upon reaching New York, where he had arranged to spend the winter, was seized with pneumonia which terminated his life in little more than a week.

A number of other gentlemen have been at varying periods members of the Association, active, earnest and devoted. Of several of them no data could be obtained in regard to their history, but only personal recollection can be stated.

_Dr. John W. Parker_, for many years superintendent of the State Lunatic Asylum at Columbia, S. C., was most earnest in the discharge of all duties; cheerful, courteous in his manner, a high-toned gentleman of the old school, with chivalrous devotion to the true and the good.

_Dr. Joseph Workman_, for many years superintendent of the Asylum for the Insane, Toronto, Ontario; learned, earnest in all matters relative to the insane and a thorough student, having passed the limit of four-score years, is resting in the calm, dignified retirement of a life well spent in the service of his fellow men.

(He died April 15, 1894, aged 89, after the above was written.)

_Dr. George A. Shurtleff_, the first superintendent of the Asylum for the Insane at Stockton, California, gave himself with all his energies of mind and heart to the proper provision for and management of those committed to his charge, and labored cheerfully, steadily, and in the face of many trials and annoyances to secure the best for those entrusted to his care, until his own health gave way under the constant strain of public and private troubles.

_Dr. Abram M. Shew_, after considerable experience as an assistant in one or more hospitals for the insane, gave the whole energies of an active, earnest spirit and a clear mind to the charge of the hospital at Middletown, Conn., until his health failed and, though allowed rest and recreation at different times he never entirely attained the bodily strength which would enable him to carry out the plans he had conceived and hoped to live to execute.

No association of men had a clearer or more definite object in view, or a better mental grasp of the whole subject then before
them, than the original thirteen members of the Association. Liberal in their ideas, philanthropic in their aims and projects and charitable in the broadest sense, they laid strong and deep the foundations on which they proposed to erect a structure which should accommodate within its limits all those for whose welfare they were laboring with an intensity of zeal and energy which knew no limit or abatement.

A simple enumeration of the subjects which engaged their attention during the earlier meetings will better make known their appreciation of the duties, and the amount of labor required to execute them in accordance with the high aim which they had set before them.

These subjects were the moral treatment of the insane; the medical treatment; restraint and restraining apparatus; on the construction of hospitals for the insane; on the jurisprudence of insanity; on the prevention of suicide; on the organization of hospitals for the insane and a manual for attendants; on the statistics of insanity; on the support of the pauper insane; on asylums for idiots and demented; on chapels and chaplains in hospitals for the insane; on post-mortem examination; on the comparative advantages of treatment in hospitals and in private practice; on asylums for colored persons; on provision for insane prisoners; on the causes and prevention of insanity; on the treatment of incurables; on the classification of insanity; on the admission of visitors into the halls of patients; on visits to, and correspondence with patients, by friends; on the comparative value of the different kinds of labor for patients, and the best means of employment in winter; on the proper number of patients for one institution; on the utility of night attendants, and the propriety of not locking the doors of the rooms of patients at night; on the advantages and disadvantages of cottages for wealthy patients, adjacent to the hospitals; on the nature and treatment of insanity produced by intoxicating liquors; under what circumstances can the insane of poorer classes be properly treated with the greatest economy; on the effects upon the insane of the use of tobacco; on reading, recreation and amusement for the insane; on the construction and arrangement of institutions for the insane in southern climates.

In a report on moral treatment, strong ground was taken in favor of schools for certain classes of patients, as a means of mental occupation. The strong expression of the opinion of men who be-
lieved in and practiced the smallest amount of restraint is con-
tained in this resolution:

Resolved, That it is the unanimous sense of this Convention that the attempt
to abandon entirely the use of all means of personal restraint is not sanctioned
by the true interests of the insane.

At the meeting in 1848, a resolution was adopted strongly dep-
recating the selection of medical superintendents of hospitals on
political grounds, "as a dangerous departure from that sound rule
which should govern every appointing power, of seeking the best
men irrespective of every other consideration."

At the meeting in 1851, the propositions on the construction of
hospitals for the insane were adopted, after full and free discussion.
While they have been classed as "iron bound rules," it may safely
be asserted that the principles laid down in those propositions
have never yet been disproved; a careful adherence to them would
have saved large amounts of money to the community and have
caused the erection of buildings which would have been secure from
fire, and thus have prevented the loss of life.

The great objection made to the propositions has been that they
favored a particular form of building, but that objection derives
all its force from the idea that, because the gentleman who wrote
those propositions and was a most ardent supporter of them,
favored a particular form of building, therefore it was so laid down
in the propositions.

A careful reading of them will show that, in the propositions
themselves, such a condition is carefully guarded against.

The two propositions which seem to favor a particular form of
building read thus: "A large hospital should consist of a main
central building with wings;" (14), and "the wings should be so
arranged that if rooms are placed on both sides of a corridor, the
corridors should be furnished at both ends with movable glazed
sashes for the free admission of both light and air." (16)

In regard to the arrangement of the main central building, I am
not aware of any real difference of opinion.

A distinct recollection of the discussion on those propositions, so
as to avoid all seeming commitment to one particular form, is still
vividly impressed on my mind. Men who had strong views as to
the particular form in which a hospital should be erected, different
from the idea so commonly held as embodied in the propositions,
voted for those propositions; and they were men who never voted contrary to their own convictions.

At the same meeting a resolution was adopted, which in the light of recent discussions and actions seems very appropriate at this time.

Resolved, That it is the duty of the community to provide and suitably care for all classes of the insane, and that in order to secure their greatest good and highest welfare, it is indispensable that institutions, for their exclusive care and treatment, having a medical superintendent, should be provided, and that it is improper except from extreme necessity, as a temporary arrangement, to confine insane persons in county poor-houses, or other institutions, with those afflicted with or treated for other diseases, or confined for misdemeanors.

The absolute necessity of thorough, forced ventilation, was emphatically expressed in resolutions adopted in 1848, which read as follows:

Resolved, That it is the deliberate conviction of this Association that an abundance of pure air, at a proper temperature, is an essential element in the treatment of the sick, especially in hospitals, and whether for those afflicted with ordinary disease or for the insane, and that no expense that is required to effect this object thoroughly can be deemed either misplaced or injudicious.

Resolved, That the experiments recently made in various institutions in this country and elsewhere, prove, to the satisfaction of the members of this Association, that the best means of supplying warmth in winter at present known to them, consists in passing fresh air from the external atmosphere over pipes or plates containing steam under low pressure or hot water, the temperature of which, at the boiler, does not exceed 212° F., and placed in large air chambers in the basement or cellar of the building to be heated.

Resolved, That a complete system of forced ventilation, connected with such a mode of heating, is indispensable in every institution devoted to these purposes, and where all possible benefits are sought to be derived from its arrangements.

The propositions on the organization of hospitals for the insane, adopted in 1853, meet the hearty concurrence of all who are really familiar with the management of hospitals, or who have the best interests of the insane at heart, based, as they are, on the principles which govern in all the affairs of life, and on sound business ideas and economies.

A careful study of them on the part of those who are so anxious to arrange the general and particular management of hospitals for
the insane on some theory having its origin in a fanciful idea of the proper care of the insane, might have the effect of modifying some of their extreme views, and lead them to see that what they propose is contrary to all experience and observation. Such persons, it is to be feared, act on the theory advanced some years since by one of that class, that the more thoroughly a man had studied a subject and the more experience he had in that line, the less competent was he to give advice and counsel.

The following propositions on the proper care of the chronic insane, adopted in 1866, seem, in the light of the events and discussions of the last few years, to be worthy of particular notice at this time.

1. Every State should make ample and suitable provision for its insane.
2. That insane persons considered curable and those supposed incurable, should not be provided for in separate establishments.
3. The large States should be divided into geographical districts of such size that a hospital situated at, or near, the centre of the district, will be practically accessible to all the people living within its boundaries, and available for their benefit in cases of mental disorder.
4. All State, County and City Hospitals for the insane, should receive all persons belonging to the vicinage designed to be accommodated by such hospital, who are affected with insanity proper, whatever may be the form or nature of the bodily disease accompanying the mental disorder.
5. All hospitals for the insane should be constructed, organized and managed, substantially in accordance with the propositions adopted by the Association in 1851 and 1853, and still in force.
6. The facilities for classification, or ward separation, possessed by such institution, should equal the requirements of the different conditions of the several classes received by such institutions, whether those different conditions are mental or physical in their character.
7. The enlargement of a city, county or State institution for the insane, which, in the extent and character of the district in which it is situated, is conveniently accessible to all the people of such district, may be properly carried, as required, to the extent of accommodating six hundred patients, embracing the usual proportions of curable and incurable insane in a particular community.

The project of a uniform law on the subject of the legal relations of the insane, which was introduced at the meeting in 1863, was discussed at different meetings and finally adopted at the meeting in Boston, in 1868. The final report, as well as all the details of the law, was drawn up in his usual clear and lucid style, by Dr. Isaac Ray, who had devoted so many years to the careful study of the legal relations of the insane and the jurisprudence of insanity.
Embodying, as it does, large, enlightened and most liberal views on all the matters embraced within its scope, it has commanded the assent and approval of all who have carefully studied its provisions, and is at this time in many, or the majority, of those provisions embraced in the statute laws of a number of the States, and has been the means of giving precision and definite direction in all matters to which its principles refer.

The following resolutions, adopted in 1871, especially the last, seem to have been drawn with a wise prevision of the attempt to cheapen the buildings and the proper care of the insane:

Resolved, That this Association re-affirms, in the most emphatic manner, its former declarations in regard to the construction and organization of hospitals for the insane; and it would take the present occasion to add that, at no time since these declarations were originally made, has anything been said or done to change, in any respect, its frequently expressed and unequivocal conviction on the following points, derived, as they have been, from the patient, varied and long-continued observation of its members:

First. That a very large majority of those suffering from mental disease can no where else be as well or as successfully cared for, for the cure of their maladies, or be made as comfortable, if not curable, with equal protection to the patient and the community, as in well-arranged hospitals, specially provided for the treatment of the insane.

Second. That neither humanity, economy nor expediency can make it desirable that the care of the recent and chronic insane should be in separate institutions.

Third. That those institutions, especially if provided at the public cost, should always be of a plain but of substantial character; and, while characterized by good taste, and furnished with everything essential to the health and comfort and successful treatment of the patients, all extravagant embellishments and every unnecessary expenditure should be carefully avoided.

Fourth. That no expense that is required to provide just as many of these hospitals as may be necessary to give the most enlightened care to all their insane, can properly be regarded as either unwise, inexpedient or beyond the means of any one of the United States or British Provinces.

Especial attention is called to another series of resolutions, adopted at the same meeting in 1871, in regard to Didactic and Clinical Instruction in Insanity, and which it is most earnestly desired should receive more careful attention and more thorough endorsement in all its details by those who have the direction of medical education.

Resolved, That in view of the frequency of mental disorders among all classes and descriptions of people, and in recognition of the fact that the first care of nearly all of these cases necessarily devolves upon physicians
engaged in general practice, and this at a period when sound views of the
disease and judicious modes of treatment are specially important. It is the
unanimous opinion of this Association that in every school conferring med-
ical degrees, there should be delivered by competent professors, a complete
course of lectures on insanity and on medical jurisprudence as connected
with disorders of the mind.

Resolved, That these lectures should be delivered before all the students
attending these schools, and that no one be allowed to graduate without as
thorough an examination on these subjects as in the other branches taught
in the schools.

Resolved, That in connection with these lectures, whenever practicable,
there should be clinical instructions, so arranged that, while giving the
students practical illustrations of the different forms of insanity and the
effects of treatment, they should in no way be detrimental to the patients.

Justice to the insane demands in the strongest terms that the
full spirit of the resolutions in regard to the over-crowding of
hospitals for the insane be lived up to at the earliest period, but,
while the resolutions of the Association have been before the public
for a series of years, they seem to have the effect of an oft told tale.

Members of the Legislature, who have slight opportunity to ascer-
tain the facts by actual observation, and who too often fear that by
voting for an appropriation for the erection of a hospital for the
insane they may not secure as many votes as they would like in the
future, listen to the siren song of those who think expediency, or
some favorite theory, of more value and importance than the relief
and restoration of the insane, and therefore relieve their consciences
by not voting for the additional accommodation so imperatively
demanded by right and justice. This balancing of the dollars
against the health and welfare of those who are now insane, or who
may become so, shows a defect of that genuine humanity and
philanthropy, which is greatly to be deplored, and calls to mind
the terrible Nemesis which overtakes all who oppose philanthropic
efforts for the relief of their suffering fellow beings. The resolu-
tions read thus:

Resolved, That this Association regards the custom of admitting a greater
number of patients than the buildings can properly accommodate, which is
now become so common in hospitals for the insane in nearly every section
of the country, as an evil of great magnitude, productive of extraordinary
dangers, subversive of the good order, perfect discipline, and greatest
usefulness of these institutions and of the best interests of the insane.

Resolved, That this Association, having repeatedly affirmed its well-
matured convictions of the humanity, expediency and economy of every
State making ample provision for all its insane, regards it as an important means of effecting this object that these institutions should be kept in the highest state of efficiency, and the difference in condition of patients treated in them, and those kept in almshouses, jails or even private houses, be thus most clearly demonstrated.

Resolved, That while fully recognizing the great suffering and serious loss that must result to individuals by their exclusion from hospitals when laboring under an attack of insanity, this Association fully believes that the greatest good will result to the greatest number, and at the earliest day, by the adoption of the course now indicated.

Resolved, That the boards of management of the different hospitals on this continent be urged, most earnestly, to adopt such measures as will effectually prevent more patients being admitted into their respective institutions, than, in the opinion of their superintendents, can be treated with the greatest efficiency, and without impairing the welfare of their fellow sufferers.

At the meeting in 1873, Dr. Isaac Ray read a paper on the ideal qualifications of officers of hospitals for the insane, written in the beautiful, pure English of which he was master, and deserving to be read and re-read by every superintendent and officer of a hospital as an incentive to higher attainments. At the same meeting the following resolutions on the proper disposition of insane convicts were unanimously adopted:

Resolved, That neither the cells of penitentiaries and jails, nor the wards of ordinary hospitals for the insane are proper places for the custody and treatment of this class of the insane.

Resolved, That when the number of this class in any State (or in any two or more adjoining States which will unite in the project,) is sufficient to justify such a course, these cases should be placed in a hospital specially provided for the purpose; and that until this can be done, they should be treated in a hospital connected with some prison, and not in the wards or in separate buildings upon any part of the grounds of an ordinary hospital for the insane.

At the meeting in 1875, a series of resolutions relative to the management of hospitals and to efforts made to change the existing order and arrangements, was read by Dr. Ray.

Written in the strong, vigorous language which he could command when necessity required, they commend the order as then existing and deplore changes which were threatened.

"The Association of Medical Superintendents of American Institutions for the Insane having been formed for the purpose of promoting the welfare of the insane, regard it as one of their duties to
inquire into and pass judgment upon any scheme, project or change, offered professedly with this end in view. They would be faithless to the trust they have assumed, were they to remain in silence while changes in the management of our hospitals are forced upon us, calculated to impair their usefulness and inflict a positive injury upon their inmates. The duty to speak at the present time is all the greater in view of the fact that the objects sought for by these new measures are sufficiently secured in the existing arrangements, and the pretended demand for them proceeds from no actual, tangible grievance, but solely from that prevalent spirit of discontent, which is ever ready to discover a fancied wrong and clamor for a change in whatever has stood the test of a little time. Were this dissatisfaction confined to the ordinary methods of discussing evils, real or fancied, it would furnish no ground of complaint, and we would cheerfully meet it in the same way. But, without reference to us, without inquiry of any kind, in fact, it has been thrust upon us in the shape of legislation, unexceptionally mischievous in its effect on the true purposes of hospitals for the insane; and thus it is that institutions which should be managed on well-matured, intelligent principles, their course guided by one animating spirit, taking in all the circumstances of the situation, are disturbed by an intrusive element, having with them no kind of affiliation, and calculated, in the nature of things, to destroy that harmony of action which is indispensable to the highest measure of success.

"Believing that whatever of progress has been accomplished by our hospitals, may be fairly attributed, in a great measure, to the free and independent action allowed to their officers, whereby they have been enabled, without apprehension of popular fear or favor, to manage their charge in the way commended to them, either by the general voice of the profession, or their own deliberate convictions, we should for that reason alone, deplore any legislation calculated to substitute for such liberty the suggestions of an outside party, entirely ignorant, it may be, of the working of a hospital, as well as the movement of the insane mind. If the time shall ever come when the legislature, in its zeal for the public good, shall establish a board of officers to supervise the medical practice of the State, with power to enter every sick man's chamber, to inquire respecting the medicine and diet prescribed, and any other matter connected with his welfare, and report the results of their examination to the constituted authorities, then it
may be proper to consider the propriety of extending the same kind of paternal visitation to hospitals for the insane.

"Without arrogating to ourselves any extraordinary wisdom, we believe that the accomplished work of this Association, as well as the character and reputation of its present members, fairly entitles it to a respectful hearing on any matters of legislation affecting the interests of the insane in the establishments devoted to their custody and treatment. We, therefore, offer the following resolutions in the hope that they will receive from the public all the attention to which the importance of the subject, and the authority of the source from which they come, entitle them:

Resolved, That the government of our hospitals, as at present constituted, whereby a physician supposed to be eminently qualified by his professional training and his traits of character, both moral and intellectual, is invested with the immediate control of the whole establishment, while a board of directors, trustees or managers, as they are differently called in different places, men of acknowledged integrity and intelligence, has the general supervision of its affairs, has been found, by ample experience, to furnish the best security against abuses, and the strongest incentives to constant effort and improvement.

Resolved, That any supernumerary functionaries, endowed with the privilege of scrutinizing the management of the hospital, and sitting in judgment on the conduct of attendants and the complaints of patients, and controlling the management, directly by the exercise of superior power, or indirectly by stringent advice, can scarcely accomplish an amount of good sufficient to compensate for the harm that is sure to follow.

Resolved, That the duty of restoring the insane, and of producing the highest possible degree of comfort for those who are beyond the reach of cure, implies a knowledge of their malady, and of their ways and manners, that can be obtained only by study and observation.

Resolved, That the work of conducting any particular individual through the mazes of disease, into the light of unclouded reason, embracing, as it does, the drugs he is to take, the privileges he is to enjoy, the letters he is to write or receive, and the company he may see, implies not only certain professional attainments, but a close and continuous observation of his conduct and conversation, neither of which qualifications can be expected from the class of functionaries above mentioned, though appointed for the express purpose of making suggestions and proffering advice.

Resolved, That one of the first things in the treatment of a patient is to secure his confidence, to make him feel that he is in the hands of friends who will protect and care for him; and yet this purpose is completely frustrated when it is incessantly proclaimed to him from the walls of his apartment that the people to whom he has been entrusted, are not trusted
by others, and that any aid or comfort he may require must be sought from a power paramount to theirs.

Resolved, That valuable information may be obtained from the letters of patients respecting their mental movements, as many will communicate their thoughts in this manner more unreservedly than in their conversation, which advantage is lost when their letters are forwarded unopened.

Resolved, Inasmuch as the letters of the insane, especially of women, often contain matter, the very thought of which, after recovery, will overwhelm them with mortification and dismay, any law which compels the sending of such letters, is clearly an outrage on common decency and common humanity.

Resolved, That the fact so much asserted at the present and offered as the main reason for the legislation in question, viz.: That sane persons are often falsely imprisoned on the pretence of insanity, and that we believe that, if ever, it is extremely rare that a single case of false imprisonment, in any hospital in this country, has taken place.

Resolved, That should such cases occur, it would require more knowledge and experience to detect and expose their true character, that any but the officers of the hospital would be likely to possess.

At the same meeting, in 1875, a series of resolutions was adopted on the custody and treatment of inebriates, which seem to offer the most reasonable and also the most practicable mode of dealing with such cases which has yet been proposed, with any prospect of permanent relief:

Resolved, That in the opinion of the Association of Medical Superintendents of American Institutions for the Insane, it is the duty of each of the United States, and each of the Provinces of the Dominion, to establish and maintain a State or public institution for the custody and treatment of inebriates, on substantially the same footing, in respect to organization and support, as that upon which the generality of State and Provincial Institutions for the Insane are organized and supported.

Resolved, That as, in the opinion of this Association, any system of management of institutions for inebriates, under which the duration of the residence of their inmates, and the character of the treatment to which they are subjected is voluntary on their part, must in most cases, prove entirely futile, if not worse than useless, there should be in every State and Province such positive constitutional provisions and statutory enactments as will, in every case of presumed inebriety, secure a careful inquisition into the question of drunkenness, and fitness for the restraint of an institution for inebriates, and such a manner and length of restraint as will render total abstinence from alcoholic or other hurtful stimulants, during such treatment, absolutely certain, and present the best prospects of cure or reform, of which each case is susceptible.
Resolved further, That the treatment in institutions for the insane of dipsomaniacs, or persons whose only obvious mental disorder is the excessive use of alcoholic or other stimulants, and the immediate effects of such excess, is exceedingly prejudicial to the welfare of those inmates for whose benefit such institutions are established and maintained, and should be discontinued, just as soon as other separate provision can be made for inebriates.

The matter of greatest interest and of most enduring importance, was the adoption of a new constitution and by-laws at the meeting on May 5, 1892, at Washington, D. C., and the change of the name of the Association to the American Medico-Psychological Association.

The gentlemen who organized this Association and those who succeeded them, during the period of the last fifty years, were men of sound judgment and rare practical common sense, and they were all well aware of the dense prejudice and denser ignorance which prevailed in all matters relating to the care and treatment of the insane, coming as the prejudice and ignorance did from the abuses and neglect of preceding generations.

With high resolve and determined purpose these gentlemen aimed to impart correct knowledge, and inaugurate a new system of treatment which should commend itself to the minds of all. They were the friends and promoters of progress; steady, consistent, persistent, not lured away from the true path by theoretical philanthropists and visionary schemers, but animated by a calm conservatism in their adherence to justice, truth and right, and guided by a faith which enabled them to look beyond the cloud bank of temporary expediency to the ever-enduring realities.

Recognizing the vital fact that mental derangement was neither ill-bred temper, nor unbridled passion, nor demoniacal possession, they held firmly to the all-important truth, that mental disorders were traceable to the diseases or functional disorders of some one or more of the bodily organs, acting sympathetically on the nervous system and brain, and thus interfering with the normal action. To these deviations from healthy states various names had been given, which were simply descriptive of certain classes of symptoms according to the peculiar form which they may have assumed.

In the confident belief that such disordered conditions required special care and treatment, they urged the erection of hospitals specially arranged to meet the peculiar manifestations of disordered action, which were essentially different from the ordinary manifest-
ations of disease, and therefore should have such special provisions as would meet the peculiar and extraordinary symptoms and the exigencies of the cases as they might develop.

While not defining the particular form in which such buildings should be arranged, they insisted that they should be so located as to provide bright and cheerful views from every part of the building; that the building should be so arranged that the sun should shine into every room at some period of the time between the rising and the going down thereof; that the internal arrangements should be light, home-like, and calculated to convey healthful and cheering impressions; that such building should be constructed of the best material in the most workman-like and substantial manner, fire-proof, with everything which the sciences, the art and the experience of the time could give to make its management conducive to the highest interests, comfort and restoration of all committed to its charge.

They also insisted that no hospital for the insane should be built without the plan having been first submitted to and approved by some physician or physicians, who had had charge of a similar establishment, or were practically acquainted with all the details of their arrangements and their special requirements. The deviation from this sound rule in late years has been the rule and not the exception, and the advice given by competent experts has been followed so far as suited the views or special ideas of the architects, or some one who assumed to know all that needed to be known.

The essential fundamental principle has been ignored too often, which teaches that every hospital should be, in all its details and appointments, specially adapted to the class for which it was erected, and should be constructed with that economy which looks beyond mere cheapness of original construction to such arrangements as will require small expenditure for repairs in the immediately coming years.

Very cheap buildings, like very cheap things, are very expensive, and those who favor them should give good heed to the sentiments of the community at large, who object to very cheap things on the same principle that they object to very extravagant things; an inappropriate application of the funds which that community supplies for the purposes intended. No expenditure will be deemed extravagant by right-minded men which aims to secure the most comfortable accommodation, the most careful, exact and scientific
care and treatment for those who need to be protected and guarded from what, by reason of disordered conditions, they might be impelled to do to themselves or to any member of the community.

The general controlling power of all such institutions should be vested in a Board of Trustees "composed of individuals possessing the public confidence, distinguished for liberality, intelligence and active benevolence, above all political influence, and able and willing to attend to the duties of their station."

They should appoint a physician who should be the superintendent and chief executive officer of the establishment. Besides being a well-educated physician he should possess the mental, physical and social qualities to fit him for the post. He should serve during good behavior, should have the entire control of the medical, moral and dietetic treatment of the patients, the unreserved appointment and discharge of all persons engaged in their care, and exercise a general supervision and direction of every department of the institution.

In too many States the office of trustees and superintendent has been made the reward of partisan political service, to the detriment of the institution. No thought seems to have been given to the need of special qualifications for such positions, and the inmates have, from the very nature of the case, not received that careful consideration which arises from an attentive examination of their mental and bodily condition, which can only be acquired by a diligent, earnest and continuous study of their special malady, and that can certainly never be given by men who are changed with the veering policy of partisan politics.

It behooves this Association, now and henceforth, to use all the influence it can command in favor of a rigid enforcement of the principles stated, that no backward step be taken in anything which pertains to the care of the insane, but that the progress should be steadily onward in the provision of the most ample means which is clearly demanded by every consideration of justice, equity and philanthropy. Those who would weigh too closely the dollars against the mental maladies of their unfortunate fellow-men should be advised to visit Anticyra, that their eyes may be brightened and their minds clarified from the mists and errors which enshroud them, by large and frequent draughts of the hellebore which there abounds in such ample quantity and of such superior quality.

An urgent demand exists for more thorough, extended and scien-
tific study of mental disorders, on the part of those who are pre-
paring themselves for the future care and treatment of disease.
While the subject has received attention in many medical schools,
it should be made much more extended by its adoption in every
medical school, "in recognition of the fact that the first care of
nearly all these cases necessarily devolves upon physicians engaged
in general practice, and this at a period when sound views of the
disease and judicious modes of treatment are specially important."
"These lectures should be delivered before all the students
attending these schools, and no one should be allowed to graduate
without as thorough an examination on these subjects as on the
other branches taught in the schools."

Every physician in charge of a hospital for the insane should do
all in his power to aid in the advance of mental physiology, mental
pathology and physiological psychology, not only for his own im-
mediate benefit, as a study, but with the intent of reaching a
better knowledge of the mental processes and elucidating, as far as
possible, the recondite problems of mind. These require careful
and exact study, but that study will give power to the individual,
while it will enable him more definitely to trace the intricate con-
nection of cause and effect in the cases which call for his exami-
nation. It is certain that the more thoroughly these processes are
studied the better will be the result of treatment, and the
more satisfactory will be the result to the patient and to the phy-
sician. He will learn more fully that while medical means are ex-
cellent as adjuvants, entertainment and diversion of the mind and
also occupation of both mind and body, with proper hygienic pre-
cautions, are essential elements in the course to be pursued to se-
cure the highest and best results. The reciprocal influence of mind
and body needs more thorough study than it has yet received, and
by the knowledge thus obtained a way will be found for the more
scientific application of medical, moral and hygienic measures than
they have heretofore received.

From the study of mental physiology and mental pathology can
also be learned the principles and rules which can be applied to the
prevention of mental disorders, and surely no higher object can
claim the attention of the alienist than the endeavor to give tone
and vigor to the mental powers, and thus prevent a disordered con-
dition.

With the highest type of the most distinctly Christian civilization
should be blended the strong features of the old Greek ideas of mental culture and the Roman model of physical development. How can this best be attained? Men too often allow their calm judgment of right thinking and right action to be overborne by their appetites, their desires and their passions, but that is only an additional reason why they should be taught that such yielding is inflicting an injury and a wrong on them and theirs.

Education, in such cases, is a very slow process in the endeavor to eradicate the errors of the past and of the present time, and because of the slowness a more determined effort should be made to instill those principles which will impress on all classes and conditions the elementary truths of genuine hygiene, to be strengthened and made more impressive by constant repetition.

It is an undeniable fact, supported by incontrovertible data, that a large class of idiots is produced by the drunken and other depraved conditions of one or both parents. It is equally undeniable that certain forms of disease are propagated by the diseased condition of the parent caused by a vicious and dissolute course of life, and that this state would go down the generations but for the self-limitation imposed on certain classes of disease, leading to their extinction. There is no limit allotted to those who obey the commandments, but to those who disobey the limit is fixed and definite.

The law makes no allowance by reason of ignorance of its provisions for those who neglect or disobey, neither do the laws of hygiene relax their vigilance or ward off the penalty because men neglect or refuse to obey them. These laws of hygiene are as fixed and inviolable as those of the Decalogue, and their enforcement of punishment more prompt and positive in all their departments.

This Association can do no greater service to its fellow-men than by the steady, persistent effort to teach them that obedience to hygienic laws means health of body and vigor and soundness of mind, while the violation of these laws means mental derangement and physical degeneration.

Diligent inquiry and careful observation will demonstrate another class of subjects to which very little attention has heretofore been given. Women of education and intelligence have stated that they could observe in their children certain traits and dispositions which they knew they possessed and indulged during the period of gestation with those children. The more thoroughly this matter is inquired into the more positive will be the information
obtained, and does it not point clearly and unequivocally to this fact, that the mother should be urged to exercise a careful control over her own temper, and other mental and bodily conditions, if she wishes to have her children free from those neurotic conditions which tend so strongly towards mental disorders? Every one must have observed in certain families a very great dissimilarity in the temper, disposition and mental capacity of the children, and sometimes also in the physical development of those children. Does not the statement given afford at least a partial solution of the difference observed?

Aptitude for certain trades and professions, special inclination to and ability in literature, science, and the higher branches of philosophy, are as clearly endowments of the individual as others are hereditary transmissions.

Another matter demanding special attention is the early education of children which comes first in the proper control to be exercised over the appetites, the desires, the passions, the emotions and the affections, which should commence with the dawn of intelligence and be carefully, patiently and judiciously exercised. This earliest exercise should be in the training of the child in the habit of obedience to parental discipline; not the stern discipline which will provoke, but that calm, quiet enforcement of the direction given which will teach more effectually and have a more enduring influence than any stern and harsh command, enforced by severe punishment. This calm discipline, steadily adhered to and not relaxed on account of some sentimental feeling, will teach the child a command over its own passions which will be of infinite benefit in the future.

The authority thus established will enable the parent, as the child advances in years, to enforce the needed advice in all matters pertaining to the regulation of the moral powers, which will give stability to the character of the child to resist more readily and more effectively the temptations to which all are more or less exposed and lead to a more law-abiding disposition.

Obedience to law, thus developed, means social order and good government; disobedience means disregard of law, anarchy and confusion. But education has a higher meaning still than this training of the moral powers, in the leading and training of the mental powers so as to fit the individual to take his place in the affairs of life. This does not mean the mere superficial glance at a given
subject, but a thorough examination of each particular matter so as exactly to understand what it means and what it leads to, and the thoughtful study of the whole in all its parts and relations, fully comprehending one point before passing to another, and thus being firmly impressed on the mind so as to be of genuine value when needed. It is this thorough mastery of a subject which makes the scholar in distinction to the sciolist, "whose pride is as great as his ignorance."

But beyond this and intimately associated with it, is the thorough and constant inculcation in sound moral and religious principles which will give each man to understand his duty to God, to his fellow-men and to himself in his relations in every department of life in which he may be called to act.

"The faculty of knowledge is closely connected with the faculty of moral obedience which is the right and duty of mankind."

The census report of 1840 gave the population of the United States as 17,069,453.

The settled area of the country, 807,242 square miles.

The number of hospitals for the insane, 21.

The report of the census of 1890 gave the population as 62,622,250.

The settled area, 2,970,000 square miles.

The number of hospitals for the insane, 125.

In the Dominion of Canada, in 1840, the population was about 1,000,000, and one hospital for the insane.

In 1890, the population was 5,000,000, and the number of hospitals, 10.

This steady increase of hospitals for the insane is clearly to be attributed to the strenuous and persistent efforts of the members of the Association to enlighten the minds of the several communities on the large number of the insane and the urgent necessity of proper provision for them, and their continuous endeavors to procure the erection of hospitals suitably adapted to the purpose designed.

In every hospital, particularly in those institutions constructed by the State governments, the larger number of the inmates belong to that class who were active, industrious, and aided by their labors and the payment of the taxes to assist in maintaining the expenses of the government. Many of them have laid by a small amount for their support, and that of their families, in case of sickness. When mental disorder overtakes any member of their family, they are
willing to pay a reasonable amount for their care and treatment in a hospital.

A gentleman, in public position, once used this expression: "Compel them to go on the county." That seemed a harsh statement to be made by a man of large wealth, but the answer was, "No, never." So long as they are willing to pay their full share to support their friends and thus maintain their liberty, their self-respect and their independence, every effort should be made to encourage the feeling that they are men and citizens of an enlightened commonwealth.

There is an old proverb, written more than three thousand years ago, which has come down the centuries with steady and earnest verification, "Whoso stoppeth his ears at the cry of the poor, he also shall cry himself but shall not be heard." Let every member of this Association use his influence, whenever and wherever the opportunity may offer, to induce men to avoid the application of this proverb to themselves, and do all in their power "to raise the fallen, cheer the faint and heal the broken-hearted."

The trials, the temptations and the labors of men, in every sphere of life, are sufficient to depress and cause to despond, many who are striving honestly and heartily to discharge the duties incumbent on them in the sphere in which they are called to act, and it behooves every man to cheer and encourage them and assist them in every reasonable effort they may make.

In this connection and in the face of the steady attempt to crowd together, and at the same time diminish the personal care of the insane, it is the duty of every member of this Association to use his utmost endeavor to introduce into every class and condition of those laboring under mental disorder, a more systematic course of individualized treatment, giving to each individual the attention needed by the constant companionship of a cheerful attendant, who shall be required to use all proper means to divert, interest, amuse and occupy such person, so as more effectually to draw the individual out of the mazes of mental disorder in which he may be involved and instill more hopeful, cheerful and practical views of duty and of life. It is worse than useless to advance the idea that the mind is too far disordered to be benefited. Hope never dies, and no one can ever know how soon a bright, healthy idea, implanted by steady perseverance and nourished by faith and love, may develop into such a mental condition as will cheer every one within the circle of
the acquaintance. This is no fanciful theory, but a plain fact which any one may verify by experiment, steadily and heartily carried out.

No one is so circumstanced that in some period of his life he may not be overtaken with trials and misfortunes which tend to try his faith and endurance, and it is therefore all the more incumbent to practice, in its fullest meaning, that rule which teaches, "whatsoever ye would that men should do to you, do ye even so to them."
ADDRESS BEFORE THE FIFTIETH ANNUAL MEETING
OF THE AMERICAN MEDICO-PSYCHOLOGICAL
ASSOCIATION.

BY S. WEIR MITCHELL, M. D., L. L. D.,

I am here to-day under circumstances so unusual, that I may be
pardoned, if I explain them in order to justify the frank language
of this address.

When your representative, Dr. Chapin, asked me to be your
speaker on this important anniversary, I declined. It is customary
on birthdays to say only pleasant things, and this I knew I could
not altogether do. I foresaw a struggle between courteous desire
to follow a kindly custom and the duty to greatly use a great oc-
casion. When Dr. Chapin, after consulting some of you, came
back to say it was still your desire that I should speak, I reflected
that men who could thus ask the criticism, which they knew must
come without mercy, were well worth talking to. I said, at last,
that I would address you to-day, but that it would be boldly and
with no regard to persons. That was a momentary insanity; I
have been sorry ever since.

You are on the dividing year of your first century of life. You
look back with just pride as alienists on the merciful changes made
for the better in the management of the chronic insane. It is to
be feared that you also have cause to recall the fact that as com-
pared with the splendid advance in surgery, in the medicine of the
eye and the steady approach to precision all along our ardent line,
the alienist has won in proportion little. This is partly due to the
nature of the maladies with which you have to deal; but there are
many other causes at work to retard the wholesome progress.
Just that which is impairing the usefulness of the lesser specialties
in medicine has been more gravely enfeebling your value, and re-
tarding your development. I mean the tendency to isolation from
the mass of the active profession. At first, as concerned the eye
for instance, this separation seemed but too complete—the new
terms, the methods, the instruments of the ophthalmologist were for
a time absurdly unfamiliar. It is not so at present. The general
practitioner has come again into touch of the oculist, and understands his terms and methods. In fact, every sudden advance of a brigade of our great line for a time appears to break our ranks; but soon we get up to it and go on as before.

With you it has been different. You were the first of the specialists and you have never come back into line. It is easy to see how this came about. You soon began to live apart, and you still do so. Your hospitals are not our hospitals; your ways are not our ways. You live out of range of critical shot; you are not preceded and followed in your ward work by clever rivals, or watched by able residents fresh with the learning of the school.

I am strongly of opinion that the influence which for years led the general profession to the belief that no one could, or should, treat the insane except the special practitioner, have done us and you and many of our patients lasting wrong.

Standing here in the home of Rush, I cannot forget that he was an alienist and a general practitioner; nor can I cease to lament the day when the treatment of the insane passed too completely out of the hands of the profession at large, and into those of a group of physicians who constitute almost a sect apart from our more vitalized existence. What evil this has wrought, what harm it has done to us and to you I shall try to show. Why it has been so much more grave in its results here than in Europe is not clear to me, or would take too long to discuss.

I should, indeed, be easy enough in mind if I had only to criticize an uneducated public, ignorant legislators, and the boards which control our civic, State and endowed institutions. But I shall have frankly to reproach as to certain things many of those who still bear the absurd label of "medical superintendents." If any here think it pleasant to fire opinions into a crowd, not knowing who are hit, whether his shot finds out the right man, or only annoys the entirely efficient, I am not that man. Moreover abrupt statements are apt to be needlessly annoying, and to seem to lack good manners, and yet I have not time to be other than brief to abruptness.

But before I go on to the uncongenial task of being disagreeable, and, perhaps, of ending with criticism which some of you are reasonably certain to characterize as ignorant, I would say a word.

I at first meant this address to be weighty with statistics and with carefully gathered knowledge of the way in which the medicine of
the alien mind grew up in this country. After immense reading I gave it up, but it left with me the conviction that within ten or fifteen years things have been improving, and that within your own ranks are men who had early seen and still see the need for much of what I urge to-day. Without this qualifying belief I should have hesitated still longer as to this ungracious work.

There were in this country in 1890, 120 public and some 40 private asylums; nor does this include insane wards of county almshouses, or those singular institutions known as sanitariums, which receive many insane and are, I fancy, little troubled by the lunacy commissioners. In 1889, the patients in these 160 hospitals numbered 91,152, and were treated at a cost of $10,692,000 over and above $2,209,000 spent that year in buildings.

The State and civic asylums are under boards appointed usually by Governors of States, or mayors, sometimes with as much regard to politics as to quality of useful fitness. The great endowed asylums are ruled by self-constituted bodies, which in certain cases have the ponderous task of also managing a general city hospital.

Then there are the private asylums which have no boards and manage themselves, and are commercial enterprises. Overall, in many States, is the more or less efficient machinery of the lunacy commissions. Usually good enough as collectors of statistics and as historians, these bodies are, as to visits and accurate inspection in the higher sense, most plainly ineffective. Too often they are made up without one member who can be called an expert in neurological medicine. Is this vast trust so handled as to satisfy the intelligent conscience of my profession? I have read and thought about its every phase an inconceivable amount. I saw that here or there some one had shown what could be done in the face of preconception, traditional usage or want of means, and was so much ahead of his fellows as to excite wonder that such intelligent examples should lack efficient following. Yet, after all I thus learned of growth and thoughtful gains, it did seem to me that the sowers of good seed were sadly few, the progress strangely slow. When indeed, I began to write what I had to urge, my charges appeared to me so grave as to require the expression of other opinions than those of a single thinker in order to give him the courage to speak them to the world. I, therefore, resolved to call a jury and use its decisions to modify or give force to my own.

The men before me see asylums from within. Some live on
quietly. Some are vaguely dissatisfied. Some are half-hopelessly striving to better things, which only in part lie within their power to change. Outside, and of late years, your asylums are relentlessly watched by one of the ablest groupes of men known to me, the neurologists and consultants of our cities. To thirty of these I addressed the following letter:

DEAR DOCTOR:—I have been asked to deliver, in May, the address on the occasion of the Fiftieth Anniversary of the Society of the Medical Superintendents of the Insane, now known under the name of the American Medico-Psychological Association. I have consented with the clear understanding that I shall be free to represent the best professional opinion in the country to the gentlemen who are at the head of these institutions. I am told that I shall have full freedom. To enable me to carry out this plan I have addressed duplicates of this letter to a few of the leading American neurologists, and to certain consultants not neurologists. May I ask you to answer the following questions:

Do you think the present asylum management of the insane in America as good as it could be made?

What faults do you find with it?

If you had full freedom to change it what would you do?

I do not want a written treatise on the subject, but within a reasonable time a reply of such brevity as will cover the ground for an expert.

Yours truly,

S. WEIR MITCHELL.

The men I called to my aid are physicians accustomed, in recent days, to treat the insane. Some of them are familiar with asylums; most of them have contributed largely and originally to neuropathology, symptomatology and therapeutics. No man can afford to set quite aside the criticism of their replies. They are severe, but not unkindly; nor do they fail to point out how largely you are trammelled by custom, lack of means, and above all, in some cases, (and this is saddest and most shameful of all), directly or indirectly by politics.

I have used also, certain communications from able asylum officers, which I cannot print, and, also, I have had in the past letters from intelligent people, some of them doctors, who speak of their own experiences as patients in the asylums, and make reflections thereon.

But it is the arraignment of the neurologist which ought incessantly to trouble you and the boards which you have to manage—for the management of managers is an important business. It is this outspoken discontent which ought to make you ask how far you,
yourselves, are responsible. If we are right, neither States nor boards nor you are ardently living up to the highest standard of intelligent duty.

And now as to boards of managers.

You know too well, I fear, how State boards are generally constituted. There the mischief begins. They meet at exceedingly variable intervals—some monthly, and some every third month. When once they have decreed a superintendent physician for the asylum his reports must largely guide them. I approach a delicate matter when I say that in some States the selection, both of these boards and the appointment and continuance in office of a physician superintendent, is said to be more or less a question of politics. I am told that this inconceivably shameful thing is past doubt. But to accept such office as a mere bit of party spoil! Can a man do that and be fit for the work? Let us hope it is all mere scandalous gossip, and turn from a too painful topic. Money changers in the temple! Ward politics at the bedside of the lunatic! How can one with patience even speak of it?

These boards have to learn duties and acquire knowledge common enough among neurologists. But what governor of a State comes to us and asks whom he shall appoint? That you depend for sympathy, intelligent help, and even your livelihood, on the continued good-will of bodies thus made up is a grave evil. It leads to this need to manage the manager, to want of decision, to rose-colored reports, to deference to potent trustees as to your minor appointments; or else these boards do not manage at all. The steward and physician run the concern. Meetings are rare; business is kept straight of course; and so we blunder along.

But, surely, the private or endowed asylums should be better off. I think not. Their boards are self appointed, and are made up of very excellent, kindly, middle-aged clergymen, merchants, lawyers and the like. They fill their own vacancies as they please. I do not see why there should not be on these boards one or more physicians, and not old ones, either. Also, I should like to drop managers every ten years, and change committees as often as once a year.

The psychology of boards is, as yet, unstudied. It is not in the text-books. The best of them get wooden and lose capacity to change with ease. A man who is too self-critical is sure to lack enterprise, and a board is nothing if not critical. Even
the feeble have this retarding power, and soon or late, the doubts and prejudices of the old cripple with splints of inertia affect the mind-joints of the fresh comers. All boards age rapidly, and acquire young the senile characteristics. They assimilate with difficulty and abhor change; meanwhile, they are dealing with an art and its assistive sciences which are changing at such a rate as taxes the industry and watchfulness of the best of us to keep in the van of their bewildering advance. All this, the boards which manage our hospitals rarely apprehend. That our art fails in the same ratio as our science falls behind, is not such a truth as the mental structure of boards can grasp; and hence half-equipped hospitals, and hence new hospitals built with small contribution from modern constructive art, the old stupidities in brick and stone repeated, as is happening even now as I write.

I sometimes think that it would be in our great cities, a wise thing to have any hospital staff say frankly what it thinks of the management back of it. Perhaps I had better pause here.

A managing board has committees, and these inspect their hospitals,—I really do not know how often. Such occasions used to greatly amuse a sometime patient of mine, convalescent from much drink in a great asylum. He was given a good deal of freedom, and his letters to me delineating a managerial inspection were really worth publication in the interests of human mirth. Once I, myself, saw a large part of such an inspection. I assure you it was interesting. The visit was, of course, expected. Is it in human nature not to get ready just a little? We walked all over the wards, we spoke kindly to a few amiable patients, we asked a reasonable number of obvious questions, we partook of a very good luncheon, praised everything, including the cook, received bouquets or grapes, and, after three hours, departed, having made an inspection! I thought it a neat little comedy; no one there suspected the audience of smiling not with, but at, the players. It seemed to please the superintendent and the managers, and, if I saw certain things which were not after my mind, I was not a manager and had no experience except of those ruthless inspections in the great war. A visit without warning, by night, or at a meal-hour, causing relentless blanks to be filled, a report to a despotic authority, and all with no least will, or wish, or reason to hide the truth. It is certain that hospital inspections
by managers are simply valueless. Every doctor laughs at them. Yet no one thinks these honest gentlemen either stupid or undutiful. They merely do not know their business, and do not know that they do not know. Yet to learn this work were easy. Why not have blanks to tell them what to see? Why not condescend to learn? Why not drop in at a meal, at night? Really this whole thing is of incredible stupidity.

Corporations are said not to have souls; I sometimes think that this grouping of men with selection limited by creed, habit, or social caste, lessens the individual good sense, or kills its large use by the cumulative curse of critical doubt. I have seen hospitals that smelt and looked like second-class lodging-houses, and have found their managers serenely contented. What we want is a training-school for hospital managers. Perhaps some of you keep one. I wish you all success.

I do not know just how the boards of your special hospitals appoint a physician. I wish I thought our general city hospitals were governed as to appointments in some degree by the scientific record of the man. I would stand on that alone if I had to be limited to one form of knowledge of a candidate, and in any case it would influence me largely. In one hospital of this city, the medical staff nominates, and the board takes or rejects at will. There, too, the staff sit in the board, but do not vote. I consider this the approach to an ideal hospital management. It works perfectly.*

I know clearly what a group of neurologists will do in the ideal days, when a board of humble-minded managers desires us to select a superintendent of the minds and bodies of men out of their poor wits. I fancy we shall ask first for large general hospital experience, for ample knowledge of psychology and pathology. Then we would want to know what books or papers on the insane the man had written, whether these were fresh with new thoughts, or made up of vague pilferings from better brains. We should wish him to have other qualities,—but of this again.

So much for your rulers—the hospital boards. They have much to learn, and those who appoint certain of them have still more to learn. I have dealt especially with these because I think

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*This is the Infirmary for Nervous Disease and Orthopaedics. The staff sit at all but the January meeting for elections. They originate and discuss measures, nominate for all appointments of medical or surgical nature.
their members do usually desire to do right, and know not how. Strangely enough, the best of boards are not always those of the endowed asylums, but the changing groups of the State boards. The permanent boards more readily acquire the contagious disease of hospital torpor. It is well known to us, and has no least excuse where money is abundant. I have seen it creep into quite young institutions, and have seen it cured only by very radical means. Also, it is strangely insidious. The price of security from hospital torpor, from the sclerosis of custom, is constant vigilance. This malady comes to one institution from a too wooden board; it comes to another from the inertness of doctors. Hospitals, good to-day, in a few years may become bad. I saw the worst hospital in this city pass quickly into the first rank; I have seen a hospital once first, drop to a second rate.

I have said the ailments of hospitals begin, as a rule, in the governing boards; they do not end there.

In our general hospitals there is a diffused medical authority, but yours is a monarchy more or less limited. And now, my next query is as to whether you, who thus govern and make reports and live amongst your armies of the insane, are, in all respects, doing what you should and might do. We have done with whip and chains and ill-usage, and having won this noble battle have we not rested too easily content with having made the condition of the insane more comfortable?

The question we here ask at starting is if you, who are so powerful within these alien camps, are really doing all that might be done without serious increase of expenditure? Frankly speaking, we do not believe that you are so working these hospitals as to keep treatment or scientific product on the front line of medical advance.

Where, we ask, are your annual reports of scientific study, of the psychology and pathology of your patients? They should be published apart. We commonly get as your contributions to science, odd little statements, reports of a case or two, a few useless pages of isolated post-mortem records, and these are sandwiched among incomprehensible statistics and farm balance-sheets; and this is too often your sole answer. Where, indeed, are your replies to the questions as to heredity, marriage, the mental disorders of races, the influence of malarial locations, of seasons, of great elevations, all the psychological riddles of a new land, a
forming breed, never weary of quickening the pace, of inventing means of hurry—relentless workers? When I put such questions I am always met with the doleful reply, "We have no time; we want more money; we have not enough assistants." I am quite willing to admit that for the careful treatment of the possibly curable insane, none of you have enough help. I grant that, but it is not all. I could say the like of many a fertile man in this city. I can but partially admit this endless plea of overwork in extenuation of the charge of scientific unproductiveness; that serious symptom of a larger malady. Surely the immense and habitual hospital work among the sick which numberless city doctors do, their professional teaching, their clinics and societies, the endless cares, trusts, and social duties of a city life, do these make them fail of scientific productiveness? No, it is not time alone you people want. There is something defective besides number in your organizations. And as to this, what prevents your endowed suburban hospitals having any quantity of young resident physicians? It is only to choose with care and to feed them. There is much they can do, and be taught to do, which will relieve you, and set you free for the higher work we ask of you.

But if your own institution is unhappily connected with a general hospital, do not let it send you residents for the first three months of their two year term, as is done, I hear, in this city. Could there be a more useless and thoughtless way of giving these young men a knowledge of insanity?

And then as to your paid assistants. You need as aids men who, first of all, have had long training in a general hospital, and here, the choice, I suspect, is left largely to you. Ask your boards to have competitions for your permanent assistants. Insist on hospital training, knowledge of psychology, of neuropathology, and then demand of your people original reports or product of some kind. I find myself that nothing is so useful as original research to urge on my aids. But then you must lead or they will not go the way you would have them go. I should insist, were I you, that your aids spend daily some hours outside of your walls and have a long summer holiday. There have been some among your best who have insisted that incessant contact with mental imperfection is not a wholesome thing.

Want of competent original work is to my mind the worst
symptom of torpor the asylums now present. Contrast the work you have done in the last three decades with what the little group of our own neurologists has done. To compare your annual output with the great English or German work were hardly a pleasant thing to do. Even in your own line, most of the text-books, many of the ablest papers are not asylum products. What is the matter? You have immense opportunities, and, seriously, we ask you experts, what have you taught us of these 91,000 insane whom you see or treat? You will point to certain books, some good work in this or that asylum, but, as we judge you, to no such amount of thoughtful output as your chances might lead us to expect.

There are other material failures by which we test as much of your work as we can see, and thence suspect the precision and general value of what we do not see. When we ask for your asylum notes of cases, or by some accident have occasion to look over your case books, we are too often surprised at the amazing lack of complete physical study of the insane, at the failure to see obvious lesions, at the want of thorough day by day study of the secretions in the newer cases, of blood-counts, temperatures, reflexes, the eye-ground, color-fields, all the minute examination with which we are so unostingly busy. It is not thus in all your asylums, but you will see from the letters appended that I am not alone in this critical complaint. Not so many years ago in a certain asylum I could not get a stethoscope or an ophthalmoscope; and too often when we receive a patient, and write and ask for his hospital record it is such as would surprise, for meagreness, the resident of a city hospital. I had recently occasion to see the printed schedule guide to symptom notes in an asylum; it was oddly defective, had been ten years in use and would excite a smile from any of my clinical aids. If, as to all these defects, I am still told that they are due to lack of means, I make answer that our criticism applies as decisively to some of the amply endowed asylums as to those for the poor of the States.

A clever woman once said to me that only the rich do not get the worth of their money, and here it is true. Set aside the State hospitals for the while, and let us consider the others. Why have not more of you started training schools? This would at once enliven the air of the place and assist you to get good nurses. Can you get these at from twelve to eighteen dollars a month? No. But for nothing you can get them, because if you train nurses during two years, the second year the nurse is of real value and can be promoted.
Some will stay on with you, and then, if you furnish nurses really trained to the care of the insane you can reward your best nurses with convalescent cases leaving your care and able to pay, as we pay outside, larger prices than you can give as wages. Try this, and see how it works. You will get better aids. Make your young men teach the nurses. There is nothing teaches the teacher like teaching. And let me helpfully insist that there is a real outside demand for nurses trained to intelligent care of the insane. I wanted a dozen this winter. The fact is your nurses are, as a rule, of an unfit and quite uneducated class. When one of them comes to me to take a case, or comes with a case and I give her a careful schedule of the day, I find I have to teach what a pack means, and a drip sheet, and Swedish movements, and massage, and soon we part. The nurse must first be trained in a general hospital, and then have a still longer training in the special hospital. I consider the double training essential.

Indeed, we with difficulty understand how you get on in your work with the nurses you employ. It must make the individualization of treatment impossible. The thinking general practitioner knows that what he has to deal with is not a disease, but a disease plus a man. This is deeply true of insanity. Nowhere is it more needful to study the human soil in which the disorder exists. We think you too largely fail to do this, and we think such success impossible without educated nurses taught to observe and to handle the insane.

Have you people in your asylums trained to use massage? I see plenty of folks in your wards who need this potent blood-stirring tonic. In how many hospitals is there an electric room and a trained electrician? I wrote an asylum some time ago to ask for a statement of the electric reactions in a certain case. I was told in reply that the muscles “moved pretty well with a faradic battery!”

Some of us think hydro-therapeutics of great value. How many hospitals are provided with the appliances for such treatment? How many of you employ it at all? How far are your nurses acquainted with its various forms of use? Much of that I hear speak of can be obtained at slight cost. But when I read your reports (I have read many of late) I do not find an urgent, repeated demand for these obviously needed things. I find too comfortable assurance of satisfaction; too much stress on mere
amusements; too little on rewarded work; too many signs of the contented calm born of isolation from the active, living struggle for intellectual light and air in which the best of us live.

The cloisteral lives you lead give rise, we think to certain mental peculiarities. I could tell you how to mend them; I shall by and by. You hold to and teach certain opinions which we have long learned to lose. One is the superstition (almost is it that) to the effect that an asylum is in itself curative. You hear the regret in every report that patients are not sent soon enough, as if you had ways of curing which we have not. Upon my word, I think asylum life is deadly to the insane. Poverty, risk, fear, send you of true need many patients; many more are sent by people quite able to have their friends treated outside. They are placed in asylums because of the wide-spread belief you have so long, and as we think, so unreasonably fostered, to the effect that there is some mysterious therapeutic influence to be found behind your walls and locked doors. We hold the reverse opinion, and think your hospitals are never to be used save as the last resource.

I have found some heads of asylums a trifle shy about discussing the question of the occasional use of mechanical restraint. There lingers a dislike to admit that it should never be used, as, we thank God, some of your best assistants earnestly believe. We think it a question settled past argument. Many years ago while using it I got a lesson never since forgotten. During the war, Drs. Morehouse, Keen, and I, had always about eighty to one hundred epileptics in charge, and some insane. We employed at times the camisole, or straps, in protracted convulsions. I tried them once on myself a half-hour for a purpose needless to mention. Before ten minutes had gone I began to have a half frantic sense of desire to fight for freedom. It was really very hard to conquer. Try it, and you will think long before you add to insanity this temptation to be violent.

We think, also, of your too constantly locked doors and barred windows, as being but reminder relics of that dismal system which we are pleased to think is gone forever. I presume that you have, through habit, lost the sense of jail and jailer which troubles me when I walk behind one of you and he unlocks door after door. Do you think it is not felt by some of your patients?

I know this is a hard question, much discussed. Grated windows and bolted doors may be more or less needed where, as the State
asylums, insane hordes are in over-crowded dormitories, and attendants are absurdly few. But elsewhere, these irritating means might be used far less than they are if only you had more and better nurses. Many of you believe that these barriers do no harm; I incline to think you wrong. Here is what an able physician wrote years ago. I once printed his comments in a paper partly fictitious.

He writes: "I then felt what I suppose thousands have felt, the exasperation of these locked doors. Twice as I passed one I furtively tried the latch, and in all my weeks of confinement I never came near such a door without a wild desire to open it. If it were of any use to lock these doors all day, except to save attendants from the need to be watchful, I should not mention the matter, but the precaution is a foolish one, save in rare cases; and if a sane man wants to test his feeling in regard to it, let him get some one to lock him in a room—it may be one he does not care to leave for hours. The effect is strange. He becomes at once uneasy and speculative as to when he will be let out. The idea of loss of freedom annoys him."

It chanced, indeed, to me many years ago to be locked up for half a day in a room. I was at a hotel in New England and broke the key in locking the door. The bell brought no one; the windows looked nowhere on man. It was six hours, or more, before I got out. I think of that when I walk down your grim, conventional wards and see some poor fellow try a door and walk away. I know how he feels.

My asylum should have no exercise yards; no airing courts. More attendants? Yes, and as little as may be of this quasi-prison business. And aesthetically there is something to be said. Into one ward I sometimes see open the rooms of people of almost all social ranks. They meet more or less unrestrainedly in the common hall. Do you think the educated and well bred do not feel this; or, too, the absence of refined table settings, or the dreadful formality of walls and furniture? I have letters which complain of these things. One woman says, "I dare say I was queer enough, but neither my tastes nor my manners were cracked," and then she goes on to criticise with some amusement the table and its furniture.

I took a clever woman through an asylum of late; she had never seen one. She is not a sensational woman—far from it.
She said to me, "Oh, I should go mad here if I were not so when I came. Why can't some one move the furniture about and make it look less sepulchral. And those parlors! I should like to be let loose there with a very little money and some women I know. How we would move things about."

I want also to say (and I am all this while speaking only of hospitals for those who pay), that the monotony of diet, the plain food, is constantly spoken of in the letters I refer to. I suspect that it is too often a just complaint on the part, at least, of people of the refined class. A friend of mine in one of the great asylums wrote, when mending, "I have heard of the horrors of asylums. Let me assure you that although there is much here that is sad, nothing is half so tragic as the diet."

Of the feeling of distrust concerning the therapeutics of asylums now fast gaining ground in the mind of the general public I have said nothing. This lack of medical confidence is of recent growth. Once we spoke of asylums with respect; it is not so now. We, neurologists, think you have fallen behind us, and this opinion is gaining ground outside of our own ranks, and is, in part at least, your own fault. You quietly submit to having hospitals called asylums; you are labelled as medical superintendents, and some of you allow your managers to think you can be farmers, stewards, caterers, treasurers, business managers and physicians. You should urge in every report the stupid folly of this. Knowing what we do of the rate of the growth of medicine, does any man in his senses think that you can be even decently competent and have anything to do with outside business? You may be fair general practitioners in insanity, but productive neurologists of high class regarding disease of the mind organs as but a part of your work? No—I think not. That, you cannot be if you are also in business. It is a grave injustice to insist that you shall conduct a huge boarding house—what has been called a monastery of the mad—and keep yourselves honestly able to move with the growth of medicine, and to study your cases, or add anything of value to our store of knowledge. Some of you have, in a measure, shed this cumbersome coil of unprofessional business, but still declare yourselves overweighted with letters to write, people to see, and so much to do that it is clear either that you do need help and more assistants, or that you are cursed by that slow atrophy of the energizing faculties which is the very malaria of asylum life. Asylum life! There is despair in the name as there is in the idea.
And the title "superintendent." Of what? You have let the word go as concerns this society. Insist to your managers that you are physicians and no more. There may be something to dread in a label.

The many grave questions which remain I can do no more than lightly mention. Some I may but touch and leave as texts for thought. I have notes of six cases dismissed as cured from great endowed hospitals without one written word of warning or direction as to the work, the play, the diet, holidays or future of these people. When you find a case getting well, and let it go home or elsewhere, is it as common as this would seem to make it that you no further concern yourselves with it? I never had much evidence that the reverse is often done, and yet with some of us mere outside practitioners the future of our convalescent, or cured, cases is a matter of the most thoughtful care and of the most anxious solicitude, of long written instructions how to live so as to avoid relapses.

As to work for the chronic and convalescent insane, I never yet saw in America the hospital where all was done that can be done in this direction. These alien people are relatively capable of bribery. Tobacco, later hours, better diet, larger freedom, a little wage, the use or non-use of certain privileged rooms, leave among women to wear this or that, putting some who shirk work with others who do work, the influence of example, all these helps may be more ingeniously varied than they are. But as long as you pay common nurses (whom, perhaps, you do well to describe as attendants), untaught and uninterested, to watch hordes of people, or to preside over men and women far better educated than those who watch them you will do little with this essential means,—work. I think there must be no effort to make this work pay. It is education we want. Moreover, if you can make the work interesting and productive, it will be best.

As I want this address to help you and to be read by laymen, I shall ask to have added a newspaper report of that noble object lesson seen at Wernersville, when one hundred and thirty insane were set to work in the open, guarded by no walls, and there did work which would amaze many a so-called superintendent. I wish the account could be scattered wide. It greatly affected me as I read it. I wish, as an object lesson, the good people of this city could have seen this merciful success where the insane were working out of
doors. For then I would take them where, in the sadness of our city wards at Blockley, the insane, who have lost even the memory of hope, sit in rows, too dull to know despair, watched by attendants; silent, gruesome machines which eat and sleep, and sleep and eat. Once in the women's wards the bright cap and white aprons of the nurse of the training school were seen. She is there no longer. I should like to know why? It is condemnation enough to say that here are 1,100 insane, and that of these a small percentage are doing any work. This is not the fault of those in charge, or of any but the people of this great city. I dare not revile you for the motes and neglect the beam which makes us seem blind to the sin of this abominable wrong.

There is another function which you totally fail to fulfil, and this is by papers in lay journals to preach down the idea that insanity is always dangerous; to show what may be done in homes, or by boarding out the quiet insane, and to teach the needs of hospitals until you educate a public which never reads your reports, and is absurdly ignorant of what your patients need. Do you not see that what I need for every hospital is a certain noble discontent, a vitalizing headship, which shall be itself scientifically productive, and shall insist on this from the aids? Believe me, the best hospitals of any kind are those where the most precise scientific work is done. There the treatment becomes accurate, the results best. In our city hospitals, the physicians are continually changing service and there is no single head. With you, there is but one head, and this may, if the head possess brains, have the huge advantage that its owner can suggest, direct and encourage research, and by his personal work and enthusiasm keep his whole hospital toned up to the highest intellectual and moral health. It is not a mere well-worked, so-called model, institution which I want to see, where easily pleased managers come and go, and routine is perfect, and every one is satisfied, and the nice little reports describe the amusements, and the new dairy and the statistics are there, and we lament the death of our efficient manager, Mr. Blank; the whole smug business as monotonously alike as are your asylum corridors.

Where, meanwhile, I repeat, are your careful scientific reports; where, the earnest note of indignant appeal to your boards and to the world without, which should help you and will not? Is this all nonsense? Not so. When you read the appended letters, you will see how constantly these men point out that it is the system which
is most to blame, not you alone. My fear is that some of you would not change your organization if you could. My belief is, as to much beside that might be, and is not, that your lives are destructive of energy. You live alone, uncriticised, unquestioned, out of the healthy conflicts and honest rivalries which keep us up to the mark of the fullest possible competence. I hardly blame you. The whole asylum system is, in my opinion, wrong, and has been let to harden into organized shapes which are difficult to reform. How further it should change, I shall presently say; but until we have you all on our side, it will not change. Nor does it surprise me that so many are contented and ask no radical alterations. I think I should in time become but formally dutiful, if I lived all my days in any kind of hospital. When I go into my clinic or wards, I take with me the fresh air of the outer world, and this is what you want. You ought not to live and sleep in your hospitals at all; you ought to be in contact with the world of sane men, having consultations outside, seeing us and our societies. At least you should have in your wards weekly consultations from without. That, I think, would be a good prophylactic against the inertia fed by the amount of hopeless cases which surrounds you. I cannot see how with the lives you lead, it is possible for you to retain the wholesome balance of the mental and moral faculties.

There should, I think, be in America somewhere one large, perfected hospital for the possibly curable insane, and it should of need, include a home for the education and uplifting of the chronic and hopelessly insane.

Let me conclude with a sketch of my ideal hospital; I seem to see it as I write. It is near to a city and close to a railway. Its grounds, fenced in, not by walls, but by railings, vine covered and hidden by trees and shrubs, are amply acred, and include some forest and wide, cheerful gardens. Without are the farm and vegetable garden. I go in with my patient. We drive through an ample gate, ever wide open and watched. There is no loop-hole for the gate guard to look out of, no mysterious opening of barred doors. We enter an avenue among flowers and trees, out of view of the larger buildings. Shall we drive up to a formal hall and cold doric portico, and be met by a smileless janitor, and then wait in sad expectancy the long delayed coming of the doctor in one of your vast, melancholy, unsympathetic parlors? No. We pause amid thick shrubbery at the side door, which is like that of a private house.
In a small room, as pretty as taste can make it, we are received by a well-dressed head nurse, neat in cap and apron—pleasant and kindly she shall be. My patient is then given a room, temporary quarters, in a special reception house, for it is part of my plan that this hospital shall be made up of grouped cottages, each with its family of ten or twelve, or less. In each is a head nurse and attendants. There are no bars, no locked doors. Apart stand smaller homes for those able to pay more. I want to get it as near to the life of the outer world as I can. At a distance, hidden by trees, is the administration building, vine clad, I trust, and flanked by the wards for those who can pay little or nothing. There are no barred windows, and here are open doors, with attendants ready to say a kindly word to the too restless. I can see you smile. It has been tried, I believe, and has not been found impossible. Connected or not (better apart) are the library, reading rooms, billiard and amusement rooms, and gymnasium. In the grounds are tricycles and bicycles, etc., tennis, and croquet grounds of course. Also, further away, are the work shops, with tools, lathes, all the means needed, and, too, the school rooms, for how do your chronic insane differ from the little defective ones at Elwyn? Yours are, many of them, like these children. I would have the kindergarten methods, and modelling and patternning and embroidery, etc. Let those who will not work watch those who do; use the contagion of example.

My patient is not at once put in charge of a nurse. An assistant, male or female, a physician, is with him for three days or more (one of his own class or above it). He shall study the case, and quietly record its mental peculiarities. As the patient gets used to him, and less suspicious, he goes over him physically with extreme care. Then there is the report with the added statements on his certificate, every detail of life, business, habits. A consultation with the physician in charge follows, and a decision as to the mental, moral and physical needs of the case, and, above all, in every instance, a written schedule as to how it is desirable that the day be spent; all this the nurse shall read; I mean all of the notes. Is this too much? We closely imitate it in our own hospitals and in our private work. Every week for the acute cases the nurse turns in her written report as part of her work. How far the patient has lived up to the schedule; how far not. It is added to the case, and the cases are kept as indexed cards, not in cumbersome books.
Of treatment I say no word. It would often include much that you do rarely use, and to which I have already alluded. You may have many means and many helps which we cannot employ except for the amply rich. Years ago I tried in vain to talk certain boards into having convalescent seaside homes, not farms near the hospital; I utterly failed. Now, this is coming; but not as yet is the need felt to have those homes where the alterative change of air is complete, as by the sea.

There is a steward for purchases and for care of farm-garden and grounds. The senior physician with no business cares, a trained neurologist, living in the city, spends two-thirds of his day in the hospital; he has only consultations in town. Then there are resident physicians in charge, who shall live in the house. On the female side it is a woman helped by women. After three to five years these aids should be transferred under a new and reasonable State system to another hospital; or, in an endowed hospital, changed yearly from one ward or group of patients to another. Here, alone, is rotation in office valuable. Under the chief are young physicians, internes who serve two years, and both classes compete to win these places, which are paid—as to the younger internes but modestly. One resident is a pathologist. There is a bath master; but in rotation a resident sees and becomes familiar with this service. We have, too, a skilled electrician. The nurses are taught massage, but there is one person who is, as to this, an expert. I would also have on the staff a city oculist and gynæcologist to be used on call, and above all, I would have once a week a long consulting visit from outside neurologists. For this visit the staff should select cases of doubt or difficulty, and this should be a serious and formal matter. The men chosen should be paid, and well paid, for I shall ask from them help in research and in the training of nurses. And as to these latter aids, they should have very little pay the first year, and more and more as they elect to stay upon receiving their diplomas after two years.

Again I wish to emphasize the fact that the nurse is by far the most important part of my organization. How can you hope for the best help from the class we usually see in your wards? I could surprise you a little with the dismay and disgust expressed as to these agents by refined and educated men and women in their letters to me. A few minutes a day make your visits, and the rest of the time, where there is an attendant, is too often spent by your patients in society little above that of the cook or maid.
One wing of my control building shall have a good library of medicine, a laboratory, rooms for pathological research, and also (as we have in the Infirmary here) a room for the study of such phenomena as reflexes, reaction times, with chronographs and the like.

And now, the life, the soul, the driving power, shall be in the physician-in-charge. The training schools, the meetings for organizing combined or individual research shall have his eager care. He shall possess the ingenuity to point out paths untrodden by discovery, the energy to lead on these and to put life and vigor and sympathy into all the work. Above all, he must be gentle, refined and courteous and insist that good manners prevail. I have seen in asylum wards, and seen unrebuked, bits of discourtesy to a well-bred gentlewoman for which I would have dismissed a nurse on the spot.

Of the rest of this great, and quite possible organization, of the rewards for scientific work, of the extra compensations, or the medals for nurses who show courage or have exceptional success I cannot speak; nor of much else besides.

A good deal of this cannot ever be had in your State hospitals, for incredible folly has put most of them remote from cities. But suppose some great-souled man, or some State, decreed such a hospital as I have made a day dream of, would it not become radiant of useful example far and wide? I used to be hopeless that any board would ever rise to an intelligent apprehension of the splendid value of such a scheme. But already at Elwyn certain steps have been taken to secure outside counsel, help and criticism, and I trust scientific use of the nine hundred defective children. The plan as yet lacks the essential element of pay, but perhaps this will come. Watch it and see how it works. The day dreams of the thoughtful sometimes materialize as practical working things, and the years will surely bring something like, or far better, than what I have sketched. If it will be created by the generosity of a man, or the educated demands of the commonwealth I do not know. But it will come.

And now, a word more. I accepted this ungracious post from honest sense of duty. I have said no word of dispraise or critical annoyance that I did not eminently dislike to say. I may be wrong as to some men and to some hospitals. It would be strange if it were not so. But let me add this on parting. One preaches to a congregation. It is impossible to select individuals for blame or
praise. Try not to be merely hurt or disgusted by the verdicts of my fellow neurologists and myself. If what we have said causes only bitterness and leaves you in thought, action and purpose where it found you an hour ago, then I have assuredly failed as I do not want to fail and had better never have spoken. If it should happen, please God, that my words bear fruit of good I shall get more happiness out of this occasion than I ever thought could come out of most distasteful task of a varied life. If I have hurt or personally annoyed any man here to-day I am, believe me, sincerely sorry. Perhaps many of you who do not feel vexed may yet rest sure that I am largely wrong in my censure and my theories; but fifty years hence, when we must all have been swept away, another will possibly stand in my place and tell your history, and to him and the bountiful wisdom of time I leave it to be declared whether I was right or wrong.

I have been very long, and you as patient. I thank you.
On this fiftieth anniversary of our Association it is fitting to review the half-century's work in the care and treatment of the insane in this country. This is a time to take ourselves seriously to account, and if we have not made due progress in the great purpose of our organization, we should profit by a frank confessing of the things we have left undone; if, perhaps, some advancement has been made, we may take pride in it and thank those who have gone before us, and who led the way.

The limits of this paper permit the discussion of little more than therapeutics proper, with only such reference to questions touching the general care of the insane as will naturally arise in such a review as this must be. We must first note the conditions under which the founders of the Association began their work in 1844. It is needful to consider what was their understanding, and that of their time, of the nature of insanity, although it is but to recite well-known facts of history. Then we may review more justly what they did for the care and cure of those afflicted with this gravest of human maladies. We know that the rational doctrine of Hippocrates and the other founders of medicine, that insanity is caused by disease, was lost in the superstitions of the middle ages. In the revival of civilization in Europe in the eighteenth century, and even before that time, a number of men in its greater countries sought to ameliorate the condition of the insane. The stories of Pinel and Tuke, and what they did one hundred years ago, are our household words; for them it was reserved to make the beginnings of a true reform, not only by taking humane care of the insane, but by treating them as subjects of bodily disease.

But it was twenty-five years later, in France, after Pinel's great triumph at the Bicêtre, that the next advance was made under the influence of his pupil, Esquirol, who began his lectures on the treatment of insanity in 1817. While Pinel had advanced the care and treatment of the insane he knew
little of pathology and got his psychology chiefly from the philosophers. Esquirol advanced the pathology of insanity, and was the prime mover in the second phase of the great reform. But progress in the hospital care of the insane was very slow in France, as in other countries. It was not until 1838 that Esquirol’s labors secured the passing of the law by which the modern treatment of insanity in a humanitarian spirit was effectively organized in that country, on a sound basis. There followed then the building of new asylums, with proper treatment by physicians in charge, and better food and attendance.

In Germany, early in the century, Heinroth and others developed Pinel’s treatment, but taught the psychic theory of the common origin of insanity and sin. But Reil had then freed psychiatry from the theory of Locke, that there is nothing in the insane but a change in the working of the intellect. In the third decade Jacobi (and Van der Kolk, in Holland) opposed Heinroth’s theory, and sought to establish the relations of mental to bodily disease, advocating the material and practical ideas of John Hunter and Bichât. But Jacobi did not regard the brain as the organ of mental activity, and believed the causes of insanity were to be found in the disorders of the organs of respiration and circulation, and especially of the large intestine. It remained for Griesinger to demonstrate the inadequacy of these views, in 1845; and as the “greatest of modern alienists,” he first established the diagnosis of diseases of the mind upon an exact basis of scientific research and sound pathology. The teaching of Pinel and his pupil, Esquirol, were received by the civilized world with enthusiasm. The development of “exact medicine” through the introduction of natural science in the third and fourth decades, both in Germany and France, contributed greatly to the establishment of the new science of psychiatry, and its emancipation from the bonds of the metaphysicians, who still claimed all knowledge of mental physiology. The Germans interested in mental science went to Esquirol and his disciples, and there got the instruction and inspiration that promoted the building of hospitals for the insane in Germany, according to the modern ideas which Griesinger first clearly taught. He was greatly aided by his illustrious contemporary, Virchow, the acknowledged head of exact medicine of the present day. That this great leader is still living, points the interesting fact that psychiatry is one of the youngest of the medical sciences.
In Italy, at the end of the eighteenth century, Morgagni, the originator of scientific pathology, had taught that the brain was the seat of mental diseases and proposed a mild and rational treatment. Chiaruggi also had undertaken the reform of the Florentine asylum by substituting a humane and judicious treatment in place of that based on superstition and cruel ignorance. After that a few asylums were built in Italy, but it does not appear that any important influence was exerted by Italian teachings as to the nature and treatment of insanity and the care of the insane, before the beginning of the half-century that is now ending.

In England, after William Tuke had built the Retreat at York, in 1796, progress was very slow in mitigating the severity of the confinement of the insane in jails and alms-houses. Up to 1828, when the first commission was appointed to look after pauper lunatics in London, the only act in force provided for their being "locked up and chained" in secure places. In 1837 W. A. F. Browne wrote that many of the worst faults existed in asylums, and few had the confidence of the public. In 1842 there were one hundred and sixty-two asylums, public and private, in England, and the abuses were so great and frequent in them that the Lunacy Commission was then appointed which has accomplished so much for England and the whole civilized world. But the great advancement of the reform was due to Connolly, who, inspired by Hill's attempt at Lincoln Asylum, began his work at Hanwell in 1839, with the introduction of the non-restraint system.

The foregoing summary will serve to indicate the ideas of the nature of insanity that were held by enlightened physicians and philanthropists in civilized foreign countries, during the half-century preceding 1844. That the advanced views of these reformers were only exceptionally in effect, is amply shown by the general continuance in those countries of the deplorable lack of humane hospital care. The prevailing ideas of the treatment of insanity, especially outside of the asylums, were equally unsatisfactory, although it had then come to be generally accepted by medical men that mental disorders are symptoms of bodily diseases. Pinel and Tuke had learned that the insane require "supporting treatment," and set themselves against the abuse of depletion by blood-letting, evacuation, and low diet. Esquirol, writing in 1816, describes in the strongest terms of reprobation the excesses to which this practice was carried, not only by physicians in general, but in the asylums
in France. But while he agreed with his master that irritation is not inflammation, and that blood-letting is not necessary in the treatment of insanity, he still held that it is indispensable in plethoric subjects when the head is strongly congested, and hemorrhages or habitual sanguine discharges have been suppressed.* Broussais, in 1828, held that insanity being an inflammatory irritation requires sedatives, counter irritants, and revulsion. He wrote that "profuse bleeding has been too much deprecated since the days of Pinel, and his school has been too parsimonious of the blood of the insane." In the time before the adequate provision of special hospitals for the insane, many were treated in the general hospitals. The theory of depletion was the common one, and the practice of bleeding, vomiting, and purging pursued at Bethlem as late as 1815, revealed by Crowther, Haslam, and Munro, has been characterized by Pliny Earle† as absurd, and as a remarkable example of the adherence to traditional custom. But Morison, in 1826, and Prichard, in 1837, though disapproving of indiscriminate blood-letting, regarded it as serviceable or absolutely necessary in some cases of insanity. Burrows, writing as late as 1828, stated that "copious abstractions of blood are almost universally adopted in cases of insanity attended with symptoms of violence, and sometimes when the patient is tranquil. The practice has received the sanction of ancient authority, and is at present very universal." But he says, further, that having followed that example for a number of years, he modified his practice. Connolly, while he became convinced at Hanwell that "great blood-letting is rarely advisable, and generally dangerous in insanity, still believed that local bleeding, by leeches, is safe and serviceable in most cases."

German writers of the earlier decades of this century express like differences, and a gradual change of opinion, on this subject; and Zeller, in 1840, stated that "the idea of irritation has taken the place of that of inflammation," and that "topical bleeding as a revulsive is better and safer." In Italy the older ideas prevailed in the period of medical decadence of that country, even until its political regeneration. It is significant that the most distinguished personality of that epoch, the great Cavour, was a sufferer from nervous exhaustion, and died in 1861, after repeated blood-lettings.

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* Dr. Hack Tuke. The Insane in the United States and Canada, 1885, p. 22.
† Dr. Pliny Earle. "Examination of the Practice of Blood-Letting in Mental Disorders," Am. Jour. of Ins., Vol. 10, p. 379.
No one incident of the time did so much as that in arousing scientific medicine from its apathy.

The importance of this question of general depletion in insanity, by venesection and otherwise, justifies its being so fully noted here. The crucial question of its time was upon this practice, which greatly flourished before the first half of this century, and lingered even later than 1850; the battle was fought over it by rational medicine against ignorance and empiricism—of insanity as a disease of weakness of body against the lingering of the conception of some invading evil that must be heroically routed, as were the obsessions of an earlier age. The part it played in American medicine shows the influence of European teaching in one respect, and the independence of it in another, to the lasting credit of American alienists. This brings us to the consideration of the conditions in which the fathers of our Association were placed just preceding its foundation.

Rush was the "American Sydenham;" to mention his name is to recall to every physician the profound impression made by him not only upon general medicine in America, but upon the treatment of the insane. His professional career covered the period from 1769 to 1813, when he died; and among his extensive medical works the last one published was the "Observations upon Disease of the Mind," in 1812. This great work is said by Ray to have been "the first of the kind in the English tongue displaying thorough observation and original thought."

Rush treated the insane in the Pennsylvania Hospital, and it is not necessary to repeat the well-known history of his faith in the lancet. He soon discarded the classification of diseases of his Scotch preceptor, Cullen, and made one of his own, including insanity. He lamented the slow progress of humanity, and most in behalf of the insane; he refers to the "humane revolution" in Great Britain, and states that a similar change had occurred in the Pennsylvania Hospital. "The clanging of chains and the noise of the whip are no longer heard in their cells. They now taste of the blessings of air and light and motion, in pleasant and shaded walks in summer, and in spacious entries warmed by stoves in winter." He had enlightened views of the importance of labor and diversion of the mind thereby, while he regarded insanity as sickness. But he had peculiar views as to its nature; he believed that its primary seat is in the blood-vessels of the brain. He employed bleeding in
melancholia, and as the first remedy in mania, it being, as he believed, "an arterial disease of great morbid excitement or inflammation." In most cases he also prescribed blisters, issues, salivation, emetics, purges, and a reduced diet. Then after reducing the action of the blood-vessels to a par of debility with the nervous system, he allowed stimulating food, drinks, and medicines, and a change of company, pursuits, and climate. He extols opium as "that noble medicine which has been happily called the medicine of the mind." He believed also that venesection was necessary in consequence of there being "no outlet from the brain to receive the usual results of disease or inflammation, particularly the discharge of serum from the blood-vessels."

These teachings of Rush long controlled the treatment of insanity by general practitioners in America. But these depletory and reducing means were practically discarded by the earlier alienists who came after Rush. The Frankford Asylum, opened in 1817 employed the mild method of the York Retreat in England, and exercised a most salutary influence by its example. At the McLean Asylum, in 1818, Rufus Wyman adopted the system of Pinel and Tuke, and was opposed to depletory treatment; and Luther Bell in 1841 wrote that "the practice of bleeding, violent purgation, emetics, vesications, and derivations has passed away before the light of experience." In the earlier years of the Hartford Retreat, which was built in 1824, Eli Todd insisted upon generous diet, and recommended a frequent resort to tonics and narcotics in the medical treatment of the insane. He found that it required considerable boldness and address to introduce this plan of treatment, contrary to the teachings of Rush. These rational views were advocated by Brigham, Ray, Bell, Kirkbride, and Curwen, and many others. But Earle as late at 1854, found occasion for a strong protest against the general practice of blood-letting in insanity as an error then generally prevalent.

The practical therapeutics of that time, from 1840 to 1850, may be summed up, truthfully perhaps, as follows, both for England and America: With the discarding of the theories of inflammation and depletion as the prime indications in insanity, the practice of a "supporting treatment" had come into favor, with medication aimed at meeting the symptoms as they appeared. About 1840 it was with many the rule of practice to regard it as an important first indication to meet the symptoms of local congestion, especially
when there was evident determination of blood to the brain. But in the treatment of this condition only local bleeding was approved in the best hospitals, and that under many cautions against exhaustion or collapse. Emetics were regarded as useful in torpid states, as in melancholia with dyspeptic disorder. The best method was to use tartrate of antimony, which was found most efficient often in mania. But care was to be taken not to be misled by the calmness thus produced, which arises from exhaustion.

Purgatives, laxatives, and enemata were used with much of the careful discrimination taught by modern therapeutists, the less drastic remedies being best approved. Preparations of mercury were used with more care than before that time. Opium, narcotics, and sedatives were in general use; these included hyoscyamus, belladonna, and conium. They were used to allay excitement or agitation, or as hypnotics. Opium and morphia, while their use was regarded as requiring discrimination, were believed to be liable to cause phrenitis in cases of cerebral congestion and great vascular action. When indicated, opium was given in large doses; but it was often contra-indicated for sleeplessness, if after taking it the patient should awake with increased excitement. Camphor was much used, and often combined with liquor ammoniae acetatis, and was regarded as a valuable remedy.

Counter irritation was still prescribed to some extent. It is to be presumed that some in America followed an English authority of the time, and regarded blisters as beneficial in mania as revulsives, and as useful in melancholia by their irritation serving to divert the mind from its morbid train of thought. It was considered injurious to apply them to the head, as they increased the excitement of the cerebral membranes and interfered with the application of cold. Tartar emetic ointment, and the like, were used to maintain a steady counter irritation on the back of the neck in recent cases of insanity. Cold to the head, the douche for the same purpose, the warm bath, with friction of the lower extremities, were prescribed in appropriate cases. But the use of cold water was regarded as requiring caution, and unjustifiable as a mode of punishment.

In the search for data as to the practice of American alienists in the use of medicines during the last half-century, the case-records for seventy-five years of the McLean Asylum have furnished a mine of information. The general results of their examination in detail will be given here, as probably affording a fair example of American practice, and showing the changes in it.
In the period from 1840 to 1850 these records confirm the indications of the foregoing summary of the therapeutics of the time, except that there is proof, by negative evidence, of Luther Bell’s statement, already quoted, as to the disuse of “violent derivations.” Tartar emetic ointment, applied to the spine, is once mentioned. A common tonic was “red mixture” (conium and carbonate of iron). Quinine, arsenic, port wine, “brandy and bark” were prescribed. Chloric ether was sometimes given in agitated melancholia. Tincture of opium in one drachm to three drachm doses was prescribed for the excitement of mania, and sometimes in melancholia. It is noted in a case of puerperal insanity that “a previous attack seven years before had doubtless been prolonged by depletory treatment—bleeding, blistering, salivation, and starvation.” It is interesting to note the use, in a number of cases, of inhalations of ether and chloroform to allay excitement and promote sleep. “Supporting treatment,” with nutritious and liberal diet, was the regular practice. The writer recalls with interest his personal experience in the preparing and dispensing, as a junior officer at the Hartford Retreat, about 1860, of a very similar list of medicines. The terms “red mixture,” “elixir pro,” and “nux and gentian,” are vividly remembered, as well as the consistent teaching and practice of the “supporting treatment.”

Moral treatment was regarded in all the asylums as of the greatest value. Taking the practice of the McLean Asylum as an example of the views prevalent from its beginning, in 1818, to 1850, its records show that great attention was paid to occupation and recreation. Dr. Bell gave interesting accounts in his reports of the means for inducing patients to take exercise, in manual labor on the farm and in the carpenter’s shop, walking in the gardens, excursions, in-door games, entertainments, etc. These methods were not unlike those employed in hospitals of the same class at the present day.

At the McLean Asylum, up to about 1865, there is little change noted in the records beyond the introduction of new preparations of iron, the occasional use of strychnia, etc. But in that year bromide of potassium appears as being prescribed for melancholia. The use of opium and morphia at that time had notably diminished to small doses, often combined with hyoscyamus; and these prescriptions were much less frequent. Chloral hydrate appears among the drugs given in 1871; but before 1890, this and the bromides were
practically no longer prescribed. Cannabis indica was given for a time about 1880, but was quite abandoned, along with all preparations of opium, except codeia, which was used in the restlessness of elderly people to allay distress, and in some cases of melancholia. During the later period the newer preparations of iron, quinine, strychnia, etc., were commonly given. A rather increased use of stimulants at one time yielded to the more common practice of frequent feeding, especially at night.

The therapeutic history of the last five years or more, of this hospital, shows an extension of the indications just noted; there was also a marked lessening of the use of hypnotics. Paraldehyde and urothan were not long used. Sulfonal then came in vogue, but after three or four years was practically disused as unsatisfactory because of its possible after-effects; it still appears to be used in many hospitals but there is evidence, in cases that come to them, that this and other like drugs are employed to excess. Then came chloralamid and trional, and these last are still prescribed for brief periods in severe cases. Hyoscyamine and the like were never used here beyond a few experimental doses. The same is true of hyoscin, although it is perhaps generally regarded as a useful drug. But gradually the practice has come to be the dependence upon food as the best tonic and the best hypnotic, frequent feeding by night-nurses, with the warm bath as an adjuvant. A few sleepless nights were not regarded with anxiety, nor even a long continuance of small amounts of sleep nightly, as long as nutrition is maintained, as it more surely is when no poisons are given that impair the digestion and aggravate irritation by their after-effects.

After 1880 there was noted the increasingly diligent use of massage, sometimes faradism, and gentle gymnastics, with increasing amounts of exercise as it was borne. Absolute rest in bed in appropriate cases was prescribed, except when unendurable, because of distressing restlessness; but such rest was insisted upon, and modified to suit the case—till after midday, or after breakfast. The practice of this later period may be summed up as the further development of the "supporting treatment" that our fathers began early in the century. It became rational and scientific under the precise methods of the "rest treatment," with which the name of our illustrious countryman is always associated. The proof of the prevalence of these principles in the past practice among the insane is not wanting. A remarkable article was written in 1868 by
E. H. Van Deusen, the superintendent of the Michigan Asylum for the Insane at Kalamazoo, entitled "Observations on a Form of Nervous Prostration (Neurasthenia) Culminating in Insanity." He wrote that his observations had led him to think that there is a disorder of the nervous system, the essential character of which is expressed by the term neurasthenia, and so uniform in development and progress that it may be regarded as a distinct form of disease. He drew a graphic clinical picture, with a completeness of detail and an analysis of symptoms, that exactly accords with our present knowledge. He applied the term "neurasthenia" as an old term, taken from the medical vocabulary, and used simply because it seemed more nearly than any other to express the character of the disorder, and more definite perhaps than the usual term, "nervous prostration." The transitions from neurasthenia to melancholia and to mania were well described, with a clear insight into the concurrent bodily conditions; the motor and sensory changes were noted, and differentiations were made between the various groupings of mental and bodily symptoms. The principles of the treatment of neurasthenia could hardly be better stated to-day, in the light of the present greater knowledge of these conditions. It is known that these views of Dr. E. H. Van Deusen's grew out of clinical observations at Utica Asylum some years before. It is interesting to note that they were published in 1869, before the appearance of Beard's original paper on neurasthenia; and that even the neurologists are not yet agreed as to the existence of such a disease.

It was the common teaching ten years ago, and by some even to the present time, that neurasthenia, as a distinct disease, rarely passes into melancholia. In this view it was hardly believed that the neurasthenic condition is the very soil out of which insanity grows. Hence there is progress made when it is shown that all insanity being nervous weakness somewhere, the fundamental principles of the treatment of the insane are included in the "rest treatment." Thus it has come to pass, at the end of the century since Pinel's and Tuke's "milder treatment," the great contribution to rational therapeutics, in the formalizing of the "supporting treatment," has aided in making a finality to the demonstration that acute insanity is a disease that presents various manifestations of pathological fatigue and should be treated accordingly. And as we change with the changing times, so "time brings in his
revenge." A hundred years ago Rush contended against the humors in the blood which, being pent up in the brain, disordered the mind; and he sought to let them out with his lancet. Now we are beginning to believe that various toxaemias work derangement of nervous and mental function; and against the depletion so largely prescribed during the first half of our century, we set up the principles of elimination in the treatment of acute insanity. The alienists all through the century have held the advanced and enlightened views of their times. They were leaders in their comprehension of nervous weakness, and in withstanding the evils of the depletory theories; they have kept pace with the logical advancement of the "supporting" method. We have now come to face with our modern problems: not only must we study the chemistry and physiology of nutrition and body weight, but the revelations of blood analysis are of vital importance as guides to treatment; and the study of the influence of infectious diseases, and the chemical pathology of diathetic disorders point directly to the rational treatment of the mental derangements that depend upon auto-intoxication. The "new psychology" now presents itself as one of the newest of sciences for us; the beginnings of the adaptation of its precise methods to clinical purposes in the laboratories of our hospitals are only yet being made in Italy, Germany, France, England, and America, but they are full of encouragement. It is on these lines that there appear the most hopeful signs of progress. The advancements that have been made in the pathology of the nervous system have been very great in some directions, but the aid that was expected from anatomical pathology, in the treatment of mental diseases, has so far been disappointing. This subject, however, is not germane to the present discussion.

This review has been quite strictly limited to the therapeutics proper of our special work. But it has of necessity touched upon one of the burning questions of the whole century in the humane care of the insane, that of mechanical restraint. We have seen that our American alienists of the first half of the century were able to begin with the methods of Pinel and Tuke. Our first asylums were new then, and in them there was little to reform. In 1844 there were twenty institutions for the insane in the United States—nine of these were founded in the preceding five years. Luther Bell then contended that, as compared with the European asylums of that time, no such abuses ever existed in American
asylums that called for the great reform of non-restraint. It is not
the place here to review that controversy of eighteen years ago.
The truth lies somewhere between the opposing extremists among
English and American alienists. Folsom has shown the fact of
American leadership by the grand men who were numbered in the
"original thirteen" of the founders of our Association; and that
this leadership may be accounted as continuing about twenty years,
covering the careers of Ray, Bell, Kirkbride, and others. But in
the half-century of events that we are now recounting, one hundred
and twenty-five institutions for the insane have been added to the
twenty that before existed. In the marvelous growth of our coun-
try, with the immense influx of foreign population, and the rapid
multiplication of the insane in hospitals, it has been an age of con-
struction. Our States, municipalities, and asylum officers have been
often overwhelmed with the problems of the mere housing of the
insane. It was a question of great poverty in some of our States.
We never fail to honor the noble woman, Miss Dix, when we think
of the time of preparation that led to the building of our many great
hospitals. We will all agree that in the struggle with the problems of
construction, there were the inadequate provision of asylum accom-
modations that left the insane in alms-houses and jails, the slowness
sometimes with which the legislators were enlightened, the interfer-
ence of political interests that sometimes worked disaster and is still
obstructive of progress. We will agree that there were many
lamentable shortcomings in the care of the insane of our country.
Doctor Tuke has done us the justice to say that the proper persons
to be blamed are not the body of alienist physicians, but the mass of
the people themselves. It is doubtless true that, so far as medical
restraint is concerned, its use has been greatly lessened during the
past ten years; by many it is practically not employed, and there
has been a large growth of the humane spirit that surely comes
with the knowledge gained through the greater experience in the
care of the insane.

Moral treatment is better understood; it is being more generally
recognized that everything available which includes healthful occu-
pation for body and mind is a most salutary medicine for the mind
diseased. While we have to lament that true progress is still sadly
retarded in some of our States, where the best interests of the insane
are sacrificed to political greed, there is growing evidence that our
country as a whole is entering upon a new stage of progress in the
care of the insane. With the incoming of a new era in the construction of hospitals there is already established a new movement for the perfecting of their use. This is animated by the spirit that leads us to keep in view the broadest principles of moral treatment, with all that this implies.

There is one other subject that has a large place in our history of the care of the insane, and is destined to have a more potent one. The problem of the nursing of the insane arose with Pinel. Tuke trained attendants at York at the beginning of this century. Jacobi at Siegburg, in the third and fourth decades, described the kind of attendance he wanted for his patients as probably not to be had unless it was inspired by religious motives. Pastor Fliedner, at Kaiserswerth, in 1836, revived the Protestant nursing sisterhoods. Wyman, and Lee, and Bell described the humane service upon the insane by New England young men and women. Ray wrote of the ideal attendant, and Curwen published rules for their instruction. Kirkbride, in 1845, recommended the giving of systematic instruction to attendants. All this was before the middle of the century. In 1854 Browne lectured to his attendants at the Crichton Institution; yet later it was still doubted by many most thoughtful minds if the humane and sympathetic service required for the insane would ever be gained except it is prompted by the religious spirit. But Samuel Tuke had already, in 1841, expressed the doubt that there could ever be an adequate supply of such service.

Then came another noble woman—Florence Nightingale—who raised up one of the greatest reforms of our time—the reform of nursing in the general hospitals. The alienists had striven for this reform long before in the asylums, and now they strove the more. The recent work of Clouston and Clarke is now a matter of history; and for the last decade of the century, which Pinel and Tuke began, it was reserved to effectively establish a considerable number of organized schools for the training of both men and women as nurses for the insane. In 1892, the centennial of Pinel’s great year, there were nineteen such asylum training-schools in America, all established within the previous ten years.

That this is but the beginning of as great a revolution in work for the insane as the like one is now coming to be in the general hospitals, no well-informed observer can for an instant doubt. Progress in our special work has been retarded, and in some vital particulars made impossible, through the lack of intelligent and
faithful attendance. Now it is the nurses of a new order in our hospitals that make possible the new and better modes of treatment. We are stimulated to apply these better methods by having the means for applying them. This movement is filled with the largest promise of good to come by the multiplied power and inspiration it brings to physician and nurse; and it is big with blessings to the sick in mind who, even in their weakness, may know and be uplifted by the intelligent and sympathetic interest of those in whose care they are.

DISCUSSION.

Dr. A. B. Richardson: Such a valuable contribution should not pass unnoticed. We are all under obligations to Dr. Cowles for his resumé of the therapeutics of insanity during the past half-century. We are only sorry that the Doctor was not able to give us a more complete review of the general care of the insane, but in the brief time allotted to him he was necessarily restricted to certain portions of the treatment and he handled it in the satisfactory manner customary with him. It is interesting in this connection to notice how truth stands out in this as in everything else and how we cannot from the very fact that truth is truth, get far away from a certain few fixed principles in the treatment of this disease any more than we can in the treatment of any disease. The fact is, as the Doctor says, that the treatment of insanity is the same in its essence, as it approaches correct principles, in every age and under all conditions. And it has been demonstrated by the experience of alienists during this past half-century that the treatment of insanity must have in view the fact that the disease is a disorder in the nutrition of the elements in the brain and that there exists a disturbance in the proper balance between the supply and the demand. On the one hand, in many cases, the ability of the brain elements to take nutrition and properly utilize it is limited. In the next there is an inability to secure the proper amount of nutrition because of conditions in the environment of the organization. Again, there is an overstrain upon the individual which has unduly taxed that particular organization. So the entire treatment of insanity must be a readjustment of this balance which has been lost, by a diminution of the demand upon the organization, upon the brain, by rest, by proper regulation of environment, and by increase in the capacity of the
organization to take nutrition, and a proper regulation and supply of this to it. The Doctor's remarks demonstrate this point clearly, that as far as the treatment has approached correct principles all the way through this half-century it has been directed to this one point. In the place of taking away good healthy blood or the best elements of the blood as well as the worst elements, the directions now is toward removing the diseased and damaging elements on the one hand and increasing the good elements on the other. It is quite an instructive review and teaches us that we have not got so many principles to keep in consideration in the treatment of insanity, but we must multiply methods of applying these few principles.

Dr. Hurd: I regret very much that Dr. Cowles did not have time to elaborate some of the other points which he undoubtedly had mind. I think the past fifty years have shown in the care of cases of insanity a great advance in a variety of directions. We probably have done as much in the treatment of insanity, as in the treatment of ordinary diseases, by learning what not to do, what things are harmful and should be avoided and how to assist nature. Another matter which has been thoroughly demonstrated by the experience of the past fifty years, is the importance of prompt treatment. When institutions were first opened they treated largely cases of maniacal excitement. When the patient's excitement had subsided he was thought to be well and was called recovered. We now know that in some instances the mere quietness of the patient was not a cure but that he may have suffered from circular insanity or possibly after an attack of mental excitement, he passed into a state of dementia and remained there. The old records regarded those patients as cured. They were cured of excitement, of noisiness and that was all. We have found that other conditions are necessary to effect a cure. The past fifty years have demonstrated that the stage at which mental disease can be successfully treated is its earlier stage, and that conditions which terminate in chronic insanity or dementia or degenerative disease may easily be arrested when the fault is originally with nutrition. When, however, the difficulty has gone farther and the nerve cells of the brain become degenerated no amount of treatment seems to be of any great service. I believe if we have done no other thing during fifty years than to establish the principle that all forms of mental disease must be treated as early as possible, much has been accomplished.
Dr. C. G. Hill: This paper of Dr. Cowles' embracing as it does a review of a half-century of psychiatry in this country is something that we would all like to have in our libraries. It would be of great value to the young practitioner to prevent him from moving in a circle, and passing over the ground that has been already traveled. The paper suggests still another agency for producing insanity—a question that we are just entering upon,—the possibility of auto-intoxication, by some toxic element, either produced by a want of proper elimination of effete tissues from the body or else by the growth of bacteria in the various tissues of the body. It would seem that there is a very strong probability of our entering upon a new era and making a new advance in the line of treatment. The history of the past would seem to confirm this. We know that we are constantly environed by elements of destruction, by germs and agencies of various characters, which we breathe into our lungs, take into our stomachs and which get into our tissues in various ways, and our only antidote is a good state of resistance, in other words, a prime state of health. One deduction that might be drawn from this paper is that while there are no specifics in psychiatry, yet there is one essential in all treatment and that is the maintaining of the tissues at a very high point of resistance.

The paper suggests also, that our forefathers (some of us would call them contemporaries) builded better than they knew, and even when they bled and used derivatives and various reducing agents, they sometimes, though acting upon a false theory entirely, accomplished great good. We are taught by modern pathologists that nature constantly makes an effort to throw off diseased tissues and diseased conditions, to eliminate various morbid products and germs productive of disease. Now, in drawing blood from the arm who can measure the number of germs of disease that were eliminated and who can estimate the advantages that might have occurred in so reducing the colony of germs with which the blood was freighted; possibly it allowed the individual an opportunity to gather his strength and make another effort to throw off the remaining causes of disease. Then we all know the value of free purgation. Very probably this had the same effect.
Will you pardon the egotism of one moment of reminiscence? Ten years ago I stood here, at the parting of the ways between the old ideas and the new respecting hospital construction, to say what I honestly thought of the progress that had been made in forty years in provision for the insane in America. In speaking, I was turning from the lessons of the past to the promise of the future. It was an attentive audience, of whom some are here to-day, but so many gone! Two who had been my teachers in the study of mental disease, C. H. Nichols and the elder Bancroft, sat here. Pliny Earle, one of the "original thirteen," was presiding, and John P. Gray, who had just quitted the chair, was listening to my words.

Only ten years, and what I said at that time, intended to be conciliatory but possibly considered somewhat radical, would be regarded as conservative, perhaps behind the age now. For the moment had come, and the time was ripe for the change.

But the success or failure of that hour has passed into history, and the shadow on the dial has moved on. To-day has its own lessons, and yet,

"For the touch of a vanished hand,
And the sound of a voice that is still,"

I would gladly stand ready to be offered now, as I stood then.

"Soul-like were those hours of yore,
Let us walk in soul once more."

This means nothing to the younger members who hear me; but there are some listening now who listened then who will appreciate the feeling, pardon the digression, and join with me, as, standing and in silence, I drink in the memories of the past and salute its illustrious dead.

I have been asked to present to the Association "The Evolution of the Present Hospital for the Insane" in twenty minutes. Either this is too much or not enough time. The most wonderful evolu-
tion that I ever witnessed did not occupy over a half minute. As a small boy I was drawn into a magic-lantern exhibition—I have learned to avoid them in later years. The showman threw upon the screen the bud of a carnation pink. Lo, while I gazed, before my eyes came the gradual evolution into the full expanded flower, about the size of the blossom of a Victoria Regia. It was over in half a minute, but it came nearer to Aladin’s palace than anything I had ever witnessed. O, happy age of the small boy! that even the miracles of nature can not stagger; who thinks the only reason why the bark slips on the willow in the spring is to enable him to make whistles. I have since performed the same expanding pink trick before assemblies of the insane without awakening a particle of enthusiasm in the audience or myself. I anticipate the same result with the twenty-minute hospital evolution this afternoon.

And yet looking at the present hospital in its completeness and perfection, instinctively to my lips come the words of Balaam,

‘‘What hath God wrought!’’

Will it not be enough, in the limited time allotted for this study in evolution, if I present to my Darwinian hearers the nomad and his environment, make plain what is the vitalizing principle that differentiated the protoplasm, and then show them the finished result, leaving to each one to fill in for himself the successive stages of development?

The early part of the present century found the lunatic in America but little changed from his Judean prototype of the first Christian era. His environment was the cage and the alms-house. He was shunned of men; hooted at; “crying and cutting himself with stones;” happy only—like him in Judea—when he found refuge in a tomb. In the incurable form of the disease, is he any happier now? Well, we have at least learned to hang garlands on his sepulchre.

The vitalizing principle that, moving on this protoplasm, has gradually evolved the hospital of to-day was formulated very long ago, but has, relatively, only recently been made applicable to the insane. It runs thus: “Whatsoever ye would that men should do to you, do ye even so to them.”

With time at our command it would be an interesting task to trace the awakening life in hospital construction which followed the touch of this vivifying principle and the organization of this Association, coupled with the discovery that the poor lunatic, smitten of
God and afflicted, outcast and neglected, living in dens and caves of the earth, had been made in the same image, and was still our brother.

Pleasant also to tell how one, a most womanly woman, recognizing that kinship, doubted not, but went forth on her mission as one having authority, calling legislatures to their duty, recalling to itself the common humanity that had apparently forgotten its own. And where she moved hospitals sprang up in her footsteps, a light shone in where the children of misfortune lay in dungeons, and sad eyes that had forgotten their smile looked up to see an angel stooping over them. Then the vision was withdrawn to heaven. In another age Saint Dorothea would have been joined to Saint Dymphna in our calendar. We err perhaps in this, but it is pleasant to think that, removed from our doubts and perplexities, these saints still watch over our work; that they aid us in our efforts to make these hospitals not unworthy, and that in

"Thoughts about the building,
The work one day to be tried,
When only the gold and silver
And precious stones shall abide,"
their freed souls still find their loving employ.

The finished work, the present hospital for the insane; which intelligent students of the needs of this unfortunate class have evolved as a labor of love under the vitalizing principle already stated, stands always in some bit of earthly paradise of grove and lawn and pleasant outlook. If you regard these hospitals as at best but the final resting places for broken lives and minds decayed, their grounds must be considered as among the most beautiful "God's acres" in the world. And this has always been true of hospital sites in America. The fathers, when they gathered these afflicted ones out of cages and noisome dungeons, while they built rooms with stone floors and barred doors for the men, who, in the language of the Massachusetts law of that time, were "furiously mad and dangerous to be at large," yet in the selection of site made careful provision for the mental treatment that comes through eye and ear. Windows opening to the country that God made and his sky; great trees with their birds and shadows and the winds sighing in their branches; valleys of peace stretching away among the hills at whose feet nestle lakes reflecting heaven. Who says suggesting suicide by drowning? Granted that some poor fellow goes that way, is not the door to death always open? Are we therefore to
cut off from eyes that tire at last of a changeless landscape, no matter how beautiful it may be, the shifting panorama of lake or river where sunlight and cloud-shadow chase each other in endless procession, and to soul-sick eyes that follow,

"The quiet sail is as a noiseless wing
To waft them from destruction?"

Chance the suicide, if need be, to keep the lake-view within your hospital horizon.

Aside from the doubtful art of the tree-pruner and landscape gardner, whose pride must often "be denied and set aside and mortified and crucified," fifty years have shown but little evolution in our sites for hospital building. For, ages since, nature finished her changes there, rested from her grand evolution of water and sky and green earth, and One higher than nature pronounced it "good."

But the hospital buildings of which these pleasant sites are but the settings? I shall not describe your hospital nor mine; no, not the new Bloomingdale nor the newer McLean, buildings of quite different types, both admirably adapted to the same end. In the evolution of hospital construction we have grown indifferent to types. In building for the insane there is less ostentation, more fitness to the end in view. The outward cathedral has given place to the higher temple within. When we have the key-note in "Whatsoever ye would that men should do to you do ye even so to them," how varied may be the harmonies.

In the evolution of hospital construction the idea of detention becomes subordinate to that of cure, or, failing to attain that end, that the hospital shall be no prison, but a home. While buildings are constructed for a class, the provision for the individual is the paramount idea. And thus in its evolution the present hospital for the insane has become—I say it not irreverently—a "house of many mansions," or, as the revised version suggests, of "many abiding places."

The infirmary building is one of first importance. This fact is now recognized in construction, viz.: that the insane have no exemption from ordinary sickness. When prostrated with disease in one or more of its many forms, a building constructed for a constant day and night service with trained nurses; with special arrangements for the preparation of articles of diet for invalids;
for baths of all kinds, including sunshine; wide piazzas with reclining chairs; well-ventilated rooms away from heat and noise, with fresh linen and shaded lights—in a word, with all the appointments of a first-class modern hospital for the sick; such a building is none too good provision for men to make for us when we "put ourselves in his place." When we build our hospitals in the spirit of the golden rule, what shall hinder us from doing for him likewise?

In the same spirit we now build homes for the epileptic insane apart from the general wards; structures in their appointments and arrangements suited to the varying individual needs of this most afflicted class. They are but another illustration of the completeness of the evolution of the present hospital for the insane.

The wards of our present hospitals are freed from the commingling of the criminal with the other classes of the insane. This undesirable and dangerous element has been provided for either in distinct hospitals or in separate buildings suited to their conditions and needs. Allowing that there is something of mere sentiment in making a distinction between the innocent and the criminal class, where both are insane, it was a separation in the line of evolution, and the result is that the insane in our State hospitals have a greater freedom, are better off for the change to-day. Of the result to the convict and criminal class, one better able to inform you than I am will speak later, but I venture to say that we have no occasion to commiserate this unfortunate class on the segregation; that the spirit of Pinel, only

"Unseen because our eyes are dim,"

still comes to those in prison, and that the evolution born of doing to others as "ye would that they should do to you," has come to them likewise.

But it is time to bring this disjointed, fragmentary paper to a close. In the rapidly waning moments that remain, I can only allude to farm cottages with their contented inmates cultivating their little gardens and pruning the vines about their homes; to summer rests that break the somewhat monotonous life of hospitals with an outing that pleasantly suggests the summer resorts of the world outside, but without their follies; gymnasiuums, where the mind may gain strength with the body's development; work-shops that divert the sickness of the soul by the hands' employment;
smoking-rooms that concede something to human weakness, in a world where nobody is strong; school-rooms, lecture-rooms, reading-rooms, conservatories—in a word, all those evolutions in construction that have made the present hospitals for the insane in America the representative exponent of the nineteenth century's progress in "the humane and enlightened care" of its dependent classes. This is a more wonderful evolution than any flower's expansion, for it is the consummate blossom of the highest civilization that our humanity has yet attained.

What lies forward we leave to the future to reveal. We only know that the evolution will continue and that we are but in the morning of that development. What its high noon may be is not given to us to see. As Bulwer in closing his Kenelm Chillingly pathetically says, it passes "beyond the verge of the horizon to which the eyes of my generation must limit their wistful gaze."

Oh, my brothers! building and toiling on we grow old intent on the completion of a work, finite indeed, but which expanding into the infinite is never finished. All we have, our energies, our fortunes, our reputations, we build into the work. I sometimes wonder if we are like that polyp, the coral zoophyte, which blindly builds up with his life islands under the sea; building toward but never reaching its surface, and dying in the dark? I hope rather that we may be found like those mediaeval workmen who, carving the wonderful tracery in the arches of old cathedrals, cut their lives into the stone, which stands there to-day with its story of devotion, to attest the sincerity of their work, whose religion was in their daily lives.

The teaching of science is that no energy is lost. The fathers built their lives into work that we have changed. We can hope for our buildings no greater permanence. But the spirit in which they wrought, the honesty of purpose in which their lives were spent, survives the structures which they reared. So true is it that "the things which are seen are temporal, but the things which are not seen are eternal."

I sometimes ask myself if the energy expended on these buildings has any counterpart elsewhere? For superintendents as a rule have very little worldly goods to show for their work here. Piles of brick and mortar, some dry statistics, an overworked heart and brain, a dependent family, and the reputation of being nearly as cranky as his patients, make up the sum of his life's his-
But history is so full of lies that I often turn from it for instruction and consolation to those old legends of things that never happened, which are yet nearer the truth than history. And here I am reminded of one of St. Thomas in India, trite and old I know, and you have heard it before, but I feel that I too am old and trite, and as this legend carries a moral I may as well close with it as any.

Gondiforus, the king of the Indies, mistook St. Thomas for an architect—a mistake often made in regard to superintendents—and giving the saint vast treasures he sent him into another province to build him a magnificent palace. St. Thomas knew nothing about architecture, but he was a saint nevertheless, and for two years he was spending his time and all that treasure in helping and converting the poor of the province. At the end of the allotted time the king came, and finding no palace, but his treasure squandered, he discharged Thomas as supervising architect, cast him into a dungeon, and decided to flay and burn him. Meantime the king’s brother died, and the punishment was necessarily delayed until after the funeral. On the fourth day the dead man rose and said to King Gondiforus: “This man whom you mean to torture and to kill is the friend of God, and his angels do always serve him. In Paradise they have shown me a marvelous palace of gold and silver and precious stones; and when I admired its beauty they said to me, ‘It is the palace that Thomas built for thy brother, but he is unworthy of it.’”

Then the king released the saint, fell at his feet and besought that he would pardon him. And Thomas said, “There are in heaven palaces without number, which are prepared from the beginning of the world, and they are to be bought with faith and charity. Your riches, O, King, may go before you into heaven, but they cannot follow you there.
A HALF-CENTURY OF AMERICAN MEDICO-PSYCHOLOGICAL LITERATURE.

BY G. ALDER BLUMER, M. D.,
Medical Superintendent, Utica State Hospital, Utica, N. Y.

Fifty years ago this very month, Dr. Amariah Brigham, the first superintendent of the State Lunatic Asylum at Utica, N. Y., wrote to his friend, Dr. Pliny Earle, then superintendent of the Bloomingdale Asylum, New York, a letter in which the following interesting announcement was made:

"I am about starting an American Journal of Insanity, quarterly, 8vo, pages 96; edited by the officers of this asylum. The first number will be published early in July. It is intended for the general reader as well as for the profession. This is an entire secret, as I have mentioned it to no one but Doctor Beck of Albany."

While, therefore, the American Medico-Psychological Association is commemorating its semi-centenary it happens, in opportune coincidence, that the American Journal of Insanity may also sound its trumpet-blast of jubilee, albeit the Journal must pipe in a minor key. Indeed, all these long years it has depended mainly upon the Association for its very existence. After all, it has but borne the relation of score to musical composition. It is the record of the main achievements of American psychiatry since 1844. In a word, the Journal is what the Association has made it, and in this view even an editor may be justified in experiencing a sense of pride, and raising the Journal's voice to swell the jubilante of the Association on this festive occasion. But to me is assigned in the programme a vastly more difficult task than the mere shouting of huzzas. I am to show if I can the substantial foundations about which our emotions of joy and pride play—to review a half-century of American psychological literature, and to do it in a paper not to exceed twenty minutes in the reading! There is a sweet unreasonableness in the task, but the time-limit is as welcome to me as it no doubt is, for other reasons, to you, since I shall certainly be excused if I but skim the surface of things currente calamo and fall far short of doing justice to a theme that calls for not only an
abler pen, an older head and a more critical judgment, but a longer association with the past history of this body than mine.

It will simplify our retrospect to avoid all reference to the living, however noteworthy the achievement of to-day, but even so, and confining our remarks to more or less definite epochs in our history, we can add, in token of gratitude and respect, but here and there a pebble to the literary cairn of the deceased brethren whose labors have made it possible to make this an occasion of rejoicing as well as of sorrow, of "weighing in equal scale delight and dole."

Dr. Amariah Brigham. In any consideration of the res gestae of the past half-century, there is one name that must ever stand out in bold relief in the fore-front. It is that of Amariah Brigham, who, in 1844, founded at private expense the first journal in the English language devoted to mental medicine as "a medium for whatever of value relating to this specialty he, in connection with his co-laborers in the field, could furnish." In view of the multiplicity of his duties as the head of a large institution, as yet imperfectly organized, as well as of the precariousness of his health, it was a bold and laudable undertaking. It is matter of history that he suffered alike in pocket and health by the enterprise, but he has left a monument of his genius and energy which can not fail to rebuke and incite those of us who, in the face of pressing administrative work, are too prone to find an excuse for the sacrifice of professional aspirations and a plea for literary and scientific indolence. Verily, of that early period of great awakening it may be said "there were giants in the earth in those days, and also later than that." We perhaps appreciate too little now Doctor Brigham's judgment and foresight in originating the Journal of Insanity, as shown by the fact that in those days the medical profession was far less acquainted with nervous diseases involving (or involved in) insanity. To the generality insanity itself was, if not a terra incognita, a trackless waste—dreaded and almost tabooed. This journal (and far be it from me to forget or ignore the great work done at a later period by such subsequent contemporaries as the Alienist and Neurologist, the Journal of Nervous and Mental Disease, and the rest) soon becoming the organ of the whole specialty in this country, and reporting the papers and discussions of our Association, served to concentrate and strengthen the scientific spirit of investigation and to give it purpose and consistency; for the
BY G. ALDER BLUMER, M. D.

science itself, in which so much still remains to be done, was then really at a stage almost elementary and inchoate.

Upon the death of Doctor Brigham, the managers of the State Lunatic Asylum, fully alive to the importance of their deceased superintendent's enterprise, assumed the entire responsibility of its publication, and induced Dr. Romeyn Beck, one of their number, to edit the ensuing volume. He accepted the trust, and retained his editorial connection with the Journal until 1855.

Doctor Beck was a man of unusual scholarliness and won laurels on our own field through his "Elements of Jurisprudence," unequivocal evidence of the estimation in which that work was held by the profession having been furnished by the honor of translation into the German language.

Dr. John P. Gray, an equally able successor, pushed the design of its founder with characteristic energy, and for many years of the last half-century, by his arduous labors, both as medical officer and editor, greatly enlarged and enriched the literature of the subject, not only for our profession, but for the community. For Doctor Gray did not believe in limiting such knowledge as could be gained to his own co-laborers merely, so as to make the science and art of mental medicine what every special trade in mediaeval times was called a "mystery," but he believed that some knowledge of the principles at least of psychiatry should be included in the curriculum of every medical college, that the whole medical profession might be fitted at least for the duties which the law imposes upon them in connection with the commitment of patients proper for a hospital. If we mistake not he was one of the first to give courses of lectures on the subject in two of the medical colleges of the State of New York. And we believe he was the first to advocate and procure the establishment of a department of pathological research in connection with our hospitals for the insane—a proposal in which he was perhaps somewhat in advance of his time, but which the further progress of physiological and pathological investigation has abundantly justified. I say "physiological and pathological" and advisedly, for, in our specialty perhaps more than in any other, that sagacious dictum of Professor Foster may be realized, that "All distinctions between physiology and pathology are fictitious—attempts to divide them are like attempts to divide meteorology into a science of good and bad weather." And while it may seem an almost impossible task to get at the basis of consciousness
and of its disorders from an objective material standpoint, it is surely a hopeful sign of the times that laboratories are now multiplying in asylums throughout the land, and that brainy young alienists are at work patiently and intelligently with their microscopes along lines of activity which were mapped out long ago, striving, in vicarious atonement for a previous generation’s apathy to wipe out such reproach as some of our more progressive brethren have lately laid at our door. But, alas, how lamentably frequent is the experience when a spirit of sneering cynicism is combined in the same superior mentor with an alluring gift of literary facility, that the good that our dead have done "is oft interred with their bones."

Those who knew the late Doctor Gray—and there are many of them here to-day—must have been aware how very definitely he made up his mind on any question that might come before him, and how vigorously he was able to maintain his convictions against all comers. But those who were in his confidence also know that no man could be more eager and ambitious to learn where anything was to be learned, and more quick to discern in what particular directions more knowledge was to be desired.

And may it not be said of the best known men of the past half-century that while they were keenly alive to the rapidity of modern progress (which, in some cases, seems to develop only a sort of pragmatical pride and Philistinism), yet in their most sanguine speculations or deductions they ever evinced that spirit of modesty which is said to be the characteristic of true science? The history of panaceas in the past, and the explosion in our day of theories fondly cherished in another, ought indeed to be enough to secure this result, though the failure of anticipated discoveries and experiments need not drive any one to the opposite extreme of scientific agnosticism or nihilism. Rather should we study, and avail ourselves of, the hygienic uses of the imagination on those lines laid down by Sir J. Crichton-Browne in his masterful address at Leeds five years ago, where he says: "The pilgrim of imagination may stand long knocking at the portal, but if he prevails the gates fly open in a twinkling and the whole glory of the vision is at once declared," and where he bids us cherish imagination till it mounts into faith and reveals to us "the substance of things hoped for, the evidence of things not seen." Such views and such exhortations may very naturally generate a temper of the most sanguine and extravagant optimism, but they are surely justifiable if always accompanied by the sober restraints of reason and philosophy.
Dr. Pliny Earle may claim an exalted place in our regard and gratitude among the pioneers of fifty years ago. His strong helping arm it was that lifted the Journal successfully over early obstacles that proved well-nigh insurmountable. He was an active, indefatigable, thoughtful, and graceful writer, upon whom the editor relied for support more than upon any other contributor.

To review even briefly the work of Pliny Earle would more than fill my allotted time. Beginning with his first essay on "The Poetry of Insanity," published in 1844, and ending with his well-known statistical studies, published in 1877 and 1885, on the "Curability of Insanity," we have a series of admirable papers which may challenge comparison with the output of any single worker in the field of insanity anywhere.

One of the most remarkable of his earlier papers, and one that well shows the characteristic thoroughness of his method of treatment, is that published in 1854, in which he discusses the then burning question of "Blood-letting in Mental Disorders." He was at that time far in advance of the majority of his colleagues in recognizing that the excitement and delirium of mania were "the prayer" of the brain for a more bountiful and more nutritious supply of the fluid upon which its vitality depends. It marked the beginning of a new era in therapeutics of a still later generation against nauseous polypharmacy. Doctor Earle was ever a believer in the vis medica-tria naturae, and anticipated the now prevalent view that the effect of drugs is "less to cure disease than to remove obstacles to the performance of healthy function and to support the physical powers until the morbid processes run their course." His papers on "The Psychopathic Hospital of the Future" and "Prospective Provision for the Insane," although published in 1867 and 1868, show a prescient conception of the needs of the insane which is realized in actual methods of care and treatment.

Among other illustrious personages of those early days looms up the figure of Luther V. Bell, scientist and patriot, for many years superintendent of the Worcester and McLean asylums. He it was who in 1849, in a paper entitled "A New Form of Disease," first described what later was called "typhomania" and "Bell's disease." This paper is a classic and its author one of those rare men concerning whom Plato said, "He shall be a god to me who can rightly divide and define."

To leave New England we find in Dr. John M. Galt of Williams-
burg, Va., a ripe scholar, well-informed physician and worthy peer of his eastern colleagues. So long ago as 1844, in a paper on "Fragments of Insanity," he refers to the effects of music in allaying maniacal excitement, about which we hear so much now-adays, as if it were a new thing. He quotes a striking passage from Shelley in which a rapid change of scene in a Venetian asylum is described as the result of the wafting to the maniac's cell of "fragments of most touching melody:"

Through the black bars in the tempestuous air
I saw, like weeds on a wreck'd palace growing,
Long tangled locks flung wildly forth and flowing,
Of those who on a sudden were beguiled
Into strange silence and looked forth and smiled,
Hearing sweet sounds. Then I—

Methinks there were
A cure for these with patience and kindred care
If music thus can move.

And those are his sweet strains which charm the weight
From madman's chains and make this hell appear
A heaven of sacred silence hushed to hear.

But at that early day, as even now in our own, both Galt and Shelley realized that such effects were ephemeral, and true to nature the poet continues:

"His melody
Is interrupted now: we hear the din
Of madmen, shriek on shriek again begin."

In a "Report on the Organization of Asylums for the Insane," read before this body in 1850, Doctor Galt contended bravely and forcibly for the concentration of executive power in the medical superintendent, subject only to a board of trustees, clearly foreseeing the danger of a system of government that involves a separate, concurrent, and oftentimes conflicting authority, when attempts are made, as in modern days, to make the chief medical officer meekly bow the neck to the yoke of an oppressive oligarchy.

In a later article on the "Farm of St. Anne" (1855) he advocated the adoption of agricultural colonies in connection with our American asylums and foreshadowed the cottage system of providing for the chronic insane.

A more industrious alienist than Dr. Isaac Ray never lived. From 1828, when his first paper was published, down to 1880,
when his last contribution to the press appeared, but a single year passed in which he had not to his credit one or more original articles. As a writer on the "Medical Jurisprudence of Insanity" he has rendered that department of mental medicine signal service. His papers on "Moral Insanity" won him world-wide fame, and were singularly free from that appearance of "playing to the gallery" which sometimes characterizes the opponents of that doctrine.

With reference to which subject of moral insanity one may well say, as was neatly said in one of our humorous papers the other day, that whenever you hear an intolerant fellow declare that there is only one side to a question, you may make up your mind that there is and that he is on the wrong side of it. Richly did his labors merit the preamble to the resolution passed by this Association.

"No tongue or pen, however apt or gifted, can describe so well the record of the life and work of Dr. Isaac Ray as its own transparent simplicity and devoted usefulness displayed it. He was at once the learned and lucid writer and speaker, the diligent, practical observer, the skillful hospital administrator, the sagacious philosopher and counselor, the alienist and humanitarian in the largest sense."

Then there was Edward Jarvis of Massachusetts, alienist, statistician, publicist. His writings, many in number, were instinct with thought and suggestion. He conferred lasting benefit upon the insane by advocating, with renewed vigor, the use of employment as treatment when, in 1862, he preached from the text "No two particles of matter can occupy the same point in space at the same moment, so no two absorbing thoughts or emotions can occupy the mind or heart at the same instant of time." It all seems very trite and commonplace now, but we were very slow to learn the lesson that when patients "are engaged in mechanical or other employment their thoughts must be given exclusively to the conduct and succession of natural events and real processes, and that as the mind can not admit, or be possessed by, both the sane and the insane idea, the insane one must be excluded, and the sane one reign paramount;" whence it follows that "all the mental powers of the worker which are in action for the moment are sane, and the mental disorder is for the moment, or that succession of moments, suspended."
In 1866 Dr. Jarvis anticipated the division of States into asylum districts—the plan adopted within a few years in New York—in his paper on "The Influence of Distance from and Nearness to an Insane Hospital," in which he showed by careful statistics that the benefits of a hospital are largely local, and that the bounties of the State in respect to hospital provision should be more equally distributed. One of his most important scientific contributions to our literature was his essay on "Mania Transitoria" (1869), not a new doctrine at that period, but then broached for the first time we believe in America. Says Billings, very thoughtfully: "There must be specialists and specialists in medicine, and the results will be both good and evil; but the evils fall largely upon those specialists who have an insufficient general education, who attempt to construct the pyramid of their knowledge with the small end as a foundation." It has been said of Dr. Hodgen that "in medicine a specialist should be a physician and something more; but that he is often something else—and something less." And no one can read the literature of those earlier days without realizing how comparatively few men there were of whom such top-heaviness could be predicated. Jarvis was emphatically a skilled physician and something more.

Joseph Workman of Toronto.—What memories the name of this Nestor recalls! At the age of eighty-nine he has just died, and in the harness. In his ceaseless activity he realized that aphorism of the Talmud: "The day is short and the work is great—the reward is also great, and the master presses. It is not incumbent on thee to complete the work, but thou must not therefore cease from it." An untiring contributor of original papers on a wide range of subjects while he was still active in the work, he knew well how to arrest processes of decay in his retirement by gentle mental exercise. Thus we find him long after he had reached his four score years diligently translating from the Italian and laying the rich stores of that psychiatric literature before us in faultless English dress. Another will attempt to tell the full tale of his well-filled life at this meeting. Let me but mention here the fearlessness of the man and the love of truth that characterized everything he touched. His, too, was a merry wit, proof against all souring comers, disappointments, ingratitude, infirmity, and all the crabbed host of peace-disturbers. Addison has called our attention in one of his essays to the danger of the talents of humor and
ridicule when possessed by an ill-natured man. Workman was
geniality itself, and, with many other attributes of royalty, was a
veritable King Cole in merriness of soul; his wit always tempered
by the saving grace of virtue and humanity. The writer cherishes
among his choicest literary possessions many autograph letters of
this truly good man, to read which in the midst of the perplexities
of journal work was often like the patter of refreshing rain after a
long drought. Let one brief extract suffice here. The reference
is to returned proof, and this is what the octogenarian wag has to
say: "I mail with this returned proofs of Bianchi’s lecture on
hemichorea. A glance over the corrections will show you that
your compositors stand in need of careful revision. Some of their
bedevilments are certainly ingenious. I used to write a rather plain
hand, but age seems to bring woeful changes in this, as well as in
other muscular processes. On reading again from Tebaldi’s little
brochure I have been nonplused over one word in your journal on
page 486 (April, 1885). I could not guess what was meant by the
cold knife with which the devil contrived to severed the memories of
her times.” No doubt the proof sheets sent to me had the word
severed, and no doubt, too, I must have been blind not to detect it.
Unfortunately I have not the manuscript to refer to, but on turn-
ing to the Italian I find that I should have written (and it is my
belief I did write) revived. Alas! alas! it is a dreadful affliction
to be murdered by a typo. I never now venture into print with-
out getting my manuscript back with the proofs. A very erudite
English critic skinned me deep, pointing out numerous violations of
orthography, etymology, and syntax, every infernal one of which
was the work of the devils, who either disregarded my corrections
or distributed the typo before receiving them. My cutaneous sensi-
ibility has ever since been very lively.

"Talking of the devil, that imp who transmogrified my augmentation,’ in the present instance, into ‘any mentation’ must be a
rare genius. Please present my loving respects to him, and tell
him to take good care of his mentation, for it must be of a high
order.”

Universally admired and beloved, and modest with the modesty
that is born of true scholarship and genuine attainments, his
life may be said to have been one of much “fame” that is not

"Set off to the world, nor in broad rumor lies,
But lives and spreads aloft by those pure eyes
And perfect witness of all-judging Jove."
How Dr. Charles H. Nichols would have enjoyed this meeting had he lived to attend it! It is as an active participator in debate rather than as a writer of papers that he is remembered, although he wrote easily and well. "But his principal work, as with all successful superintendents of institutions for the insane," as Doctor Godding has written of him, "has been in the daily hospital routine, whose record is silent but for its results."

Richard Gundry.—Another genial soul who wrote gracefully and brought to bear upon the work of his pen the resources of a wonderful memory. Tributes from Doctors Richardson and Hurd to the memory of this departed brother have been read before you such a short while ago that I need not itemize in this presence the sum of our indebtedness to him.

Anything that might be said of Dr. Thomas S. Kirkbride's contributions to our literature would seem inadequate in this city where his honorable and useful life was lived and where his great activity was best known. Few men have done more than he to impress upon their fellows the correct principles of construction and organization. Indeed, in this department of work he was facile princeps. We have outlived the Kirkbride plan to large extent, but the principles he instilled can never die. And would that his views as to what should be the size of hospitals for the insane might gain a wider acceptance to-day!

Dr. A. O. Kellogg filled a rôle peculiarly his own as an author, and as the profound critic of Shakespeare, from the point of view of the alienist, has secured for himself a safe, permanent, and exalted place in our literature. Some may accuse him of "reading in Homer more than ever Homer knew," but his Shakespeare's "Delineations of Insanity, Imbecility, and Suicide" will ever remain a token of his keen powers of psychological analysis.

In a brief address like this, one can not mention a tithe of the men whose literary claims entitle them to a hearing in our court of record to-day. Even Goldsmith must receive scant notice. He belonged to the newer school, was perhaps our first typical representative of it, and, in the few years of his brilliant career as an alienist, did much by his example and his writings to point the way and light the "lamps of life that pass from hand to hand."

It is a cheering thought that to-day our literature was never more worthily represented. Our fathers may on the whole have written better, but they certainly had no better message to bear than our present generation of contributors. To-day the question is not,
Can he write? but rather, Has he something to say? there being few opportunities in this busier and more scientific era for the display of the gift of utterance without communication, or, to be more technical, the exhibition of symptoms of reckless logorrhea.

There is one thought that presses as I close. It is that the reorganization of this association has probably done more for the cause of American psychiatric literature than any single factor of our evolution. The mere holding of a medical office in a hospital for the insane is no longer per se a qualification for membership. Shall not the value of that membership be fully enhanced by requiring of candidates a scientific contribution of merit by way of thesis for admission? Would not such a rule tend to the enrichment of our literature and the fostering of a spirit of original research? While in the action of this association we have occasion for profound gratitude, we must beware of the enervating effect of self-satisfaction. There is always promise and potency in frowning discontent and naught but inertia in a bland complacency. Let then the uplook and outreach go steadily on and contentment as to the status of American psychiatric literature come to us, if at all, only when it can safely stand the test of comparison with that of any other civilized country in the world. Lord Bacon it was, we remember, who compared his sanguine outlook of the field of science under his new philosophy of induction with the aromatic inspiring breezes that seemed to be wafted from the newly discovered continent of America.

Fain would one linger over the catalogue of stars that have brightened the firmament of our literature during the past half-century and that reveal to us, who grope and seek, the iter ad astra. Many the sermon that has been preached before this body and printed in our journals—great the diversity and conflict of doctrine—many the convert and pervert, but heaven grant that we may all profit by all that is worthy and useful in the lives of our professional forbears and ever stand firm in the faith in our cause.

The late Bishop Bloomfield once, late in life, visited the University Church of Cambridge and there recognized a verger whom he remembered when he was himself an undergraduate. The bishop said he was glad to see him looking so well at such an advanced age, and the old man made answer thus: "Oh, yes, my lord, I have heard every sermon which has been preached in this church for fifty years, and, thank God, I am a Christian still."
NEW ENGLAND ALIENISTS OF THE LAST HALF-CENTURY.

BY T. W. FISHER, M. D.,
Superintendent Boston Lunatic Hospital, Boston, Mass.

On this first semi-centennial of our Association the duty has been assigned me of making appropriate reference to our deceased members from New England. It has been thought fit to call the society together in the place of its birth to review its history and to award to each fellow his place in the Ruhmeshalle of our specialty. To state "concisely and appreciatively" the life-work of twenty-seven men so accomplished in twenty minutes would entitle the writer himself to a seat in Walhalla!

The faithful worker in the field of modern psychiatry must be at once a scientist, a humanitarian and a man of affairs. Until our recent very satisfactory change of name and organization, membership in this society implied the management of some hospital for the treatment of insanity. Like the United States, we began with thirteen members, of which seven were from New England. With our numbers augmented by the increase of hospitals, and the admission of assistant physicians and other alienists, New England still holds numerically a high position. Of two hundred and eighty-one members in 1893, she had forty-eight. The society, as well as the States, has prospered; yet if the original thirteen sat down with unbroken ranks to dinner in Jones' Hotel, the death of Vice-President White within the year was "confirmation strong as death" of the old superstition.

And what a long death-roll of noted men has followed. Of the twenty-seven from New England, I have known eighteen, most of them intimately. In reviewing this list of pioneers in American psychiatry, the name of Ray, to my mind, like that of Abou Ben Adhem, leads all the rest. Not that "he loved his fellow-men" more than all the others, but because of a certain intellectual pre-eminence. To have called him, as I did when we last met, the Nestor of his department of medicine, was a feeble compliment. We all too soon become, by reason of age, in some respects distinguished above our confreres. In him were combined fullness of
years and ripeness of intellect. And his intellect was naturally of a high order.

Doctor Curwen says of him, "No one who ever enjoyed these opportunities of hearing him pour forth the richness of a mind well stored with the treasures of literature in general, and of insanity in particular, will ever forget the instruction he then received. His sound judgment and matured views always gave him a commanding influence."

He was educated at Bowdoin and Harvard. In 1841 he was appointed superintendent of the Augusta Hospital, and of the Butler Hospital in 1845. He spent a part of this year in Europe, and devoted the next two to the building of the hospital. He remained in charge twenty-two years. He published a work on the jurisprudence of insanity of seven hundred pages, which at once gave him a wide celebrity. It was the first and, for many years, the only important contribution to the scientific study of insanity in this country. It is still a standard authority at home and in Europe, and a monument of wisdom, learning, sound judgment, and large experience. It is destined to hold a high place in the literature of insanity in spite of the great advances of the last ten years. His books on "Mental Hygiene" and "Mental Pathology" are of equal importance.

Doctor Woodward, our first president, must have been a remarkable man in many ways. Doctor Curwen gives an interesting account of the formation of our society as the result of a conference between him and Doctor Stribling of West Virginia. He, with Doctor Todd, was active in raising funds for and establishing the Hartford Retreat in 1823. He was first superintendent of the Worcester Hospital, opened in 1832.

His printed works are confined to reports, but these were widely circulated, the usual edition being three thousand, and making for fourteen years a volume of six hundred pages. I have before me a presentation copy of the first four reports bound. It contains Doctor Woodward's autograph, and was presented to Edward Everett, then governor. Horace Mann was chairman of the building committee. There is a lithograph of the hospital, with a stage-coach driving up, and the present fine grove of elms dwindled to currant bushes.

The floor plan shows a hospital for two hundred and forty patients, all in single rooms. The corners show the present cages,
or verandas, as they were called. Each ward opened on a square room with two sides of unglazed iron sash, making a fine airing-room for all weathers. Aside from their suggestion of a menagerie when in use, these verandas would be desirable adjuncts to any hospital.

Doctor Woodward showed in his reports ideas quite up to the present concerning insanity and its treatment. In 1833 he recommended small detached homes for convalescents. "They should form a large family and not one should be idle. . . . They would require but little restraint, and might ride or range the grounds at pleasure." He also advocates separate buildings for quiet and chronic cases. Also detached lodges for the noisy and violent. This was essentially the cottage system, though Doctor Spurzheim had already advocated it.

In his third report he considers labor as a remedial agent, and advises the erection of workshops and a chapel. In his fourth, besides fifteen tables of statistics, he gives a detailed account of the results of treatment in ten cases. He describes the great improvement in numerous cases from prisons and almshouses, where they had been subjected to neglect and hardship. In an appendix he discusses the moral insanity of Pritchard and Pinel, with several cases. He also wrote a series of articles on asylums for inebriates.

Doctor Bell was also one of the original seven. He was a son of Governor Bell of New Hampshire, and his social and intellectual qualities were of a high order. He was educated at Bowdoin and Dartmouth, and continued his medical studies in Europe. He was active in founding the Concord Hospital, and was superintendent of the McLean Asylum for twenty years. In 1845 he went to Europe for the purpose of studying hospitals there. The results of his observations were embodied in the plans for the Butler Hospital.

He was for two years president of the Massachusetts Medical Society. At the breaking out of the rebellion he was appointed surgeon of the Eleventh Massachusetts Volunteers. He was soon promoted to be brigade-surgeon of General Hooker's division. He died suddenly in camp of endocarditis in 1862. His writings on subjects relating to general medicine, as well as to insanity, were numerous and important. He is best known for his description of that form of acute mania called Bell's disease.

In 1839 the Boston Lunatic Hospital was opened to relieve the Worcester Hospital of its city cases. Doctor Butler was its first
superintendent. He was, like Doctor Woodward, a man of modern ideas with reference to insanity and its treatment. He regarded employment, amusement, and moral management as essentials, and discouraged the use of restraint. He found a number of the worst cases at the neighboring almhouse permanently confined in wooden cages. As a specially humane feature of their treatment, these cages were put on wheels, and in fine weather were drawn out of doors. Doctor Butler released all these poor creatures, and he often told me of one woman, especially dangerous, and maniacal, whom he won by presenting her a dandelion. She was soon restored to comparative sanity and good conduct.

In 1887 I had the pleasure of introducing him to one of his original patients, who for forty-eight years continuously had resided in the same hospital in comfort and contentment. Doctor Butler was appointed superintendent of the Hartford Retreat in 1843, and served thirty years. He converted the dreary, cold, dark and forbidding walls, the narrow passage-ways, and the comfortless rooms and dormitories of 1843, into an institution well nigh perfect in its appointments. He had a hobby, which we might all ride to advantage, in the individualized treatment of the insane.

Doctor Stedman was the second superintendent and served nine years. He was educated at Yale and Harvard, and for ten years was surgeon to the Marine Hospital. After 1851 he was surgeon at the City Hospital. He first introduced the use of associated dormitories for the insane. The addition to the hospital in 1846 for one hundred and twenty beds was all in dormitories. During his term of service severe epidemics of cholera, ship-fever, and malignant dysentery occurred, but he was well fitted by experience and education to cope with them. Doctor Curwen says: "Few men had greater opportunities for observing disease than he, and he improved them with great earnestness. He educated many students before the days of medical schools in Boston."

Doctor Earle was educated at Leicester and the Friends' Schools, Providence, of which he became principal. He took his medical degree in Philadelphia, and spent a year in Paris visiting hospitals for the insane. He was four years physician to the Friends' Asylum, Frankford. In 1844 he was appointed superintendent of the Bloomingdale Asylum. In 1849 he visited thirty-four hospitals for the insane in Europe. In 1864 he succeeded Doctor Prince, superintendent of the Northampton Hospital, remaining twenty-one
years. The financial result of his administration was the purchase of land worth $25,000, and an increase of the plant to the amount of $173,000; also increase of cash assets to the value of $43,000.

Doctor Earle's three visits to Europe were followed by papers giving the results of his extensive observation of foreign hospitals. He also became acquainted with many famous philanthropists in England, and was made a member of several foreign medical societies. He lectured on insanity in New York in 1853, and in Pittsfield in 1863. His most important recent article was on the "Curability of Insanity." It was a useful study of an important subject, but in my opinion was not such an "epoch-making work" as one of his reviewers claimed it to be. The opinion that from 75 to 90 per cent of cases of insanity could be cured was never entertained by any reputable authority. Some sanguine superintendents may have claimed for very recent cases a high rate of recovery. Doctor Woodward says "that as many such cases will recover as from any other acute disease of equal severity." He gives in his report for 1834, 55 per cent of all cases discharged as recovered; 20 per cent of old cases and 82 per cent of new. This method of calculating recoveries on discharges instead of on admissions, as at present, may have misled some writers. Reckoned in this way, Doctor Woodward only discharged 24 per cent recovered in 1834. According to Wilkins, in 1870 the percentage of recoveries in the United States was thirty-three. This has been gradually reduced by reason of the custom of sending large numbers of mild chronic cases to the hospital, until in this State it is about twenty-five. Recoveries on readmissions alone would not reduce the rate in any year more than 1 per cent.

Doctor Brigham, in 1844, was superintendent of the Utica Hospital, but previously for two years had charge of the Hartford Retreat. He was distinguished as a physician, as well as an alienist, and published many works on general medicine. He was professor of anatomy and surgery in New York, and was the first editor of the Journal of Insanity.

Doctor Cutter was almost an original member, attending the second meeting. For many years he was superintendent of a private institution at Pepperell. He died in 1859, having labored forty years for the insane.

Doctor Chandler, successor to Doctor Woodward, also joined
the association in 1845. He resigned his position in 1855, and resumed the practice of medicine in Worcester.

Doctors Bates, McFarland, and Rockwell also joined in 1845. Doctor Bates left the Augusta Hospital in 1851. Doctor McFarland removed from Concord to Jacksonville, Ill., in 1852, where he was fifteen years superintendent. Doctor Rockwell was the first superintendent at Brattleboro, a position he retained thirty-five years. By careful management he built up a fine institution from a small bequest of ten thousand dollars in 1835. Until recently all the State patients were boarded in this private hospital. From a central building, and one wing with nineteen patients, the Vermont Asylum in fifty years had grown to a capacity of four hundred and fifty patients, and a plant worth half a million dollars. Doctor Rockwell was not only a good manager, but a skillful physician. He had been an assistant with Doctor Woodward at Hartford, and shared his advanced views concerning insanity.

Doctor Jarvis, as early as 1836, took insane patients into his family, and for many years had a private hospital in Dorchester. He was more than an alienist, as he had a strong bent for statistical research. He achieved a European reputation in this difficult field. He was a member of many foreign societies, and had a library unsurpassed in this country in this specialty.

I well remember the kind advice, the numerous letters and commissions the Doctor gave me on my first visit to Europe; also, the huge box of pamphlets I sent him. He had a most insatiable appetite for the driest sort of mental pabulum. His love of figures was but one expression of his ardent love for the exact truth. He was a member of a commission in 1854 to ascertain the number of idiots and insane in the State, and the hospital accommodation they would require. He was for years a trustee of the Worcester Hospital and the School for Feeble-Minded Youth.

Doctor Harlow was superintendent of the Augusta Hospital from 1850 to 1883, a period of thirty-three years. He rebuilt the hospital after the fire. He was a man of sound judgment, a model superintendent, a good physician, and a most kind and sympathetic friend of all his patients. He was often called as expert in his own State, and was president of the Maine Medical Society.

Doctors Tyler and Walker are closely associated in my mind. They were classmates at Dartmouth, and were warm friends for a lifetime. They, for many years, had charge of hospitals near
Boston, and were connected by many social and professional ties. Doctor Tyler was five years at Concord, and fourteen at the McLean Asylum. A memorial by Doctor Bancroft, is an eloquent tribute from another lifelong friend to Doctor Tyler's remarkable qualities. My acquaintance with him began, as he often used to remind me, on the day of my birth. Although I knew him quite well, I feel with Doctor Bancroft, "that it is not an easy thing to form and express in words a true and just estimate of a human life," especially such a life as Doctor Tyler's. He was intellectual, cultivated, learned in his profession, a good administrator, a firm friend, kind-hearted, social, and witty, it is true; but saying this tells little to a stranger of the real individual. The personality escapes continually in these descriptions.

He had a vein of humor which bubbled over even into his little business notes, and which made his society attractive to the younger men of his staff. His lectures, which he gave at Harvard, were rendered more popular by the same happy way of putting things. His only predecessor in this field was Doctor Rush, early in the century. Doctor Tyler took a medical degree at Philadelphia, as well as at Harvard, and made two trips of observation to Europe.

Doctor Walker took his degree in medicine at Harvard. He then became an assistant at the South Boston city institutions. In 1847 and 1849, when cholera and ship-fever prevailed, he volunteered with Doctor Upham to assist in the "fever sheds" at Deer Island. He was appointed superintendent of the Boston Lunatic Hospital in 1851, and retained the position thirty years.

He at once gave up the use of stone cells for excited cases, diminished restraint, and improved the hospital in many ways. After many years of effort the city government bought a site for a new hospital. Plans were made and money appropriated, but the project was unexpectedly killed by the mayor's veto. Dr. Edward Everett Hale said of him, after his death, in 1883, "He was the personal friend of all his patients, and brought to the miracle of cure the only power which can effect it—the loving sympathy of the physician. He fairly commanded his broken patients by what we choose to call the magnetic power of his personal care. Behind all the resources of medicine, he had this requisite for victory—that he made them believe they would get well."
The recent deaths of two of my immediate predecessors in the chair of the New England Psychological Society have given that office painful associations for me. I saw Doctor Bancroft, as he was speaking, grow pale and drop into his seat, entirely hemiplegic. He was conscious and finished his remarks, and put the motion to adjourn. He remained conscious and calmly gave directions about his removal, and requested that his sickness be kept out of the papers, lest his wife be suddenly informed of it. He died a year afterward, and maintained that thoughtful consideration of others, so characteristic of him, to the last. He had nearly reached the limit of his years, and his seizure at the post of duty was a fate to be envied and not dreaded.

He was educated at Dartmouth, taking also a medical degree in New York. He had a large general practice for twelve years, and was chosen superintendent at Concord in 1857. During the thirty-two years of his incumbency he modernized and enlarged the hospital, adding, not long before his death, a beautiful detached ward for private patients, called the "Bancroft Building," which will be an appropriate monument to his memory.

Doctor Draper took cold while presiding at the same society, and died of pneumonia. He was in the prime of life, and also fell at the post of duty. His monument is to be found in the "Annals of the Vermont Asylum," a book of three hundred pages, and covering a term of fifty years. This history of the growth of a large hospital from small beginnings I have read carefully to the end, and found it as entertaining as a novel. Goethe says: "Grasp anywhere into the thick of human affairs, and you will always find them interesting." This is true even of life among the insane, especially when depicted with skill, as in this case. There is characteristic modesty, too, and nothing but a change in the superintendent's name shows that in 1873 Doctor Draper took up the work of his predecessor and carried it steadily on till his death in 1892.

Two more names are naturally associated by reason of their connection with the same hospital and their untimely or tragic ends. Doctor Sawyer died as the soldier dies, by accident, in the meridian of life and in his line of duty. He was seized by the throat by a maniac, causing fatal laryngitis. This risk we all share, though daily exposure, year by year, makes us indifferent to it. The danger is a real and ever-present one, as the lengthen-
ing list of martyrs in the cause of humanity shows. We all have
known a sinking of heart at the threat of the paranoiac, especially
when at large and full of his imaginary grievances.

Doctor Sawyer was a classmate of mine at Harvard, and went
immediately to the Butler Hospital in 1859, on graduation, as an
assistant. For nineteen years before his death in 1886, he was
superintendent, and carried on the work of Doctor Ray with great
success. "His personal qualities were such as endeared him to
all his patients and friends. His manners were gentle and win-
ing, and his character marked by a singular modesty, united
with great firmness of purpose."

His successor, Doctor Goldsmith, died of pneumonia after two
years' service at thirty-four. He had previously been superintendent
of the Danvers Hospital for five years. His was another of those
all too rare characters, singularly fitted for the service in which he
engaged. He graduated at Amherst, and took his medical degree
in New York. He was an assistant at Bloomingdale, and also with
Doctor Clouston at Edinburgh, and Doctor Major of West Riding.
In 1883 he passed a second year in Europe, studying with West-
phal and Krafft-Ebing, and visiting foreign hospitals.

A small memorial volume is before me with a portrait of Doctor
Goldsmith. It is a face full of intellectual beauty, of high char-
acter, with an expression serious and gentle, fit exponent of his
life. The book contains tributes of respect and affection from
Doctors Gorton, Folsom, Nichols, Chapin, Cowles, Hack Tuke,
Miss Phelps, and Whittier. Who could wish more appreciative
biographers?

"And what more shall I say? for time would fail me to speak of
Brown, and Knight, of Booth, and Whittemore, and Shew. They
also have obtained a good report." Like St. Paul, "They have fought
a good fight; they have finished their course; they have kept the
faith." The first two were active members for many years, and
engaged in a work akin to ours—the care of the feeble-minded.
Booth and Whittemore, after serving most faithfully for many
years as assistant physicians, each had charge of the McLean
Asylum for a year. They were both men of high character
and marked ability, and died in middle life in the midst of their
usefulness.

Doctor Shew took his medical degree at Jefferson. He was
post-surgeon at Hilton Head during the war. In 1866 he was
chosen superintendent at Middletown, and served twenty years, his death resulting from an accidental fall. He was of a cheerful and hopeful temperament, and of large executive ability. He was a skillful physician, and a sympathetic and appreciative friend, so that many of his patients became greatly attached to him.

Of living New England alienists it is not my province to speak. They are all young men, or of middle age, and belong to the new era of psychiatry. They work under the inspiration and by the light of the new psychology; they are all working to perfect their hospitals, public or private; to build new ones, or to improve their methods of treatment. May it be long before any of them needs a biographer. Outside the hospitals, but interested either in the practical or theoretical side of our specialty, are such men as Hall, Donaldson, Hodge, Bowditch, Councilman, James, Royce, Münsterberg, Folsom, Jelly, Prince, Putnam, and Knapp.

The new school is less absorbed in hospital routine, is broader and more scientific than the old. As proof of this proposition, I would cite the fact that clinical and didactic instruction on insanity are given in all our New England medical colleges, and have been made requisites for graduation at Harvard. Laboratories for experimental psychology have been established at Harvard and Clark Universities. As further evidence, take the four training schools for nurses of the insane, the first established at the McLean Asylum; also the pathological laboratory there, and the work of Doctor Gannett at the Boston Lunatic Hospital. Also the fact that in Massachusetts there are now in process of erection a chronic asylum for the State, a municipal hospital for Boston, and a private hospital for the McLean Asylum. These are all on the segregate plan, and it is believed each will be the best of its kind in this country at least.

Another proof of the scientific spirit is the fact that the Boston Medico-Psychological Society not only includes nearly all the alienists of New England, but all the neurologists as well. It is a large and flourishing society, with monthly meetings for the reading of papers, and subscribes for a long list of special journals in several languages. It also invites distinguished specialists from distant cities to read before it, and to meet the physicians and surgeons connected with our hospitals and colleges socially. The last reader was the superintendent of the Johns Hopkins Hospital, your honored secretary.
The same spirit of progress has happily infected our larger society, once limited to superintendents alone, and naturally most interested in the practical side of hospital management. Now any physician sufficiently qualified and interested may be elected to our number. Any unqualified superintendent may be kept out, being no longer a member ex-officio. Two-thirds of our assistant physicians are already associate members, so that young blood and new ideas ought hereafter to visibly affect our transactions. As we take our new departure, let us lay one wreath of immortelles on the altar of the past.
THE ALIENISTS OF THE PAST HALF-CENTURY.

BY HENRY M. HURD. M. D.,
Baltimore, Md.

A word of explanation is due to the Association for the imperfect and inadequate presentation of this paper. Under the division of subjects for the semi-centennial addresses decided upon by the committee of arrangements it was proposed to ask Dr. Fisher of Boston to treat of the alienists of New England and to leave to Dr. Callender of Nashville the duty of writing of the work done by alienists in other portions of the country. The eminent fitness of Dr. Callender to prepare such an address by reason of personal acquaintance with the majority of those who were to be spoken of was so obvious, it was a matter of sincere and lasting regret that the state of his health finally precluded him from undertaking the task assigned. As the preliminary programme had already been printed before this fact was known, it became impossible to appoint another person at such a late date and the writer as secretary of the committee of arrangements felt morally bound to do what he could to fill the gap in the programme. Hence this brief and imperfect presentation of a most interesting topic.

It is evident in considering the work of alienists outside of New England during the past fifty years that they occupied peculiar and often trying positions. Their work was not generally initiated by medical men nor dictated by scientific zeal. The dependent insane as a rule, then as now were most neglected in those large cities, like New York, Philadelphia, and Baltimore, where the flame of scientific medicine seemed to burn the brightest. Outside of New England the movement for the care and treatment of the insane was a philanthropic rather than a professional one and we should do scant justice to the men who promoted it if we measured it alone by the modern standards of scientific neurology and psychiatry. These men were pioneers in a great philanthropic movement which spread through the whole land largely as the result of the work of one disinterested, self-sacrificing woman to relieve the suffering and distress incident to insanity. They moulded public sentiment to found and support institutions for the insane, originated laws, set
in motion the machinery of public aid and built asylums and hospitals to meet crying necessities. With them it was not so much the question of securing the most scientific and approved methods of caring for the insane as of securing any care at all. They were compelled by the hard conditions of pioneer life to be business managers, architects, social reformers, statisticians, and physicians. They organized modes of support, devised systems of sewage disposal and of heating and ventilation, planned buildings, created modes of accounting for receipts and disbursements, grappled with the problems of public relief, initiated systems of industry, trained nurses and attendants and in these and countless other ways stood in the forefront of the battle for the humane care and treatment of a most unfortunate class of citizens. They made mistakes and often lost sight of their functions as medical men in business details, but they labored earnestly, self-sacrificingly and efficiently. The present state of public provision for the insane in the United States to-day attests the earnestness and fidelity of their labors.

A writer in the Journal of Mental Science, once referred disparagingly to the tone of "strained philanthropy" which pervaded the reports of superintendents of State institutions for the insane in America and it was pardonable for one who was not familiar with the genesis of most of these institutions from a broad philanthropic movement to make this criticism. To disregard it, however, in any estimate of the men who took part in it is to miss the whole spirit of asylum construction and organization during the past half-century. The need of provision was so pressing, it appealed to self-sacrificing earnest men everywhere and brought into the service of the public a rare company of men who labored wisely and efficiently for the public good. Their source of power was the confidence which plain people felt in their disinterested devotion to the humane care of the insane. This devotion was not assumed for the purpose of securing support from a grudging and unsympathetic public. They keenly felt the duty of better provision and this conviction pervaded their whole lives. There is danger that the freshness of the original philanthropic impulse will be lost now that institutions are more complete and can be organized on a more scientific basis. The personality of these men was an important factor in their success and their peculiar circumstances and special environment which made them what they were should not be for-
gotten. In my references to these leaders, I shall for obvious reasons, limit what I have to say to those who have passed from earthly scenes and employments.

As they were men of varied endowments, it is my intention to group them under their most prominent characteristics. Some were eminent as students of mental disease and famous for their learning and scholarship, others as builders and planners, others as administrators and still others as medical men excelling in the treatment of insanity.

Students. Among those who excelled as students, Amariah Brigham of Utica, New York, John M. Galt of Virginia, Joseph Workman of Toronto, Richard Gundry of Maryland, W. S. Chipley of Kentucky, A. O. Kellogg of New York, Andrew McFarland of Illinois, may be taken as examples. [In view of the fact that biographies of these men are given elsewhere, the special account in the text is omitted].

Builders. When the first buildings for the accommodation of the insane were erected in America, an attempt was made to follow plans of building already existing in Europe—notably those of France and England. These, however, owing to differences in climate and the necessity of providing additional facilities for heating and ventilation to meet the demands of our more capricious climate especially in the North and Northwest, proved to be ill-adapted to the requirements of the insane, and it became necessary to elaborate new plans. Hence there grew up among superintendents, a number of men who developed a peculiar talent in the elaboration of plans and in the construction of buildings. The most distinguished of these or at least the man whose plans at one time were the most generally adopted was Thomas S. Kirkbride of Philadelphia. The principal features of his plans were plainness and solidity of construction, ease of administration and economy in heating. As originally contemplated for the accommodation of two hundred patients of the middle class, the buildings erected in accordance with them were admirably adapted to the treatment of cases of recent disease and it was not until they were modified to contain 500 or possibly 1,000 patients that they fell into disfavor. These buildings were so thoroughly and economically constructed as to demonstrate even to pioneer communities that proper buildings for the treatment of the insane were possible everywhere.
Dr. C. H. Nichols of Washington and later of New York also developed especial talents in the planning and erection of buildings for the care of the insane. The Macy Cottage which he erected in connection with the Bloomingdale Asylum constituted a genuine advance in provision for the wealthier insane.

Mention ought also to be made of the excellent work done by Dr. Francis T. Strible in Virginia in constructing an asylum for the insane upon the pavilion plan with due regard to the segregation of patients and special provision for recent cases. Before his original plan had been irretrievably marred by ill-advised additions made without regard to the spirit of the first construction it must have been a model of a comfortable institution. When I visited this institution two years ago I was struck with the convenience of its arrangements which combined adequate separation between the different classes of the insane and at the same time such a grouping of the buildings as to secure easy and economical administration.

Physicians. While all the alienists were compelled to excel in building, administration and the medical care of patients, certain of them were better known as physicians than as administrators or builders. Of these men, John P. Gray, Geo. F. Cooke, W. H. Stokes, J. H. Worthington, Peter Bryce among others were good examples. They grappled with problems of cure from many sides. Some, like John P. Gray of Utica, insisted constantly upon the medical aspects of insanity, its dependence upon disease, its care by physicians and its cure by proper medical treatment. Some, like Peter Bryce of Alabama, were equally convinced that occupation rationally directed and systematically pursued was of paramount importance in the treatment of conditions of insanity and were disposed to present this aspect of treatment. Others, like J. H. Worthington of Philadelphia, were disposed to believe that different forms of baths systematically applied were of great service. They all labored earnestly and efficiently and had the satisfaction of knowing that each made a valuable contribution to the therapeutics of insanity. These men have all passed away so recently you are familiar with their life history and services.

Administrators. The time allotted is insufficient to permit me to do more than to barely enumerate the names of those who excelled as administrators of asylums and hospitals for the insane. Awl of Ohio, Ranney of Iowa, Landor and Metcalf of Ontario,
Catlett and Smith of Missouri, McDill of Wisconsin, Patterson of Illinois, Fisher of Virginia, and many others, achieved deserved success in the arrangement and good ordering of their institutions,—a success as helpful often to the cause of the insane as the study of mental disease or the more practical subject of therapeutics.

Of them all, students, builders, physicians and administrators, we may say "these having obtained a good report" for their labors in behalf of the insane are held in lasting and loving remembrance by the members of this Association.
PSYCHIATRY DURING THE COMING HALF-CENTURY.

BY DANIEL CLARK, M. D.,
Medical Superintendent Hospital for Insane, Toronto.

The committee of the Association has done me the honor of delegating for my consideration the subject of "Psychiatry During the Coming Half-Century." It is evident that my position as a prophet is an enviable one, seeing that should my capacity to foretell future events for half a century be called in question at the end of that time my membership will only be a memory and irony or sarcasm will be lost upon the seer.

At the same time it is not unprofitable to look forward; to aim high and to prognosticate along the lines of advancement. This has been the object of the Association during the half-century of its history and seldom has pessimism found an entrance into its deliberations. In my connection of eighteen years with it, I have found the spirit of enquiry among its members, as to what is best, and not as to what is antiquated, and therefore to be conserved. This tendency to progression has done wonders in the care of the insane, and in the spread of medical knowledge as to the causes and cure of mental disease. This trend of enlightened enquiry gives much hope for the future as the impetus thus given will continue into the years to come. Throughout the many centuries of the past the educated races were so taken up with polemical discussions of a religious, political and metaphysical nature that little or no attention was given to mind and matter along the lines of embryology, biology and pathology, hence the errors in the treatment of the insane, not only in practice of medicine, but also in respect to the importance of housing, sanitation and hygiene. In these respects especially there is much hope for the future, seeing that the age of transcendentalism has been followed by that of practical experience in the study of natural phenomena.

It is comparatively safe then to outline what is likely to occur in the progress of psychiatry in the future from what has been done, say, for the last twenty-five years.

In the first place, the construction of huge buildings as hos-
hitals for the insane will be supplanted by villages of cottages erected instead; there will be an attempt to make such places of custody more homelike than can be the case in immense corridors placed one above the other, where large numbers of the insane are congerated, and where of necessity little classification can exist. The advantage of this system is now being recognized, and largely acted upon. In fact it is hard to gainsay the cottage system. The capacity of better classification; the better ventilation; the more sunlight; the comparatively less danger from fire; the facility to go out and in of the aged with only one stair to climb; the easy isolation on the outbreak of an epidemic; the opportunity for greater outdoor life for the infirm as well as for the healthy and strong, are a few of the advantages of village life, which I have exemplified in my own work.

It is only by looking backwards for even a few years that we can see so many possibilities for the future in respect to the discoveries in the various fields of investigation of living structure. The earnest explorations after the sources of functional activity in the nerve centres; the endeavor to fathom that terra incognita which lies between the molecular life and psychic energy; the strenuous efforts to bridge over the hiatus between a nerve wave and a sensation or a volition are praiseworthy; the glimpses of future discovery beyond what the microscope or micro-photography now reveals along the lines of the phenomena of the correlation of forces give great promise in the near future, and the parallelisms closely watched between nerve complexity and mental capacity are all in a direction which gives much hope of great discoveries in the field of psychiatry. The brain cell is an individual of paramount importance as it and its co-workers are the points where mental energy makes itself manifest. They come in contact with the unknowable and give direction and force to that entity which we call mind. The fact is, that in the life and death history of a cell are contained all the enigmas of life. There is a great world of change and relation in the groupings of the millions of atoms and molecules in each cell which so far has eluded human ken. We see this in chemical molecular arrangement which has not the complexity nor possibility of the ultimate elements of living structure. Along this line of investigation indefatigable workers are seeking new worlds to conquer in all the branches of natural history. I have no doubt that the next fifty
years will see a radical uprooting of many of our crude theories of brain disease and be the means of establishing less empiricism in its treatment.

There has been a tendency of late years to multiply the kinds of medicine in use. Chemists and druggists are now having their innings in the multitude and variety of their manufactured medicine especially for nervous diseases. Synthetical chemistry has added its hundreds of new remedies to the pharmacopoeia and, as usual, all are lauded by some medical men as being, if not specifics, at least invaluable in the treatment of all "the ills which flesh is heir to." Laudatory pamphlets in the best form of the printer's art are thrust forth broadcast all over Christendom. As the result thousands upon thousands of so-called remedies are now swallowed in faith more than by works. This influx of poly-pharmacy is now at flood-tide but the ebb is sure to come as the age of credulity passes away. All medicines are of secondary importance in any disease and in the near future the tendency will be to trust to sanitation, hygiene and proper pabulum rather than to drugs. The master-builder asks for material and the vital entity needs, primarily, food to build up and also proper excretion to carry off the dead. So food, cleanliness and fresh air are paramount requirements. These are fulcrum agencies, as without them all the medicines that were ever discovered or invented would avail little. The trend of medical opinion is already in this direction and in that good time coming these essentials will hold a more prominent place. As a result, legal and illegal quackery will fade and fail in a corresponding degree.

There is nothing more disheartening in the practice of our profession than the receptivity of medical absurdities by weak-minded members. The personal equation is seen of each person, as readily as degrees are in a thermometer, by the eagerness of many to accept new-fangled theories and practice on first presentation. These credulous mortals, who are always seeking after the marvelous and are never satisfied with waiting for the slow but sure progress of scientific truth, swarm in every community. They would accept voodooism or fetichism did it come through professional channels, because medical ultraism with a spice of mysticism suits some minds. Some of the older members will remember how they were treated to a treatise not many years ago, on the benefits of the administration of raisins as a sedative for acute mania. The more the excite-
ment intensified the larger the quantity given, until—as was suggested by me—the consequent dyspepsia put to flight, the maniacal ogre. We all remember how blue glass was extolled to quiet the maniac. Some even went so far as to erect buildings with blue glass in them, and told us wonders as to its quieting effects. It would have been thought that the blue sky had enough of that color in it to satisfy the most fastidious. There would have been some semblance of fitness in it, had the brilliant intellect which had discovered this remedy made it a therapeutic agent to cure "the blues" of melancholia.

We all know of an alienist who became afflicted with senile decay, and in this mental deterioration thought he had discovered the "Elixir of Life." This was the secret which philosophers had been seeking for throughout the ages, and herein was to be found eternal youth. There was the other day placed over his tomb "Sacred to the memory." Strange to say he has to-day a number of deluded followers, who laud with many adjectives the fluid extracts of cerebrine, testine, cardine, *ad infinitum*. These ingredients go through the mechanical process of extraction, to be followed by the chemical and vital changes in the system and yet maintain a peculiar aptitude to raise dead issues, and revivify moribund tissues. This pristine nastiness catches the vulgar imagination and I see that in a capitol city it is used to ensnare the weak and unwary. The arch-quack finds thousands of dollars in it because of multitudes who swallow the glittering bait. This catch-penny method is not new for the Romans gave the raw lungs of foxes to consumptives to strengthen their lungs, and fed the brains of deer to racers to increase their running power, and fed liver to cure melancholia (black bile).

This retrospective glance is given to emphasize my prophecy that in the near future, common-sense methods will prevail where not only will such nostrums be relegated to limbo, but mere medication will take a secondary place where it virtually belongs. In this way legal and illegal questions will be subordinate to intelligent methods and far removed from the disgraceful ways of the "cure-alls" of to-day. When it is shown that we rely for cure primarily upon the "Gospel of fatness" and the powers which belong to physiological righteousness, then will therapeutic quackery be largely disarmed of its malign influence in the community.

In the future the question of personal and chemical restraint of the insane will no longer be debated, as it is to-day.
After ten years of non-restraint treatment in the Toronto Hospital for Insane, and after a longer or shorter period of non-restraint in a large number of other institutions of a kindred nature, it is evident that personal liberty of the most liberal kind will be the method for the future. The days of mitts, camisoles, straps and crib-beds will be consigned to the past, unless exceptional circumstances should arise.

In some countries it has been the custom to appoint chief officers of public institutions, not because of fitness, but because of political bias. The man who has the correct party ear-mark, or who shouts the proper shibboleth of political sectaries is sure to be one of the elect. He may be qualified for the position, or he may not; that is of secondary importance if only he has been an orator for his party, and has faithfully turned the crank of the voting-machine. I knew of one of this kind, who was not very long ago appointed to a splendid institution after a brilliant administrator had been superseded, who had given efficient service for fourteen years, but was ostracized because of former allegiance to a party.

The new incumbent was so ignorant that he knew nothing about spelling, or the use of capitals. In writing, periods, commas, semicolons and all such punctuations were ignored and even the word God was written with a small "g". These were not lapsus-pennae but rather the result of mental vacuity. The battle-cry of "To the victors belong the spoils" should stop short at charitable institutions where the highest talent and best executive ability are needed. It is proper to say that such untoward things belong only to the untutored savages of Soudan and Uganda, and will be remedied with the march of civilization. In the next fifty years a Jubilate will be sung over the extinction of such a selfish and disastrous policy.

Some heroic and outspoken member of the Association will in the near future classify and describe in faithful portraiture a large class of persons of neurotic and hereditary tendency, who have relatives in the various hospitals for insane. Chief officers come in daily contact with them, and much of the trouble with such is the innate tendency there is to be exacting, suspicious and complaining. This is not so much their fault as their misfortune. They have a certain amount of mental instability which leads them to have vivid imaginations which conjure up the worst phases of life and conduct, and which leads them to believe in all the supposed horrors of asylums.
The lack of ordinary judgment, the feeble discretion and the credulous nature deprive such of the possession of the normal modicum of common sense, which is so necessary to have in all well-behaved persons. Of course, there are many exceptions to this statement but the class exists, and it is from among such the asylums, however well conducted, are libelled, often with honesty of purpose, but with circumscribed mental vision. When the intellectual and moral standards are raised in the near future these persons will disappear and with them one of the plagues of asylum official life.

The writer might thus wander on into the hypothetical without end. Let him say, however, that there is great advancement in all branches of psychiatry and greater promise for the future along the lines of experimental and clinical exploration. The best minds in our profession are working to this end and have justly discarded mere metaphysical speculation for the entities of vital phenomena in all their multifarious manifestations. As a result new continents of the hitherto unseen have been discovered and there are yet more worlds to conquer. For the sake of our common humanity, we are glad that in our noble profession so much solid ground has been found and cultivated by many of those seeking after the truth. We have great faith in the discoveries of the near future, as eager and honest workers are everywhere seeking to solve life's enigmas.

It may be said, however:

"There is a good time coming,
We may not live to see the day,
Yet, earth shall glisten in the ray
Of the good time coming."
THE PREVENTION OF TUBERCULOSIS IN HOSPITALS FOR THE INSANE.

BY J. W. BABCOCK, M. D.,
Physician and Superintendent, South Carolina Lunatic Asylum, Columbia, S. C.

In large asylums, reformatories, and prisons, the prevalence of phthisis is a matter of common observation. While statistics prove that tuberculosis causes one-seventh of the deaths among the whole population of the world, the figures collected by Hagen in 1850 from the reports of many asylums showed that among the insane more than one-fourth of the mortality was due to this fatal disease. In 1892 Clouston, who has studied this subject more than thirty years, concludes that "The fact that, under the most favorable conditions of life and treatment that we can at present devise for the insane in the best asylums, three of them die of pulmonary phthisis to one person in the general population at the same age, is one full of interest and significance." Ireland says fully two-thirds of all the idiots die of phthisis. So great is the liability to tuberculosis in certain prisons that commitment to them is almost equivalent to a death sentence. Cornet found that during a period of fifteen years the mortality from phthisis among males in Prussian Prisons was 45.82 per cent of all deaths; in females 49.33 per cent. In the prisons of Austria the mortality from this disease reached 61 per cent during four years, while in the penal institutions of Bavaria it was only 38.2 during eight years. Among the 1,400 convicts of the Illinois State Prison at Joliet fully one-third have consumption, and nearly all the deaths in that penitentiary are due to this single cause.

The frequent association of mental disease with pulmonary consumption and scrofula has, for over half a century, attracted the attention of alienists. Well-sustained evidence ascribing this relationship to heredity, habit, or diathesis is to be found in the standard works on insanity. A special form of mental disease called phthisical insanity is also recognized by some authors. In commenting upon this association Bucknill makes an abstract from his annual report of the Devon County Asylum for 1861: "The number of patients who die of phthisis is always a source of peculiar anxiety, inasmuch as the development of this disease may be regarded as a test of the sanitary conditions of an
institution." After thirteen years of additional experience and observation, Bucknill\(^9\) concludes: "That phthisis, which forms so large a proportion of the mortality of asylums for the insane, is the produce of the institutions and not of the cerebro-mental disease."

Clouston says,\(^{10}\) in writing upon phthisical insanity, that "In the older institutions, where the hygienic conditions were bad, the number of deaths from phthisis was often from 25 to 30 per cent of the whole number who died. And when the post-mortem records of these institutions were examined, from 30 to 60 per cent showed signs of tubercular deposit to a greater or less extent. The sanitary conditions of modern hospitals for the insane are, however, much better than they were fifty years ago, ... so that recent statistics of the prevalence of phthisis are far more favorable than they used to be. In the Royal Edinburgh Asylum for the Insane, from 1842 to 1863, the percentage of deaths from phthisis in the whole number of deaths was twenty-nine, while for the ten years from 1879 to 1888, it was only 13.6 per cent."

During the first twenty-three years of the existence of the Inverness (Scotland) Asylum, 35.4 per cent of the whole deaths were due to phthisis. In commenting upon the report of that asylum for 1887, a writer in the *Journal of Mental Science*,\(^{11}\) remarks that "When eighteen deaths out of forty-seven (38 per cent) are due to phthisis, it is time to cease speculations concerning the prevalence of phthisis in the Highlands, and to take active, practical steps to discover the real cause of the pest."

According to the summary given by Griesinger\(^{12}\) "Esquirol considered more than a third of his melancholics phthisical, and Calmeil found tuberculosis in two-fifths, and Pinel in one-sixth of their autopsies. In Vienna it was met with in more than one-third in a total of six hundred and two autopsies made in three years; in Prague in more than two-fifths, and in the asylum for chronic cases at Colditz, in five-elevenths; in Palermo, in thirteen years, in one hundred and ninety-two cases of death, in almost one-fourth. In certain asylums, as the Bicêtre, its rarity was remarkable." More recent investigators\(^{13}\) estimate that phthisis causes but nine per cent of the mortality of Italian asylums.

In the United States the death-rate from tuberculosis is also high in some hospitals for the insane. According to Workman\(^{14}\) in 1862, in eight American asylums consumption was the cause of 27 per cent of the whole number of deaths.
In the Lunatic Asylum of South Carolina the proportion of deaths from tuberculosis upon the whole mortality for the ten years ending November 1, 1893, varied from 14 to 34 per cent, averaging 22 per cent. Careful observation and inquiry shows that the disease prevails in some wards of the old building, built in 1822, and now occupied for the most part by colored women; in the section of the new building, built in 1856, and now assigned to white men, and in certain wooden pavilions occupied by colored men and women. The remaining eighteen wards for white men and women are free from the disease. Prior to 1868 very few negro patients were admitted, and records of phthisis are rare. Since that date there has been a steady increase in deaths from tuberculous diseases. In 1883, with an average population of 564 there were ten fatal cases of tuberculosis, while in 1893 there were thirty-nine deaths from that cause in an average population of 764. That is, in the decennial period the population increased 35 per cent, and the mortality from tuberculosis, 290 per cent. The old building, which is most infected, was the fifth insane asylum built in the United States, and, conforming to then existing ideas, is very like a prison. It occupies a city square of four acres, is built in the form of a crescent, and is shut in by high brick walls. The bedrooms are small, and poorly lighted and ventilated. Judged by modern standards, the whole building is typical, both architecturally and hygienically, of what a hospital should not be.

Tabulating the mortality from tuberculosis for thirteen years I find that thirty-two more negro women—the class of patients occupying this old building—have died of the disease than the sum total of deaths from the same cause among white men and and women and colored men.

**TABLE I.**

**DEATHS FROM TUBERCULOSIS FROM 1880 TO 1893.**

<table>
<thead>
<tr>
<th>WHITE.</th>
<th>COLORED.</th>
<th>Grand Total.</th>
</tr>
</thead>
<tbody>
<tr>
<td>38</td>
<td>52</td>
<td>90</td>
</tr>
</tbody>
</table>

These figures are the more appalling when we consider that our average population is 190 white men, 240 white women, 170 colored men and only 140 colored women. Granting that the
negro race is peculiarly subject to tuberculosis—and facts may be cited to the contrary—we are forced to admit that there have been other causes in operation to produce such a frightful mortality as is here shown.

The second table shows that of the whole two hundred and ninety-eight cases, somewhat less than a third died during the first year after admission to the asylum, the remaining two-thirds after an asylum residence of one to twenty years. In other words, the chronic cases of insanity are most prone to tuberculosis.

**TABLE II.**

**LENGTH OF ASYLUM RESIDENCE OF FATAL CASES OF TUBERCULOSIS.**

<table>
<thead>
<tr>
<th></th>
<th>WHITE.</th>
<th></th>
<th>COLORED.</th>
<th></th>
<th>GRAND TOTAL.</th>
<th>PER CENT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 month...</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>1 to 6 months....</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>7</td>
<td>25</td>
<td>32</td>
</tr>
<tr>
<td>6 to 12 months....</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>4</td>
<td>27</td>
<td>31</td>
</tr>
<tr>
<td>1 to 2 years.........</td>
<td>1</td>
<td>9</td>
<td>10</td>
<td>8</td>
<td>30</td>
<td>38</td>
</tr>
<tr>
<td>2 to 3 years.........</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>6</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td>3 to 5 years.........</td>
<td>8</td>
<td>14</td>
<td>22</td>
<td>7</td>
<td>34</td>
<td>41</td>
</tr>
<tr>
<td>5 to 10 years........</td>
<td>9</td>
<td>17</td>
<td>26</td>
<td>7</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>10 to 20 years........</td>
<td>4</td>
<td>4</td>
<td>8</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Over 20 years........</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total.................</td>
<td>38</td>
<td>52</td>
<td>90</td>
<td>43</td>
<td>165</td>
<td>208</td>
</tr>
</tbody>
</table>

**TABLE III.**

**FORM OF MENTAL DISEASE OF FATAL CASES OF TUBERCULOSIS.**

<table>
<thead>
<tr>
<th></th>
<th>WHITE.</th>
<th></th>
<th>COLORED.</th>
<th></th>
<th>GRAND TOTAL.</th>
<th>PER CENT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melancholia, acute...</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>Melancholia, chronic</td>
<td>4</td>
<td>14</td>
<td>18</td>
<td>6</td>
<td>19</td>
<td>25</td>
</tr>
<tr>
<td>Mania, acute...........</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>6</td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td>Mania, chronic.........</td>
<td>10</td>
<td>19</td>
<td>29</td>
<td>13</td>
<td>54</td>
<td>67</td>
</tr>
<tr>
<td>Secondary dementia...</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>4</td>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td>Epileptic insanity...</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>7</td>
<td>16</td>
<td>23</td>
</tr>
<tr>
<td>Senile insanity.......</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Idiocy.................</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Imbecility............</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Total.................</td>
<td>38</td>
<td>52</td>
<td>90</td>
<td>43</td>
<td>165</td>
<td>208</td>
</tr>
</tbody>
</table>

From the reports of ninety-eight other American asylums I have calculated the death-rate from tuberculosis, and find that in many
of them also the disease is virulently prevalent, while in others it is rare or entirely absent. The latter comprise small institutions; the former large hospitals, the highest mortality being found in colonies for the chronic insane.

**TABLE IV.**

**Mortality from Tuberculosis in Ninety-Eight American Asylums.**

<table>
<thead>
<tr>
<th>No. of asylums</th>
<th>Percentage of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>0-1</td>
</tr>
<tr>
<td>1</td>
<td>1-5</td>
</tr>
<tr>
<td>14</td>
<td>5-10</td>
</tr>
<tr>
<td>16</td>
<td>10-15</td>
</tr>
<tr>
<td>24</td>
<td>15-20</td>
</tr>
<tr>
<td>14</td>
<td>20-25</td>
</tr>
<tr>
<td>13</td>
<td>25-30</td>
</tr>
<tr>
<td>6</td>
<td>30-35</td>
</tr>
<tr>
<td>3</td>
<td>35-40</td>
</tr>
<tr>
<td>1</td>
<td>50-60</td>
</tr>
<tr>
<td>1</td>
<td>60</td>
</tr>
</tbody>
</table>

As these asylums are located in all parts of North America—North, South, East, and West—these figures seem to indicate that regardless of climatic conditions, the disease is ubiquitous.

The reports from eight asylums show the total mortality, including that from tuberculosis from their beginning, and give a sum total of deaths amounting to 5,760, of which 1,215, or 21 per cent, were from tuberculosis. Out of one hundred and four cases of melancholia, upon which autopsies were held by Blackburn in the Government Hospital at Washington, 37 or 35 per cent were found to be suffering from tuberculosis, which was "the direct or indirect cause of death."

These figures do not overstate the truth regarding tuberculosis as a cause of death in asylums. For, as was pointed out by Clouston in 1863, "when such expressions as 'exhaustion,' 'general decay,' 'natural decay,' and 'marasmus' are put down as causes of death . . . we can not arrive at any correct idea of the true causes of mortality in asylums," and when "phthisis pulmonalis" is the clinically "assigned cause of death in only about one-half of those in whom tubercular deposition is found after death." It is important here to recall Bucknill's opinion that the insane in private dwellings are not more liable to phthisis than is the general population.

In the face of such facts are we not forced to raise the question, whether there does not lurk in some of our institutions a pernicious form of hospitalism which demands rigid investigation into its causation and earnest efforts toward its extermination?
PREDISPOSING CAUSES.

The chronic forms of insanity are most prone to phthisis. While Table III assigns to chronic mania the largest percentage of cases of tuberculosis, most writers give precedence to chronic melancholia, terminal dementia, and epileptic insanity.

According to Savage, 18 "The vital depression (of melancholia) seems to prepare a fit site for the lower organisms to flourish in." It is Clouston's opinion 19 that, "If the bacillar theory of phthisis is true, the general conditions within the body and outside it that produce a suitable nidus for the development of the tubercle bacillus must always be of the highest consequence. And here we have something that increases the fertility of the soil threefold for the bacilli. We know that almost everything that depresses the nutrition tends toward phthisis if long continued. The nutrition of the tissues is commonly depressed, this going along with the mental phenomena as an essential part of the morbid process."

While the direct inheritance of tuberculosis may be admitted as a rare possibility, yet the congenital transmission of phthisis pulmonalis is now subjected to doubt. In the light of modern investigations 20 it appears the old idea of consumption being inherited in from 24 to 59 per cent of all cases can not be accepted. On the other hand, the fateful predisposition to the disease is undoubtedly transmitted by the tuberculous to their offspring. Von Ziemssen 21 aptly describes this tendency to the disease as that "unknown pathological something we call predisposition to tuberculosis, applying this term to a certain constitution of the tissues of the organism which furnishes a favorable soil for the reception of the germs." This predisposition may be congenital or acquired.

The bacteriologists have recently taught us that animals by nature insusceptible to a disease may be rendered susceptible by change of environment. In other words, they have shown how predisposition may be acquired. Thus, pigeons which, as a species, are immune to anthrax are rendered susceptible by starvation (Canalis and Morpurgo), or dogs, hens, frogs, and pigeons by enforced thirst (Pernice and Alessi), and "Guinea pigs and white mice which are resistant against avian tuberculosis can easily be infected on being kept in a warm chamber at 33–35 degrees C." 22

In man's environment also are found some of the acquired predis-
posing causes of tuberculosis. Thus overcrowding, imperfect ventilation and absence of sunlight, dampness, and defective plumbing and drainage, singly or in combination, have been repeatedly shown to be the predisposing cause or causes of a high death-rate from phthisis in asylums in Great Britain and elsewhere.23

In prisons Cornet found as predisposing to pulmonary tuberculosis such influences as insufficient ventilation and exercise, want of variety in food and improper care of cells. Von Ziemssen24 justly considers such psychical factors as remorse, yearning for liberty and family, loneliness, and absence of excitement among predisposing elements.

EXCITING CAUSE.

The theory of the infectiousness of tuberculosis began with Isocrates and Aristotle, and has had its individual advocates through succeeding ages.25 On the other hand, the investigation of the disease by the experimental method belongs almost to one generation. Corroboration of the experiments and discoveries of Villemin, Koch, and Cornet, seems to have established the truth of the hypothesis of contagion so long held by isolated clinicians, and as a result a large body of physicians now class tuberculosis among the infectious diseases. After mature deliberation such well recognized authorities as the boards of health of New York City and the State of Michigan have within a year placed tuberculosis upon the list of diseases dangerous to the public health. It is believed by many competent authorities that one case of phthisis can not develop without infection from a previous case. Infection usually takes place by inhalation of pulverized sputa containing the tubercle bacillus, which is the sole exciting cause of the disease.

The bacillus tuberculosis is from 1-7,000 to 1-12,000 of an inch long, and about one-fourth as wide as long. It is a spore-bearing, parasitic micro-organism requiring for its development a temperature of 86 to 104 degrees Fahr. Patients in a moderately advanced stage of pulmonary consumption expectorate in twenty-four hours from seven hundred and twenty million to four billion tubercle bacilli. Neither the germs nor their spores grow outside the living body except under artificial culture. In any medium they are of slow development, no signs of growth being visible before ten days or two weeks. They are extremely susceptible to direct
sunlight, which kills them in a period of time varying from a few minutes to some hours; and in well-lighted rooms they live only six or seven days (Koch). In dried expectoration the bacilli and their spores retain their vitality and infecting power from six to ten months or even longer. In sputum they are destroyed in twenty hours in a 3 per cent solution of carbolic acid. Freezing does not kill all the germs, and boiling for a shorter time than half an hour is probably not effectual. The bacillus lives in an alkaline or neutral medium, but is probably killed by strong acids, such as the gastric juice at the time of active digestion. Infection through the milk or meat of tuberculous cows is not uncommon, especially in children and persons subject to indigestion. Salted meat may also infect, as the bacilli are not destroyed by the process of salting. That direct infection through mucous membranes, cuts, or abrasions may take place is well authenticated.

In addition to predisposing conditions most people require prolonged exposure to the exciting cause to contract the disease, and the extent and the intensity of the affection depend upon the number of bacilli introduced, or in other words, upon dosage.

Such is the conception of the causation of tuberculosis that with remarkable slowness has been gaining ground since Koch announced in 1882 his discovery of the tubercle bacillus.

Upon the evidence I have presented the following conclusions seem warranted:

1. That tuberculosis is two or three times as common in institutions as in the general population.
2. That among the insane two-thirds of the cases have had an asylum residence of over one year.
3. Therefore, in asylums the chronic insane are most liable to the disease.
4. That the disease is frequently the result of hospitalism and its prevalence may be regarded as a test of the sanitary condition of an institution.
5. That improved sanitation alone has diminished the death-rate but has not exterminated the disease.
6. That the disease is really ubiquitous, although some small well-conducted asylums are free from it.
7. That asylum statistics, based upon clinical diagnosis alone, do not give the full mortality of tuberculosis.
8. That in private houses the insane are not more liable to phthisis than are other people.

9. That direct heredity is probably less potent than has been supposed.

10. That predisposition to tuberculosis may be congenital or acquired.

11. That among the more important external predisposing influences are imperfect ventilation, absence of sunlight, dampness, defective plumbing and drainage, insufficient exercise, want of variety in diet—in fact, an unhealthy environment; but such psychical elements as depression of spirits, homesickness, loneliness, monotony, etc., may also play a part.

12. "The history of the disease, clinical observation, and bacteriological investigation all prove the disease communicable, the element of infection being a specific germ contained in tuberculous discharges." 2 6

13. "Being communicable the disease is therefore preventable."

What, then, are the means of prevention? In hospitals for the insane the methods of prophylaxis against tuberculosis seem naturally to fall under four heads:

I. Management of tuberculous patients.

II. Disinfection of rooms, wards, and buildings.

III. Protection of non-tuberculous against infection.

IV. Prophylaxis against infection of new hospitals, wards, or rooms.

I. MANAGEMENT OF TUBERCULOUS PATIENTS.

The danger lurks in the discharges—sputa, pus, or dejections—from tuberculous lesions. All such excretions must therefore be promptly destroyed. Cornet is authority for the statement that "With proper care as to cleanliness the phthisical patient is innocent even to his immediate surroundings." Commonly the most important procedure is that the sputum of the phthisical be received first in spitting cups or cuspidors containing water* which must be afterward thoroughly sterilized. The paramount importance of this requirement is accentuated by Cornet’s investigations which showed the presence of tubercle bacilli in the dust and wall-scrappings from rooms of phthisical patients who were at all careless in expectorating, while no bacilli were found when the patient faith-

* Carbolic acid solutions can not safely be intrusted to insane patients.
fully carried out instructions to use sputum-cups. The use of handkerchiefs or similar material to receive sputa is highly objectionable because of the rapid drying and easy pulverization of sputa.

The shaking out of an infected handkerchief readily diffuses the bacilli through the air.

There seems to me no valid reason against isolating insane patients who have reached the advanced stage of phthisis. Assuredly the tuberculous should not be permitted to sleep in associate dormitories with the non-tuberculous. Even if allowed to mingle with others by day, each phthisical patient should sleep in a single room prepared with special reference to his disease. The sentiment which still prevents the isolation of the phthisical in private families should have no influence in hospitals. The disease will be stamped out or its ravages minimized when physicians and others recognize it as a communicable disease, and take steps toward complete isolation and disinfection. Cases of diphtheria, or any of the commonly recognized infectious diseases appearing in asylums, are isolated as a matter of course. Shall we be less vigilant in dealing with a more insidious and numerically more fatal disease?

Each consumptive should be provided with eating utensils for his use alone, and these articles should be boiled after every meal. The bedding as well as the clothing of such patients should be kept separate from other clothing, both in the wards and in the laundry.

The walls of the sleeping-rooms should be made germ-proof by impervious plaster, paint, and varnish. The entire walls should be cleansed with a cloth wet with carbolic solution (1 to 20) twice a week, or rubbed down with squares of bread, which, with the crumbs carefully swept up, should be burned. The bedroom floor requires perfectly fitting linoleum for its proper protection and cleansing, unless the floor has been made and prepared by modern methods. The floor should be mopped daily with carbolized solution rather than swept in the ordinary fashion. In fact, brooms and dusters have no place in the management of the apartments of consumptives, even if allowed elsewhere in the hospital. The furniture must be confined to necessities, and the use of curtains and carpets forbidden. The bedstead should be of painted iron, so as to be subjected to regular disinfection with carbolic acid solution.

Nurses should be instructed to give especial attention to the phthisical, see to their proper exercise and nourishment in the
early stages of the disease, and prevent them from carelessly expectorating about the wards and staircases, instead of using the cuspidors. In fact, I am inclined to think that on account of the general lack of coöperation on the part of insane patients, and because of the importance of carrying out minute details in the management of the tuberculous, our main reliance in preventing the spread of phthisis in asylums must rest upon the intelligence of the nursing service.*

II. DISINFECTION.

That the rooms occupied by consumptives may become the source of danger to themselves and others has been demonstrated by Cornet and confirmed by other investigators.

The experiments of Delepine and Ransome seem to indicate that chlorine and sulphurous acid gas are not effectual in disinfecting rooms that have been contaminated by the tuberculous. The usefulness of milk of lime (whitewash) in destroying tubercle bacilli is also open to serious doubt.

After a room has been vacated by a phthisical patient, ordinary walls should be scraped and replastered. Hard-finished walls that have been specially prepared by painting and varnishing should first be rubbed from above downward with bread forty-eight hours old, cut six inches square with crust on each piece, and afterward washed with 5 per cent carbolic solution, the floors also being subjected to the same treatment. Subsequently a thorough cleansing with soap and water should follow. Nuttall states that corrosive sublimate is not effectual in destroying tubercle bacilli, while the Philadelphia Board of Health recommends its use in a 1 to 1,000 solution.†

*In commenting upon the mortality in the female department of the Harrisburg, (Pa.) State Lunatic Hospital, Dr. Jane K. Garver, in her report for 1893, says: "Fourteen deaths (out of thirty-nine) were due to phthisis alone, and two to phthisis with other diseases. Eight of these cases developed in the new building, four in the old building, and four were contracted before admission. Excepting these four, all were residents of the hospital for from two to sixteen years, and those in the new building had resided there for several years. These facts point with an emphasis greater than words to the reality of all that has been said in regard to overcrowding in this hospital. It also seems to corroborate the theory of communicability of phthisis. Disinfection and isolation have been used in each case as far as our means permit, but it seems that further efforts in the direction of hygienic and sanitary precautions are called for."

†This apparent disagreement arises from the well-known fact that corrosive sublimate alone coagulates albumen, and is, therefore, not efficient as a germicide for tuberculous matter. The addition of tartaric or citric acid prevents this coagulation and enables the mercury to act upon the germs. Corrosive sublimate combined with these acids or analogous substances is probably used by the Philadelphia Board of Health.
Infected clothing requires boiling or exposure to super-heated steam for one hour, or disinfection in 5 per cent carbolic solution for twenty-four hours.

III. PROTECTION OF THE NON-TUBERCULOUS.

The importance of nutritious diet and warm clothing, and of proper ventilation and other methods of sanitation in hospitals, need not be dwelt upon at length before this Association. The danger of infection through meat and milk renders necessary the inspection of meat supplies and the test of dairy herds by means of tuberculin in the hands of experts, especially when the prevalence of tuberculosis gives reason to suspect them as possible sources of infection.*

Among the smaller details, to which sufficient care seems not to be given, is that of sweeping and dusting. In the rooms of consumptives these daily requirements of hospital housekeeping should be done with moistened cloths rather than in the ordinary way, which only serves to scatter the dust. Moistening the floor by sprinkling and then sweeping with a broom is at best an unsafe compromise. Scrupulous cleanliness should be observed in assembly rooms and workshops.

Doctor Trudeau's conclusion† about the treatment of phthisis is here apropos:

"All means which tend to increase the vitality of the body cells have been found to be precisely those which are most effectual in combating tuberculosis; one by one, specific methods of treatment, which for a season enjoyed popularity, have fallen into disuse, and hygiene, climate and feeding—in other words, a favorable environment—have alone stood the test of time." To this may be joined Von Ziemssen's statement‡ that of all the depressing "factors which impair the resisting power of the tissues and cells none has such an important influence as the want of sufficient muscular action out of doors and of sufficient fresh air."

The well recognized beneficial effects of an out-of-doors life upon the phthisical gives us additional reason for encouraging our able-bodied patients to join in the work about farm and garden, or to take part in regular gymnastics. It also emphasizes the necessity of walking parties and tennis, croquet, etc., for the less robust. Since it appears that cases of chronic insanity and dementia are

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* The State Board of Health of California found more than 50 per cent of the cows used at the Stockton Insane Asylum infected with tuberculosis in 1894. (Jour. Amer. Med. Assoc., Aug. 25, 1894, p. 368.)
particularly prone to phthisis they should be forced to exercise out of doors instead of being permitted to mope in corners. In brief, when the season or weather is favorable, all classes of the insane who are not bedridden should live out of doors, a part of the day at least.

IV. PROPHYLAXIS AGAINST INFECTING NEW HOSPITALS AND WARDS.

In planning new hospitals, attention should be given to the need of having isolating wards or rooms especially adapted for the care of contagious diseases. In these wards phthisical patients should be cared for and treated apart from the non-tuberculous. The walls of these rooms should be impervious and without corners or angles. There should be no crevices in the floors, and when cracks appear they should be calked.

"With the downward systems of ventilation, having foul-air ducts on the floor level, much may be done toward lessening the number of micro-organisms inhaled with the dust of floors, carpets, etc., by giving the foul air a downward instead of an upward tendency." The freest natural ventilation is demanded in addition to any artificial system that may be employed. An additional plea for more sunlight in asylum wards is given by the knowledge of its destructive action upon the tubercle bacilli.

You may ask, if this conception of the infectiousness of tuberculosis and its prevention is true, what results have been attained by it? Let me quote from Dr. Lawrence F. Flick, the president of the Pennsylvania Society for the Prevention of Tuberculosis:

"Italy, in less than a century, reduced the mortality rate from the disease in her midst from that of a most virulent epidemic to a comparatively rare disease. England, by establishing special hospitals for the treatment of pulmonary tuberculosis, and the consequent isolation, of its tuberculous poor, reduced its mortality 50 per cent in forty years, and Philadelphia, by preaching the doctrine of contagion and teaching its people methods of avoidance and prevention, has reduced the mortality rate from the disease 20 per cent in eight years."

According to Doctor Woodhead, proper management and disinfection have brought about a diminution in the deaths from phthisis in the Grand Duchy of Baden from 3.08 in one thousand in 1882 to 2.80 in one thousand in 1887, a percentage of decline
which, Doctor Woodhead estimates, would in the British Isles amount to a saving of nearly ten thousand lives per annum.

In Nuremberg's orphan asylum, with four hundred children under perfect prophylaxis, there have been but two or three cases of tuberculosis in eight years. 33

This paper has been prepared that the truth of the facts presented may be judged by the experience and knowledge of the members of this Association. All of us recognize the necessity of eternal vigilance in matters of hospital hygiene. If my facts are true, then a high death-rate from tuberculosis means bad hospital hygiene; and a very high mortality, criminal negligence. The causes must be found and eliminated. Several years ago Prudden34 justly said: "We are apt to forget that as soon as we know the cause and the means of prevention of a disease like consumption, the responsibility for a large death-rate is no longer to be laid to the charge of Providence or fate, but at the door of human ignorance or carelessness:

REFERENCES.

3. Ireland: Idiocy and Imbecility. Quoted from Clouston.
7. Clouston, Spitzka, Ball, Krafft-Ebing, and others.
12. Griesinger: Mental Diseases, p. 443.
PREVENTION OF TUBERCULOSIS.

32. Woodhead: Bacteria and Their Products.
34. Prudden: Dust and its Dangers, p. 88.

DISCUSSION.

Dr. LAWRENCE F. Flick, of Philadelphia: I appreciate the honor very highly of being allowed to discuss this subject before you, and I certainly feel that I ought to compliment Dr. Babcock upon the very able manner in which he has presented the subject. He has opened up a field for thought and action the importance of which can scarcely be appreciated. As he has said in his concluding remarks, if he presents the facts as they are, a grave responsibility rests upon all those who have to do with public health and who have to do with public institutions. If tuberculosis is a preventable disease, then it is certainly no longer proper, and it is probably not putting it too strong to say it is a crime, to permit the large mortality which at present exists to go on.

The paper touches upon so many important points and presents the entire case so well that I scarcely know what to take up for discussion. One point that is brought out very forcibly by the paper I would like to expatiating on. It is quite evident from what has been said here of the prevalence of tuberculosis in insane asylums and from what has been shown by other men that the secret about the spread of tuberculosis lies in house infection or in room infection, in other words, that there is something peculiar about this disease which limits the infecting power to a small circle. Cornet has shown this very well in an excellent series of experiments. He has shown that a room which has been occupied by a tuberculous patient, if that patient has been careful about sanitary matters—has spit into a spit-cup only and never on the walls or floors or cloths—that such a room is absolutely free from infection and that it is not possible to produce the disease by inoculating animals with dust taken from such a room. On the other hand, where such a patient has not taken these precautions and where
spitting all over the room has been practiced, the dust taken from any part of the room, from the walls, chairs or bed-clothes, will, invariably, successfully inoculate animals. Again, where sanitary measures have been practiced to a certain extent—where the patient has used a spit-cup but has occasionally, clandestinely, spit into the handkerchief or upon the bed linen—in such cases dust taken from the immediate vicinity of the patient, within say five feet, will inoculate animals, whilst the dust farther removed will not have this effect. In other words, Cornet’s experiments show that there is a limited environment which has the infecting power, and that environment depends to a large extent upon the amount of material which has been ejected and the opportunity afforded for spreading it around the room. My own clinical investigations and those of others lead to the same conclusions. I, a few years ago, made a careful investigation of the deaths from tuberculosis in the Fifth Ward of this city and many of you may have seen the diagram which shows the results. The Fifth Ward of this city is made up of a pretty even population and is moderately densely populated, but not the most densely populated that we have. During twenty-five years the deaths occurring in this ward were confined to about 30 per cent of the houses of the ward and many of these houses have recurrences as high as eight and ten times. During the year 1888, I investigated all the deaths from tuberculosis that occurred in the ward, and I found that of the deaths which occurred in the ward during that year, nearly 80 per cent occurred in infected houses and only 20 per cent in non-infected houses;—80 per cent of the deaths occurred in 30 per cent of the houses whilst only 20 per cent occurred in 70 per cent of the houses. This is too striking to be a mere coincidence. The chances for the occurrence of deaths were so much greater in the non-infected houses than in the infected houses that we could not explain these results by coincidence. This line of investigation has been taken up by Dr. DeForest, of New Haven, and he has been able to elucidate a very striking fact which I was not able to bring out. In New Haven he found the same state of things—that the deaths were limited to a comparatively small number of houses—but in addition he found there that the deaths occurred not in the houses of the extremely poor but among the better class of people. His diagram shows that the arguments that have been used that deaths in these cases are due to bad
hygienic surroundings, to poverty and want, are not true. Here in Philadelphia, I have found that in the streets in which the sanitary conditions were exactly the same for all houses—where they were as bad as they could be, there were a large number of houses which during 25 years never had a death from consumption.

The results in Italy, in Philadelphia and in England have been quoted here as illustrating what could be accomplished by sanitary measures. Italy at one time probably suffered more severely from tuberculosis than any other country in the world. Those of you who will care to investigate the matter and who will take up contemporary writers of that period, will find that the disease was so prevalent that visitors from England, Germany and France wrote home to their people not to come to Italy, that the climate seemed to be adapted to tuberculosis and that everybody seemed to be dying of it. During 1764 there was an epidemic of what was apparently tuberculosis, in which people died, as it was then expressed, like flies, and the post mortems which were made all give the same conditions which we find now in acute tuberculosis. I will read for you some of the sanitary laws which were established at that time for the prevention of this disease:

On July 19th, 1782, the sovereign of the kingdom of Naples gave his sanction to a legal enactment for the prevention of tuberculosis, which, according to DeRenzi, the medical historian of Italy, contained the following propositions:

1. That the physician shall report the consumptive patient, when ulceration of the lungs has been established, under penalty for the first offence of three hundred ducats, and upon repetition, of banishment for ten years.

2. That an inventory shall be made by the authorities of the clothing in the patient's room, to be identified after his death, and if any opposition shall be made, the person doing so, if he belong to the lower class, shall have three years in the galleys or in prison; if to the nobility, three years in the castle and a penalty of 300 ducats.

3. All household goods which are not susceptible shall be immediately cleansed and those that are susceptible shall at once be burned and destroyed.

4. That the authorities, themselves, shall tear out and replaster the house, alter it from cellar to garret, carry away and burn the doors and wooden windows and put in new ones.
5. That the sick poor shall at once be removed to a hospital.
6. That newly built houses cannot be inhabited before one year from their completion and six months after plastering has been finished and repairing has been done.
7. That superintendents of hospitals must keep in separate places clothing and bedding for the use of consumptives.

Other severe penalties are threatened to those who buy or sell objects which had been used by consumptives, to servants, members of the family, and to any transgressor whosoever."

The result of the enforcement of this law was the almost complete extinction of tuberculosis in the kingdom of Naples. For those of you who have seen the statement made that Naples still has a large mortality from tuberculosis, I wish to bring to mind that the kingdom of Naples is not the city of Naples, but the entire southern half of Italy and the Island of Sicily, and that this law was promulgated for all that district. The city of Naples and a few other cities which have been health resorts for consumptives have still a high mortality from consumption but the lower end of Italy has practically no consumption, the mortality being less than one per thousand for the entire district. These laws whilst they were made at a time when there was no scientific knowledge about tuberculosis were, nevertheless, excellent and accomplished their purpose. This brings up to my mind a point brought out by the paper and that is, that in the insane hospitals in which there has been a large mortality from tuberculosis, probably the best thing would be to burn them down or tear them out clean and clear. Ordinary methods will not remedy such places as that and disinfection by means of sulphur or whitewashing I think amounts to nothing at all.

The methods so ably presented by Dr. Babcock, I think if care fully followed will in the newer institutions accomplish the purpose, but in old institutions where the disease has been rampant for years, the best thing would be to tear them out or burn them down.

There is one point that was referred to in the paper which I would like to say a word about and that is the permitting of consumptives to mingle with others during the day, in insane hospitals. I believe that complete isolation is the only measure that will prevent the spread of tuberculosis in an insane asylum, because even though you have nurses watching these cases during
the day, if you permit them to associate together they will spit around and the dried up sputa will be inhaled by the non-tuberculous patients. It probably would be more expensive to separate these cases entirely from the well, but I believe it is the only thing that will prevent the spread of the disease. I must say from the study I have made of this disease, that I believe it is possible to entirely eliminate it from institutions in which there is absolute control. Of course it would not be possible to prevent the introduction of insane patients suffering from tuberculosis, but I do believe it possible—and the public has a right to expect it with our present knowledge about this disease—to prevent the development of tuberculosis within the institution. Of course, in this connection it must be borne in mind that many cases of tuberculosis are dormant for many years—that a person can carry tubercular nodules or tubercular glands for many years without any symptoms of ill-health and later on develop the disease in a more acute form. I have no doubt that many of the cases of tuberculosis which swell the mortality rate in insane hospitals are of this character. Cornet has shown that this is true of the mortality rate in prisons and I have no doubt it is equally true of the mortality rate in insane asylums.

I have been anxious to hear this paper because it deals with a phase of tuberculosis which I have wanted to study for many years and about which I have never been able to get any information in this country although it has been well discussed in Germany.

I will say one more word as bearing out what has been said in regard to the prospects of reducing the mortality from tuberculosis by proper effort. Berlin, which is probably at present employing the best sanitary arrangements for the prevention of tuberculosis of any city in the world, has, since the introduction of its new sanitary regulations, reduced its mortality within about eight years nearly 20 per cent. In fact there never has been an effort made anywhere in the world, that has been recorded or that can be brought forth, to prevent tuberculosis, that has not been successful and I am myself convinced that within a very short period tuberculosis will be a rare disease considering the effort that is now being made throughout the entire world to stamp it out.

Dr. J. B. Chapin: I want to state an incident. While connected with an institution in the State of New York, with a popu-
lation of about 2,300 persons, including the insane and all employees, it was discovered that the herd which furnished the milk were badly infected with bovine tuberculosis. The herd numbered about 150, more or less, and it became necessary to destroy all of the cows. This was in the year 1883. At the time the question arose among the physicians of the hospital as to the effect, if any, of the milk from those diseased animals upon the health of the patients. While investigating this point we found that for several years tuberculosis as a cause of death among the patients had been steadily decreasing, although it is probable the herd of cows had been infected several years. I think the impression might go out from this meeting that the mortality of our hospitals from this cause is greater than it really is. I am satisfied that it is less now than formerly. I can understand why the mortality in the chronic asylums or among the chronic insane, might be much greater. Many patients sent to the hospitals remain for life, and the causes of their deaths are plainly inserted in the statistical reports. I do not attach much importance to the mortality statistics of many of our hospitals, as it is well known many patients are removed to their homes when failing health and mental condition permit, and on the other hand, much the larger number of cases of tuberculosis contracted the disease before entering the hospitals.

Dr. B. D. Evans: There is one point which I have not heard mentioned which impresses me very forcibly and that is the possibility of communicating tuberculosis by means of playing cards. Every medical man connected with an institution for the insane knows of the popularity of card-playing among the patients and employees. It would seem rather harsh and cruel to stop this popular and interesting amusement, yet I am convinced that it is a means by which tuberculosis may be easily transmitted. My attention was particularly called to this in one of the wards of the hospital with which I am connected. I have one attendant who has tuberculosis and his lung is so seriously affected that he has frequent hemorrhages. He is very fond of playing cribbage and a number of patients upon that ward are also very fond of the game. It is a custom which we all know of, that each player sticks his thumb into his mouth, especially if the cards get gummy, as they do in hospital wards, to assist him in dealing. Then the cards are handed in turn to another player who also sticks his
thumb into his mouth and gets from it some of the saliva which
was upon the back of the cards from the previous dealing. If
this is not a convenient means of transmitting the disease, I know
of none and I think it merits our attention.

Dr. G. H. Hill: I thank Dr. Babcock for his practical and
valuable paper. I think it is very fortunate for our institutions
that our patients having this disease do not expectorate as much
as do persons who are not insane. At least that is my experience.
If this is true, that there is not as much expectoration from
tuberculous insane persons, unless it be, perhaps, in the last
stage of the disease, then that method of transmitting the disease
is much less injurious than it would otherwise be. We know
very well that tuberculous patients in our hospitals very seldom
have pulmonary hemorrhage. In all the cases that I have
known in one institution for 20 years, I can only recall two
cases of pulmonary hemorrhage, although we make frequent
autopsies and often find tuberculous lungs. We use the sputum-
cups in our institution in all cases as far as practicable and
these little paper linings are frequently removed and burned. But
there are patients too much demented or too contrary to use these
cups. In these cases we always tear up old bed linen and thin
clothes into pieces the size of ordinary handkerchiefs and try, as
far as possible, to have the patients expectorate on them and then
we have these cloths burned and clean ones used in their stead.

It seems to me a very easy matter to prevent the transmission of
the disease by means of playing cards. The cards are very cheap
and decks can be burned up almost every day if there is any dan-
ger in using them, besides the attendants and patients can be
enjoined from moistening their thumbs with saliva when they deal
the cards.

Dr. William L. Worcester: I want to take up your time for
a few minutes in giving a little personal experience. At the
Arkansas State Lunatic Asylum, during the five years I have been
there, pulmonary tuberculosis has caused not far from 30 per-
cent of the deaths. On the 1st of May, 1893, two new buildings
were opened, one for men and one for women, and the one for
women, of which I have had charge, contained on the average
about 120 patients, about 70 white and 50 colored patients. None
of the patients that were removed to that building were known to
have tuberculosis, nor was it discovered at the time of admission:
in any of the newly admitted patients to that building, whom I examined in every instance with reference to that as well as to other points. Up to the time that I left, the 18th of April last, there had been seven deaths from pulmonary tuberculosis in that building, five in colored, two in white women. Deaths from tuberculosis had occurred on every ward in that new building. Now whether all or most of those patients were infected at the time of their removal I cannot undertake to say positively; I presume that some of them were. In both white women the disease was initiated, as far as anything was known of it, by pulmonary hemorrhage.

I will only say in regard to prophylaxis, that I do not believe in the efficacy of any measure short of isolation of the patients in entirely separate buildings as soon as the disease is discovered. I do not believe that amongst insane patients it is possible to carry out any such directions in regard to the disposal of the sputum as will be at all efficacious.
VARIETIES AND ANALOGUES OF GENERAL PARESIS.

BY R. M. PHELPS, M. D.,
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My object, as indicated by the above title, is not to obliterate distinctions between variously named diseases, so much as by a study of resemblances and alliances to bring out the differentials. For, under any decision as to names, it will be understood that the mere name is the least important part, and that by studying the broad underlying principles, we lose the narrow idea of a group named as an invariable entity, and gain conversely in the idea of each as symptomatic of certain brain and nerve changes. For example, in our subject, we would find "general paresis" and "syphilitic dementia" not exclusive of each other as are measles and typhoid fever, but blending and combining with each other, the name in each case being determined by the preponderance of certain elements.

It was not until some five years ago that I became sufficiently impressed with the immense value of tabulating and recording symptoms in asylum work in order to compare cases, and with the way it opens up new light and interest on all the work. On this account as well as for convenience I will in this discussion confine my comments to cases thus tabulated and personally studied in the past four years, cutting out with considerable rigidity any doubtful cases. I will aim at a passing study of the relationship of those forms of mental trouble, resembling in their characteristics that most studied yet most hopeless of insanities—general paresis.

Folsom and others have brought out prominently both the difficulty and possibility of diagnosing the prodromal or initial and neurasthenic stage of general paresis. But I would here go on record, though few have previously done so, as to the occasional difficulty of a decision in cases which are so definitely insane, as to be confined in hospitals for the insane. Even though a single speech or half a minute's observation of face or walk suffices in typical cases, yet occasionally in extremely atypical cases, no firm basis can be found.

Though I have made diagnoses when speech and co-ordination seemed correct, and have had the satisfaction of later seeing typical symptoms develop, I will also confess to having ventured in
other similar cases and to have been obliged later to cross some names from my list. Doubtless I would make fewer mistakes or ventures now, but I do not believe surety of conviction can be obtained in some cases. Before trying to speak of outlying forms, it is best to set before ourselves the main elements determining the diagnosis of general paresis. These are given with uniform sameness by everyone. The prominent ones are as follows:

1. Gradual invasion through neurasthenia, loss of high moral tone, irritability, to manifest dementia.
2. A more or less excitable stage.
3. Sense of well-being and frequent ideas of grandeur.
4. Steady progression through deepening dementia, toward exhaustion and death in from two to six years.

The motor symptoms are supposed to follow closely along with the mental; they are:

6. Inco-ordination and tremor or "stammering" movements.
7. Facial blankness.
8. Disordered knee-jerk, usually exaggerated.
10. Frequent convulsions, vertiginous attacks, or spells of like character.
11. Adult age, usually about 40.
12. Syphilitic history frequent.
13. Pupils unequal or unresponsive.

Cerebral Syphilis. These preliminaries being settled the first variation from general paralysis to be noted, is that of "syphilitic brain disease," or "cerebral syphilis." The relationships of these two forms have been more earnestly considered than those of any other forms.

Of these discussions, however, none but the most prominent and recent of studies, need call for note. Dr. Kiernan in 1883 is reported as holding that "neither from clinical, therapeutical or pathological standpoint, could leuetic paretic dementia be differentiated from leuetic dementia." Dr. Henry Hurt in 1886 in an excellent article, in which he starts out with the proposition that general paresis is not of syphilitic origin later describes a "congestive" form of syphilitic dementia which he admits as distinguishable only by long observation. Savage in 1888, in leading the discussion in the Pan-American Congress, aimed to make clear that, in his opinion, there is no possible line to be drawn between some cases of nervous
syphilitic degeneration and general paralysis of the insane. He also maintained it as not true that all general paralysis must have a syphilitic origin. In the discussion following Dr. Mickle and Dr. Spitzka seemed to quite closely agree with these views. In the Annual of 1888 Dr. Spitzka sums up European authorities as chiefly in favor of syphilitic causation. The Annual of 1890 refers to A. Morel Lavelle, as concluding that syphilis produces a pseudo-paresis, very hard to distinguish from true general paralysis. At the first Congress of Mental Medicine, at Rouen, this subject was discussed. Rubuisson is reported as claiming only a slight causal connection; Regnier considered them entirely distinct; Régis found 80 per cent. of paralytics to be syphilitic; Cullerre found that general paralysis of the syphilitic is not of a special clinical form. Voisin found syphilis in only 9 of 560 cases, but demanded "real tertiary syphilitic lesions" for his diagnosis.

Sachs, tabulates general paresis as a sub-heading under the general subject—syphilis of the nervous system. Peterson utters probably the latest word in December, 1893, in quoting many writers to show a consensus of opinion that 60 to 70 per cent. of cases have syphilis as a cause. He concludes by denying the probability of its being more than a predisposing factor.

But, selecting the commonly admitted matter from the various reports, we find practical unanimity, that syphilis is a common precedent of general paralysis, and that when it affects the brain in what is called variously a "congestive" form or the "diffuse," or a "meningeal infiltration," it sometimes produces a brain and motor trouble quite indistinguishable clinically from typically pure general paralysis.

Keeping in mind our purpose of differentiating, as well as showing resemblances, we would point out also that brain syphilis tends usually to show more gross brain signs, more localized motor impairments, a less steady progression, a more easily produced remission, and a less typically exalted mental state than does general paresis. But finally, we would claim it probable that in a series of 100 cases, there could easily be outlined a series showing gradations from the gross syphilitic lesions and signs, to a quite smoothly progressive general paralysis. The varieties of syphilitic brain trouble vary among themselves, even more than do the cases of general paralysis. And the whole ground of variation is probably what could rightly be expected, from the varied location and extent of lesions which are found.
Counting in this way, though persons might differ as to the placing of special cases, yet using our own judgment we find in the four years' study as above noted, among the list of 88 diagnosed as general paralysis about 6 cases of the syphilitic form yet so typical as to best deserve the name of general paresis. During this same time 7 syphilitic cases have been admitted, with other insanities of various kinds, none of them so closely resembling general paresis as to deserve the name.

I give a case of nearly typical symptoms.

Case I.—Man, age 35, barber, single, syphilis 6 years previous to admission, no heredity determined, admitted October 17th, 1892, gradual, rather quiet mental failure. The history described "Syphilis of the nervous system." The motor signs on admission are unequal pupils, sight somewhat impaired, inco-ordination, sluggishness and awkwardness, tremors and "stammering" use of the hands, patellar reflex extremely exaggerated, articulation markedly hesitating and slurred, facial expression typically dull and blank, has had semi-conscious conditions, has had delusions of electric currents in his head; specific treatment has had no effect. The only prominent element lacking seems to be the grandiose ideas.

During the first three months of his stay here, he passes through a rather irritable and demented activity; during the year 1893 he gradually becomes more dull and quiet, and talks very little, has said that he was President Cleveland, &c. He is usually very dull, sluggish, and seemingly too stupid to talk; at present is extremely so, will not talk intelligibly, and stumbles about in a sluggish way when he moves, which is rarely. In short his appearance is typically that of the last stage of paresis. Although starting out with prominent syphilitic signs, he seems now in a typically paretic condition.

Senile Dementia.—Senile Dementia at first seems to be widely different from general paresis, and is less often mentioned as resembling it yet at times seems to afford as close an analogy as does the syphilitic form. In a goodly proportion of senile dementias we have a distinct progressive downward tendency, manifested by both motor and paretic signs, and mentally a dementia progressing rapidly onward toward a death from central nerve deprivation, exactly resembling that of paresis. I find perhaps more trouble
in distinguishing paresis from senile dementia of this type than I do from either the syphilitic or alcoholic forms. There seem to be fewer of the diagnostic differences.

These cases seem to be included in the class of cerebral atrophy, which Norbury \(^7\) last year (following Bevan-Lewis) sought to make a separate class. He analyzed 196 cases of over 60 years of age, and declared that senile insanity was not duly studied in our hospitals.

He does not, however, state the exact proportion of cases of cerebral atrophy, though speaking of them as many. From his description, they are, seemingly in part, the paretic forms which we are now studying. He hardly makes them clearly distinguishable, or distinctly set apart in any clinical way, however. He also finds seven cases of true general paralysis, and five cases of syphilitic brain disease, included in the 196.

Following out his method, we find that we have had here in the past four years 129 cases, varying from 60 to 87 years of age. Although we realize that to separate these into classes is like separating spring from summer by inspection of the weather, yet by careful consideration we would separate out of the 129 cases approximately 37 of ordinary senile dementia, 17 cases paretic senile dementia, 10 cases organic dementia, 18 cases mania, 31 cases melancholia, 6 cases alcoholic dementia, 2 cases epilepsy, 1 case adult chorea, 3 cases paranoia, and 4 cases designated as general paresis though only approximating the typical form. Of the type cerebral atrophy we must confess to not being able to distinguish clinically with greater clearness than is given above.

Clouston is reported to have spoken of general paresis as premature senile degeneration. Though the two seem so different at first, yet by close inspection they are not so different after all. The reasons for such combination seem to stand on fairly firm ground. For example paresis occurs in the decade just preceding that of senile dementia; it occurs in cases in which there are such powerful causes of premature senility, as syphilis, alcoholism and overwork; the motor symptoms of paresis can be found in some of the senile cases in modified form; the mental state tends in each to a pronounced dementia; death is by a similar exhaustion; and progression is usually quite marked and rapid.

The differences distinctive of the senile form seem to be greater age, a more quiet dementia, a less tendency to inco-ordination and
more toward weakness, absence of a marked excited stage and a somewhat different invasion.

During the last stages, however, the cases seem occasionally not very different, and we think that a series of cases could be outlined leading from the most distinctive and typical senile dementia, to the most purely paretic forms and that most of the gradations could be filled in with their proper cases.

I present one of the cases of senile dementia of paretic tendencies:

Case II.—Man, age 64, married, 2 children, duration said to be about 5 months, but probably (of course) of longer duration. History dates from a "fall on plank" on October last but I can not learn that the fall was of any importance. First became absent-minded, then irritable and violent. On admission motor signs were coarse tremors of the tongue, with tremors and hesitations on all movements. Considerable inco-ordination of hands and legs; speech jerky, sluggish and slow. Facial expression extremely paretic. The whole person had a markedly paretic appearance, and grew steadily into the typical picture of the last stage.

He died here after five months' stay. His general appearance, behavior, motor and mental state, were quite indistinguishable from those of our paretics; died of a typical exhaustion with no fever or special localizing symptoms.

With the 88 cases of paresis we have had also in the four years' period, 44 cases of senile dementia, 17 of which could be well designated as of the paretic type.

Alcoholic Paresis.—A third derangement frequently mentioned as resembling paresis, is found in chronic alcoholism or inebriety. Although the resemblance is far more often noted yet I would think it far less frequent and accurate than that of senile dementia. In studying alcoholism I have had the advantage of a combined inebriate and insane asylum. Among over 200 individuals committed as inebriates and for inebriety although considerable of insanity has been found, yet only one case has developed typical paresis. One more case was on my list for a time from close resemblance, but was cut out as making no progress along typical lines.

Among these inebriates inco-ordination and exaggeration of patellar reflexes is quite general; while frequently is found facial sluggish-
ness, confusion of speech and a self-satisfied state of mind. These cases lack, however, the most essential element of progressive character, and "alcoholic dementia with paretic symptoms" best describes the most of them. I would generalize then to the effect that the tendency of alcoholic paretic symptoms to assume a progressive typical form is very slight. Of course I would admit as alcoholic many pareties admitted as such, but usually the alcoholism is an accompaniment or predisposing cause. As occasionally, however, a case of alcoholic general paresis may so accurately resemble true general paresis as to defy distinction, we would again state it as seeming to be quite possible to select a series leading from true alcoholic dementia to seemingly straight general paresis. The following cases are added:

Case III.—Man, age 30, admitted Aug., 1888, telegraph operator, very intemperate, had perhaps had syphilis, had delirium tremens, and lay helpless in a hospital for several weeks before admission.

On admission mind confused, and was quite ataxic, but this soon passed away. Memory quite gone, though was very bright in some ways. Knew many tricks at cards and sleight of hand; played the organ at our dances for years; during 1889, 1890, 1891, 1892, he was the same quiet, cheerful case of alcoholic dementia, of mild character. No marked motor signs noted until in December 1892, when they commenced to appear. He then went into and through a typically excited stage of general paresis, with a silly, self-satisfied state of mind and grandiose ideas, fairly well marked.

He passed from this into a more quiet dementia, steadily progressing, however, until in December 1893, when, being very weak, his death was hastened by an attack of pneumonia.

Another case, briefly outlined, might designate a gradation somewhere between the two:

Case IV.—Man; admitted Jan., 1891, age 53, widower, mental state quite sluggish, answers vaguely but promptly, has hallucinations in regard to receiving messages, &c.

History states him to have been a thorough-going drunkard for years. The motor signs were tremors, sight of one eye lost by ulceration, some inco-ordination, speech fair, facial expression only slightly impaired. During 1891 gradually brightened up, rarely mentioning hearing the voices though likely having hallucinations all the time. During 1892 stationary, on parole quiet and well-behaved; self-satisfied state of mind; memory fair. During
last of 1893 delusions of grandeur creep in, that he is Governor of the State, extremely wealthy. This state seems at present to be a gradually progressing one.

Case V.—Of still another type is a man who was on our inebriate ward for some years, with slight dementia hardly noticeable. He went out on trial and returned in three months in a grossly paretic condition. One seeing his condition at that time, without knowledge of previous history, could hardly well diagnose it from the last stage of general paresis. Facial signs were marked, talk hesitating and difficult, gross ataxia, vertiginous attacks, eyesight failing, mental condition also quite typical except for the presence of grandiose ideas. But from its history it was considered an acute effect of some more gross brain lesion, and by its gradual receding during the eight months since that time, it has so proven itself. Yet it would be quite possible to call such a state general paresis if one wished to force the meaning somewhat. We have had within the four years one other case of similar character.

Pubescent Insanity.—It will probably seem a little surprising that I name an inherited defective state as similar to paresis, and I will therefore hasten to mention a case to make my meaning clear; nor should it be so surprising on second thought, that inherited or early brain defects should occasionally affect the same brain centers and in approximately the same way as the adult disease, paresis. The case is as follows:

Case VI.—Girl, aged 19, admitted Jan., 1892, single, history mostly unknown, attack dated "from 1890." Examination on admission showed considerable anaemia, tongue only fairly steady, pupils dilated, inco-ordination very marked, facial expression sluggish and tremulous, knee-jerk exaggerated, speech hesitating and uncertain, mental state sluggish, confused, and says that she "gets easily mixed." She hesitates peculiarly before being able to give answer to simple questions, is emotionally unstable, cries easily and is easily irritated. Memory seems vaguely unreliable. Her story seems to indicate her to be illegitimate, to have been placed in an industrial school, and since that time to have wandered about. Says she has foster parents, but probably ran away from them. Was in a general hospital at one time, with what complaint is not known.
Her last employer, (evidently very sympathetic), was afraid that we would consider her as sane, and wrote to us describing her variable behavior. She had known her two years and describes her as part of the time fairly reliable, yet not thoroughly to be depended upon. She describes a gradually growing, though rather irregularly manifested, mental impairment.

Patient stayed here about 12 months. The motor difficulties of speech, etc., together with the mental confusion, gradually cleared up during the first three months, until she was a very intelligent and pleasant girl. Suddenly in March she had a spell of violence, with return of mental and motor confusion. During these spells she has extreme headache, and in fact has had during all her stay frequent headaches which produce more or less depression and seeming tendency toward mental confusion. In July she had a similar attack of confusion of mind without the violence, which lasted the most of the month. During the first part there was a suicidal attempt rather ill-planned, with somewhat of hysterical tendency. As a whole, however, the attack was not at all hysterical, but was accompanied by very marked mental change, only gradually clearing up. During the rest of the year, she had no farther attack of the kind mentioned, and was finally let go on trial to work for her former employer. She at no time could be said to be entirely well, although comparatively so.

The case as a whole bears the unmistakable features of pubescent cases, and yet during the first few weeks of her admission, so strongly marked were the motor symptoms, and so evident seemed the progressive character at that time, that I was inclined to call the case one of paresis. The subsequent history, however, makes it a fairly stationary case, with variations. Other cases having motor signs, of variable character and significance, could be mentioned, but none of them so nearly the typical paretic state as this one.

Choreic Dementia.—The last decade has decided quite positively that there is a kind of chorea of adult years, with heredity of extremely direct character, which tends to appear about the age of forty, and to progress steadily through increasing motor weakness, and increasing mental dementia, to death by exhaustion. Its duration from beginning to death seems two or three times longer than paresis, and its symptoms are all, to a certain degree, lacking in the typical form but few of them are entirely absent.

Moreover, the later study does not make heredity an essen-
tial element. In an essay two years ago, published in the *Journal of Nervous and Mental Disease*, I outlined the disease with the especial aim of showing its resemblance to that form of mental disease called paresis. It has motor symptoms increasing gradually in strength, and mental symptoms increasing gradually, through mildly excited irritability, into dementia. It has frequently a satisfied state of mind and occasionally expansive ideas. It has a vague state of excitement or irritability, and it has the typical termination in death by exhaustion.

I quote one case from the article referred to, merely commenting that there are a good many of them, and that we have had with more or less perfect history seven, during the last nine years, in this institution.

*Case VII.*—Male, age about 50, picked up in St. Paul, native of England. Exposure to cold while at work in Rocky Mountains was put down as cause; admitted Oct. 8, 1885, died March, 1892.

During stay here showed a slow, gradual deterioration, through all of the stages of growing weakness, both bodily and mental. Talked of vast amounts of property, later thought the Queen of England was his wife. Delusions were not systematized, but did not change rapidly, nor were they prominent. His talk was jerky, and accompanied by jerks of limbs, body, and face. He walked always in a shuffling, hesitating manner, his dementia was such that we were never able to get his previous history from him. Patellar reflex exaggerated. He died from exhaustion in a lingering way, just as from general paresis. He had always a quiet self satisfied-mind.

A post-mortem upon this case was obtained and there were found moderate adhesions and thickening of the dura, and a pachymeningitis of the convexity of the brain. Atrophy of the brain, especially the anterior part, was manifest at a glance on removal of the dura. In the pia-arachnoid were found serous accumulations, forming a kind of spongy covering. A milky, plastic exudate was found, thickest upon the convexity and in the sulci of the brain. This was whitish, the combination being similar to the customary gross appearances of general paresis. A pearly or ground glass appearance of the floor of the lateral ventricle was noticeable, also congestion of the choroid plexus and a cystic formation of the same in the right lateral ventricle. The weight of the brain after removal of dura was 39.4 ounces. Although a microscopic exami-
nation was desired, yet owing to defective preparation of the specimens it was not satisfactorily obtained.

Lastly, we might, in collective form, note some occasional and scattering cases of differing character. The motor and mental condition called "hemiplegic chorea," occasionally either accompanies or assumes a similar condition. After noting two such cases and thinking of them, as probably cortical troubles taking their start from an initial apoplectic lesion, I was pleased to find in Tuke's Psychological Dictionary, that Mickle speaks of such occasional cases, as paresis by extension. I do not doubt at all that such cases (of course imitating paresis somewhat imperfectly) are fairly common. I will give briefly the notes of the two cases.

Case VIII. Man, admitted Nov. 16, 1892, widower, laborer, temperate, duration 7 years. History does not give an account of an apoplexy, in fact very little history is given.

Examination on admission, tongue deviates to the left, pupils about normal, sight and hearing somewhat impaired, co-ordination of right hand moderately good, left very poor, legs the same though less of difference. Hands show extreme excursive involuntary movements on attempt to do anything; left hand could not carry glass of water to mouth. In fact has to be fed for the most part. Slight tremors of the face, general facial expression very blank and strained; right knee jerk exaggerated, left one absent even on re-enforcement. Articulation slow, somewhat blurred and rather difficult; mental state—weak-minded, always rather cheerful in character, and with a few vague delusions.

Died after nearly fourteen months' stay here; spent most of the time in bed, the excursive movements more than the weakness, produced helplessness; appearance fairly typical of a paretic in third stage. Three days before death, although there was no distinct apoplexy, yet he grew slowly stupid, lost motor control of left side and failed gradually until death.

Case IX. Man, age 53, saloon-keeper, intemperate. Had first attack of insanity in 1891, form, melancholia of strong alcoholic type. Second attack came on March, 1892, was depressed, agitated and dull. From this went into a state of mild acute delirious mania; symptoms of Bright's disease became somewhat prominent. On May 10, was found during the night to have developed some paretic symptoms, face and eyes turned to the right, right side of face partially paralyzed.
May 25th had a sudden spell of the same paresis, was conscious and could talk and explain himself, but could not prevent deviation of eyes, and slight paretic symptoms of the right side. His talk was indistinct and his eyesight dim. Following this he gradually grew better, mentally and physically, and was left as he has been upon the ward ever since—a quiet, pleasant, apparently intelligent yet really feeble-minded man, having always essentially a self-satisfied and hopeful state of mind.

The paretic symptoms, however, continue and have grown. His face is exceedingly blank and smooth, though a little one-sided, his gait that of extreme locomotor ataxia; knee jerk exaggerated, most on the right side, excursive movements of the right hand so extreme that he cannot drink water. Left hand the weakest, but under better control. Inco-ordination generally most extreme. This is his state at present, although the probabilities now are that he will die of Bright's disease before any farther progress of symptoms.

While a good deal of literature has been devoted to the relationship of locomotor ataxia and general paresis, yet I would incline to the conclusion drawn by Peterson, that the two diseases usually hold themselves quite exclusively aloof. The seeming resemblance lies chiefly in the early ataxic gait of some cases of general paresis. The later history does not show them to run in such parallel lines. In the four years' period under consideration we find two cases of locomotor ataxia, which have been declared also insane, but they have declared themselves in a rather different type of insanity. We will not try to detail these cases.

One case was met and diagnosed as a localized brain lesion, perhaps a minute hemorrhage. This case had very many motor signs and obscure dementia, but of the symptoms unfortunately I have lost the record.

It seemed to be easily designated as a border-line case and had been diagnosed as general paresis.

Now if we can conscientiously clear our minds of the idea of general paresis, as an entity peculiar and not blending with other diseases, (as we regard measles), and bring ourselves to think of it along with other insanities as only a grouping of symptoms varying as the lesions happen to vary in position, we can then think of these diseases mentioned, as producing similar symptoms, when the lesions invade similar tracts and in similar ways.
The pathology we could not fully discuss here, but it seems too undecided to disprove this clinically gained impression. Mickle says "Speaking summarily, we may consider general paralysis as essentially commencing with cerebral hyperæmia, and ending with chronic cortical degeneration, cerebritis and usually embryonic and connective tissue substitution." Specific lesions have varied so much, however, that it has been declared difficult to say that any one thing is thoroughly pathognomonic.

Now we do not want to be misunderstood as trying to bring everything which has cerebral-motor signs under general paralysis. We would strive to exclude all cases of tumor, all cases of apoplectiform lesions, all cases of atheroma with vertiginous and motor symptoms, except as they are vaguely included under our senile cases, all cases of meningitis, which are sometimes slow and obscure. We have still left out of our discussion, also, epilepsy, which occasionally develops marked paretic signs and multiple sclerosis, a somewhat parallel disease. The whole effort, however, is even a little more one of differentiation than of combination.

Our conclusions, then, would be somewhat as follows:

1. While cerebral syphilis ordinarily presents gross mental and motor lesions, it occasionally adheres closely if not exactly to the type general paresis, and the latter name then seems fitting to use in regard to the case.

2. While senile dementia is usually a rather chronic failure to death, accompanying old age, it may begin comparatively early and a motor failure may accompany the mental failure, the combination progressing steadily and rapidly toward a death from central exhaustion.

3. Alcoholic dementia has usually some inco-ordination and motor impairment; occasionally has very much motor and mental impairment, approximating though rarely adhering closely to the type general paresis.

4. Pubescent insanity, using the term to include strongly inherited defects growing into instability, at or near the time of puberty, exhibits occasional cases with motor symptoms, strongly suggesting paresis, though lacking in the essential element of progressive failure.

5. Locomotor ataxia occasionally presents mental similarities, but they are usually not marked and the tendency is toward other forms of insanity.
6. Post-hemiplegic chorea may develop a motor and mental state resembling paresis, this state being practically secondary to or an extension from the initial gross lesion.

7. Chronic progressive chorea or hereditary chorea has nearly all the elements which mark paresis and clinically its course is quite parallel, after substituting "choreic movements" for "inco-ordination."

I append a tabulated statement concerning the last four years' admissions:

<table>
<thead>
<tr>
<th>Case Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number cases admitted</td>
<td>1,340</td>
</tr>
<tr>
<td>Number cases diagnosed general paresis</td>
<td>88</td>
</tr>
<tr>
<td>(a) Number of those having convulsions at some time</td>
<td>24</td>
</tr>
<tr>
<td>(b) Number having &quot;spells,&quot; not convulsions</td>
<td>9</td>
</tr>
<tr>
<td>(c) Number studied till death</td>
<td>56</td>
</tr>
<tr>
<td>(d) Number cases of quite surely temperate habits</td>
<td>—</td>
</tr>
<tr>
<td>(e) Number of those having typical grandiose excited stage</td>
<td>—</td>
</tr>
<tr>
<td>(f) Number of those having marked melancholia</td>
<td>4</td>
</tr>
<tr>
<td>Number of cases having hemiplegic chorea and paretic state</td>
<td>2</td>
</tr>
<tr>
<td>Number cases adult progressive chorea</td>
<td>7</td>
</tr>
<tr>
<td>Number cases pubescent insanity with marked paretic symptoms</td>
<td>2</td>
</tr>
<tr>
<td>Number cases vague brain defect (vascular)</td>
<td>1</td>
</tr>
<tr>
<td>Number cases tumor</td>
<td>1</td>
</tr>
<tr>
<td>Number cases locomotor ataxia</td>
<td>2</td>
</tr>
<tr>
<td>Number strongly syphilitic (but not paresis)</td>
<td>7</td>
</tr>
<tr>
<td>Number cases over 60 years of age</td>
<td>129</td>
</tr>
<tr>
<td>(a) Of these—number ordinary senile dementia</td>
<td>37</td>
</tr>
<tr>
<td>(b) &quot; &quot; paretic senile dementia</td>
<td>17</td>
</tr>
<tr>
<td>(c) &quot; &quot; organic dementia</td>
<td>10</td>
</tr>
<tr>
<td>(d) &quot; &quot; cases mania</td>
<td>18</td>
</tr>
<tr>
<td>(e) &quot; &quot; cases melancholia</td>
<td>31</td>
</tr>
<tr>
<td>(f) &quot; &quot; cases alcoholic dementia</td>
<td>6</td>
</tr>
<tr>
<td>(g) &quot; &quot; cases epilepsy</td>
<td>2</td>
</tr>
<tr>
<td>(h) &quot; &quot; cases adult chorea</td>
<td>1</td>
</tr>
<tr>
<td>(i) &quot; &quot; cases paranoia</td>
<td>3</td>
</tr>
<tr>
<td>(j) &quot; &quot; cases general paresis</td>
<td>4</td>
</tr>
</tbody>
</table>

**Literature Referred To:**

1. Folsom,—Journal of Insanity, July, '91, and Transactions Asso. Amer. Physi-


5. Sajous' Annual, 1891.


THE EYE SYMPTOMS OF EARLY PARESIS.

BY NEIL JAMESON HEPBURN, M. D.,
New York.

The attention of the writer was specially directed to the ocular disturbances in the early period of general paresis by the observations made in the case of one who was a personal acquaintance, and hence afforded, perhaps, more than ordinary opportunities for observation.

G. Z., æt. 38, asked for advice regarding the care of his eyes, which troubled him when reading, particularly at night. This was in December, 1884.

He claimed that his vision was as good as ever, but that his eyes tired easily. He was a theatrical manager, a man of exemplary habits, used neither liquor nor tobacco in any form, and was especially happy in his family relations. His family consisted of his wife and one child, three years old and healthy.

He was very ambitious and a hard worker. No constitutional taint could be elicited, and he was especially reticent on the subject of his parents and early life. On physical examination his vision was found to be nearly normal, but the field cut off, on the temporal side in each eye, slightly and to the same extent. (See Chart No. I.) He accepted no glass for distance, but was able to read with comfort only with −1/34 over each eye. He continued to do very well till December 12, 1885, when he began to complain again of the same indefinite discomfort. An examination at that time disclosed −0.75 in each eye, and he was more comfortable with that correction. He also had an insufficiency of the internal recti of from two to three degrees at twenty feet. The optic-nerve entrance at this time disclosed no marked deviation from the normal, except that it was too pale, perhaps, with a slightly bluish tint. The vessels in and about the disc were normal in appearance and color, except that they appeared to stand out in bolder relief, which was supposed to be due to the marked contrast they presented to the bluish-white background. Glasses were ordered, which corrected the error, both visual and muscular.

On March 28, 1886, he complained that the discomfort still existed, and another examination was made. Nerve bluer tint,
vessels still prominent, but beginning to show signs of atrophy in
the narrowing of their caliber; not marked, however. Field more
narrowed on temporal side (Chart No. II) and $V=\frac{2}{4}$. Refraction
unchanged and tension normal. Examinations made on April 11th
and May 2d of the same year gave similar results, except that the
signs of atrophy became more marked and his vision was reduced
to $\frac{2}{4}$. On the advice of friends he then consulted Dr. David
Webster, who made a diagnosis of optic-nerve atrophy, and ordered
iodide of potassium in increasing doses. $V=\frac{2}{4}$. No improvement
resulting, on June 5th Doctor Webster ordered the hypodermic use
of strychnia. A curious feature of the case was that at this time,
when the test showed vision to be steadily deteriorating, the patient
was positive that he was improving, and insisted that he could see
as well as ever; but would sometimes refuse to make the trial when
requested.

In the latter part of June he became restless and irritable, did not
sleep well, and was somewhat changed from his usual quiet
demeanor, but his friends laid it to a press of business matters, and
urged him to take a rest. None of the toxic effects of strychnia
were apparent at any time.

From July 1st to 4th his wife states that he scarcely slept at all,
was continually on the move, and acted so strangely that she was
afraid for herself and the child.

On July 5th could not be controlled or kept at home. Owned all
the street-car lines, etc., and threatened to shoot conductor who
refused to obey his commands. Was arrested, examined by the late
Dr. W. R. Birdsall, found to be a paretic, and confined in Blooming-
dale, where he grew more quiet, but died July 9, 1886.

The apparent correspondence between the eye symptoms and the
progress of the general affection, with the knowledge of the fre-
cquency of optic-nerve atrophy in old cases of general paresis,
suggested the idea that perhaps cases presenting the appearances
seen in the early history of this case might, if kept under observa-
tion, give some light as to the relation of the eye symptoms to the
cerebral condition.

With this object in view all the eye cases coming under observa-
tion since that time have been carefully examined, and where found
to present similar appearances, or so nearly so as to excite suspicion,
they have been followed up as thoroughly as it was possible to do
without exciting the suspicion of the patient. As a result nine
cases have been observed from an early stage of the disease, and most of them followed to their final termination. Of these I propose to offer a short account, and draw from the conclusions which have suggested themselves, with the hope that in the wider and more fertile field occupied by this society they may be further corroborated or shown to be only incidental.

Case I.—T. H., â®. 55. First seen December 24, 1888. Complains indefinitely of discomfort in vision. $V=\frac{3}{4}$ in right eye;
II—In left, with correction. All the intrinsic ocular muscles are weaker than normal, internal recti more than the rest. Abduction four degrees. Adduction five degrees, but no apparent insufficiency. Optic discs creamy pink, with vessels too prominent on the surface. Retina and choroid apparently normal. Field slightly contracted on temporal side, and perception of blue poor in right eye, with micropsia in the same eye.

January 18, 1891.—Patient has consulted other physicians without obtaining any relief from his disagreeable symptoms. Now he has periodic dilatation of the right pupil, migraine, and some photopsia in same eye. V=\(\frac{20}{40}\) R. E., and \(\frac{20}{60}\) L. E. Fields narrowed ten degrees on temporal side. Muscular conditions about the same. Optic discs white, tending to blue. Vessels still prominent, and no marked change in caliber. Facies changing, naso-labial fold not so sharp and signs of echo speech. Says business worries him.

January 20, 1892.—Informed by a friend of Mr. H. that he had gone abroad in the preceding autumn for the purpose of getting rid of his nervousness, and that a physician whom he had consulted in Germany had said that his brain was affected.

Case II.—O. E. F., æt. 50. Pilot. First seen on December 26, 1889. He had been complaining of his eyesight for some time previous. Has V=\(\frac{20}{40}\) R. E., \(\frac{20}{60}\) L. E., with correction, and no accommodation. Esophoria two degrees at twenty feet. Discs whitish-blue, vessels prominent, slight atrophic crescent on temporal side of disc. Field cut off fifteen degrees on temporal side in each. Pupils normal.

This case was seen at intervals of two or three months till January, 1890, when he was removed from the city for his health, having developed some signs of mental disturbance, the nature of which was not easily made out from the account furnished by his friends, except that he had developed extravagant habits. He died in March of the same year from injury. On the last two visits he had exhibited marked paretic tendencies in articulation when he became excited.

Case III.—G. B. B., æt. 47. First seen March 11, 1890. Paresis external rectus right eye twenty-six degrees at twenty feet. V=\(\frac{20}{40}\) R. E.; \(\frac{20}{60}\) L. E. Discs leathery white, with pinkish center. Vessels stand out on surface of disc, no change in caliber. Fields cut off temporarily, more in left. Ordered potassium iodide
in increasing doses. March 24th, same year, paresis of external rectus only twenty degrees at twenty feet. Vision unchanged. Objects to medicine.

April 20th.—Fields and vision same as on previous visit. Has stopped taking his medicine and refused further treatment; said he could see as well as ever. Lost sight of till heard from in the Butler Hospital, where he was admitted March, 1893, and I am informed was discharged July, 1893, improved.

Case IV.—W. J. S., æt. 53. First seen October 2, 1890, with paresis of external rectus of right eye, five degrees at twenty feet. Occasional diplopia. Previous history good. Fundus oculi apparently normal, but discs white and vessels prominent. \( V = R . \ E. \frac{3}{2} \); \( L. \ E. \frac{3}{2} \), with correction, paresis of accommodation. Fields cut off fifteen degrees temporarily in each eye. Suggested an alternative course of treatment, and that he be watched. In the spring of 1891 he was supposed to be suffering from neurasthenia, and was taken abroad for his health.

Case V.—Mrs. R. B., æt. 55. First seen on April 12, 1891. Had a good family. Had brought up a large family, and had had much care. She complained of vertical headache, for which I was consulted. No pain in eyes. \( V = \frac{9}{2} \) o. u. with correction \( \frac{1}{4} = \frac{1}{6} \); and read Jäger No.1 at 9\(^\circ\) w. \(-\,5.00\), o. u. No apparent heterophoria. Discs show shallow cup, creamy or leathery white, vessels of normal caliber and prominent, giving pronounced parallax on motion. Tension normal. No disturbance of vision. Fields cut off as per chart. Occasional disturbances of speech. Since that time the patient has been seen occasionally, and now exhibits a typical case of so-called general paralysis of the insane, with acute attacks, interspersed with gradually lengthening quiet intervals, with intelligence disappearing and bodily strength much reduced. On January 10, 1894: \( V = \frac{9}{2} \); fields cut off as per chart No. IV. Discs blue, and vessels considerably diminished in caliber and slightly tortuous.

Case VI.—Mr. F. P., æt. 47. First seen on July 14, 1891, complaining of impaired vision. No history of constitutional disease. \( V = \frac{9}{2} \) o. u., discs leathery, vessels prominent, and of normal caliber. Fields cut off as per chart No. V. Hesitating and echo speech, and flabby naso-labial line, slight bilateral ptosis. On suggesting the possible outcome of the disease to the friend who accompanied him, he was very indignant; insisted that he could see and do business as well as ever, and refused treatment. He was
afterward taken west for rest and recuperation, and in a dispute on
the plains was so injured that he died in the spring of 1892.

*Case VII.*—J. W. H., æt. 43. First seen on October 27, 1891.
Complains of discomfort in use of eyes when busy. It was hard to

get his previous history without exciting too much suspicion, but he
may have had syphilis. V = 0.5 o. u., with correction. Exophoria,
three degrees at twenty feet; discs creamy pink; whiter on the
temporal side, not abnormally vascular; vessels prominent and of
normal caliber. Retina normal except a few patchy spots. Has been seen at intervals since, and at last visit exhibited the characteristics of general paresis. Has now white discs; fields as per chart VI. He will no doubt soon become the inmate of some institution.

Case VIII.—Dr. G. E. H., aet. 35. First seen professionally in 1891, when he was fitted with glasses. Had good previous history. Had been a constant but not excessive cigarette smoker, and a very moderate drinker. Had a good practice and was ambitious. \( V = \frac{20}{60} \) — with correction, discs creamy or leathery white, no cupping, vessels prominent and normal. Field as per chart VII. Color perception good, especially red. Seen again in May, 1892, when he complained that his eyes gave out occasionally, and that then he could not study or read with comfort. Advised rest, and cautioned a relative, also a physician. In October, 1892, he was seen again, complaining that he was worse. \( V = \frac{20}{60} \); fields as per chart No. VIII, nerves bluish-white, and vessels prominent and not much diminished in caliber. Field for red larger than for white. He soon after became violent and was admitted to the asylum at Middletown, N. Y., where he died a few months after admission.

Besides the above, several cases are now under observation, but the termination is as yet too uncertain to render them of any value as corroborative evidence.

In three of the cases mentioned above, the diagnosis of general paresis was made by examiners who did not know the results of the eye examination, and consequently based their diagnosis upon the general manifestations of the affection.

The number of cases thus far observed is of course too small to more than suggest investigation, but the following appear to occur with sufficient regularity to be fairly good diagnostic marks in the early period before the classical symptoms are well enough developed to attract attention:

The appearance of the optic nerve entrance creamy pink or leathery. A better idea of this appearance may, perhaps, be conveyed if it is stated that in this, the earliest period, the surface looks of the normal reddish white hue, with numerous laminated striations through it of a slightly deeper color. Over this is an extremely fine layer of transparent nerve tissue on which the vessels of the disc appear to lie. In one of the cases observed, one could almost imagine he could see behind or around the vessel, so
apparent was the stratum of transparent tissue. These vessels show no change from the normal in their appearance or direction.

Later the disc becomes gradually whiter and whiter, then takes on a bluish tint, from the connective tissue changes in the deposit, and becomes slightly cupped, which changes are accompanied by changes in the blood-vessels that are much less marked than in cases of ordinary atrophy.

In the retina there is some connective tissue deposit in between the nerve fibers in small striae or patches, confined to the nasal side till an advanced period of the disease, but later invading the temporal side rapidly.

Of the extrinsic ocular muscles, the interni appear to be most often affected, though all the muscles moving the eyeball may be affected to a greater or less degree. Cutting off of the field of vision on the temporal side to a moderate degree may be looked on as a fairly constant symptom, and the rate of its increase as a measure of the progress of the disease. Steady deterioration of vision, especially when accompanied by the patient's statement of improvement in vision, looks to a rapid course of the general affection. Inequality in size of pupils is by no means a constant symptom, and where it exists the case is likely to be complicated by some constitutional taint or habit.

Should the above conclusions be confirmed by further observation, an important factor will be the gain of from one to three years in the time of diagnosis, thus affording opportunity for the arrangement of affairs of business, etc., and, perhaps, of postponing the termination by judicious treatment, as well as presenting a means of positive determination not so liable to dispute as are some of the symptoms at present recognized as pathognomonic. This was one of the most marked characteristics of all the cases above related, and would appear to show that the progress of general paresis is slow, but at no time stationary.

The clinical appearances suggest that the affection of the optic nerves and retina is a connective tissue hyperplasia, or an interstitial optic neuritis, which results in substitution of connective tissue for true nerve substance, resulting in true atrophy, and strong corroboration of this view is found in the results of the researches made by Dr. J. A. Oliver, and published in the March number of the University Medical Magazine.
THE TROPHO-NEUROSES OF PARETIC DEMENTIA.

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In presenting for your consideration a brief review of the vaso-motor abnormalities exhibited in the clinical history of paretic dementia, I do so, not that I am able to offer anything new, but to accentuate the important part which neuro-angio-paralysis plays in the production of many of the most interesting phenomena of this dreaded malady.

The vaso-motor and trophic changes, which are observed in both the early and late stages of the disease, are characteristic and important. Glancing hastily over the clinical picture presented by the early stage of paretic dementia, we find an array of symptoms, some of which, if not all, are found in every case. Among these may be mentioned vertigo, flushing of the face, and other evidences of transient anæmia and hyperæmia of the brain; alterations in the tension of the pulse, it being high in the more active forms of the disease and low in the depressive form (Spitzka), frequent attacks of headache, associated with a sense of pressure in the head; occasional slight apoplectiform attacks, and many other symptoms familiar to all who have observed cases of paretic dementia in their incipiency. These symptoms are, however, evanescent in character, failing to furnish satisfactory evidence of structural changes in the interstitial or parenchymatous tissues of the brain, they are explicable only on the hypothesis of vaso-motor paralysis. The mental symptoms at this stage of the disease also bear evidence of very slight cerebral disturbance, and are accounted for more satisfactorily by the theory of functional circulatory disturbances than by the belief that real structural changes in the cerebral tissues have occurred.

The slight impairment of the mind, which makes its appearance and progresses so slowly; the sudden attacks of mental confusion, synchronous with the flushing of the face and the attacks of cerebral congestion; the blunting of the finer sensibilities, the mild exhilaration, the abnormal development of the Ego, the unnatural changeableness of the moods and temper of a formerly well-balanced individual; the irritability and the frequent attacks of excitement or melancholy, are suggestive of vascular abnormalities and of vaso-
motor disturbances. It is in this prodromal stage that Meynert, Folsom, and others believe that the line of demarcation between functional and organic diseases can be drawn; and by proper treatment and regimen the malady be stayed in its progress, if not actually cured. Later in the history of paretic dementia, we have the episodical attacks of epileptiform and apoplectiform seizures which not infrequently, after a few days of mental and physical impairment, result in the patient emerging from the attack with apparent rejuvenation of mental power. These attacks are often recovered from too quickly to have been due to any inflammatory process, as is claimed by some writers.

As the disease advances, the progressive impairment of mental vigor, the frequency of profound apoplectiform and epileptiform attacks, the marked ataxic and other symptoms of progressive paralysis of all striated muscles, mark the era of more serious brain changes. We now find the vaso-motor and trophic abnormalities presenting themselves in more tangible form. The vaso-motor paralysis is evidenced by changes in every tissue of the body. The oedema of the feet and limbs, hyperidrosis, malnutrition of the cutaneous surfaces, localized anaesthesias and hyperæsthesias, herpetic eruptions following the course of branches of the trigeminus, brittleness of the hair, sponginess of the gums, ulceration of the mucosa of the cheeks, acute decubitus, neuro-paralytic congestion of the lungs, othæmatoma, sub-dural haæmatoma durae matris, etc., all are consequent upon trophic changes. Post-mortem, the findings are still indicative of grave vaso-motor changes, which, by long-continued disturbances, have produced organic lesions of the cerebral structures. These may be briefly summarized as follows: An atrophy of the brain as a whole or in part, degeneration of the cells and neuroglia, of so pronounced a character as to lead Clouston to speak of general paresis as "essentially a death of that tissue, and equivalent to a premature and sudden senile condition; senility being the slow physiological process of ending, general paralysis the quick pathological one."

The vascular changes are as important as constant, the vessels of the pia and cortex being tortuous, looped, varicose, their walls thinned, the peri-vascular lymph spaces dilated. The membranes of the brain, especially the pia-mater, are almost constantly changed, being injected, infiltrated, thickened and opaque, the vessels giving ocular evidences of their inability to bear the strain put upon them.
The ependyma of the ventricles is granular, softened, and often detached. These abnormalities may with reason be attributed to a primary vaso-motor paralysis, which resulted in weakened vascular walls, and later, structural disease of the many vessels of the cerebral cortex. The condition known as "pachymeningitis interna hemorrhagica chronica," so frequently observed in advanced general paresis is an interesting phenomenon. Many authors hold that this condition is primarily and essentially an inflammation of the internal layer of the dura-mater.

From a series of investigations which I have carried on for a number of years, I have become convinced that this condition is caused by a neuro-angio-paralysis of the vessels of the pia-arachnoid, and that the hemorrhage which produces the sub-dural haematoma is due to a rupture of these vessels; and that any inflammation of the internal surface of the dura-mater is secondary to the hemorrhage.

To be brief, it appears to me that after a painstaking clinical and pathological study of the many vaso-motor abnormalities and tropho-neuroses to be observed in a case of paretic dementia, the observer is almost forced to adopt the advanced views of Meynert, Folsom, and Spitzka. These writers hold, in the main, that the symptoms in the primary stage of paretic dementia are largely due to functional or vaso-motor disease of the cerebral vessels, and that this disease begins in the vaso-motor paralysis of the cerebral vessels; and that the cortical encephalitis and degenerative processes, seen in the later stages, are secondary to the neuro-angio paralysis.

Folsom, who has written an able monograph on this disease, adopts Meynert's doctrine; and Spitzka regards the progressive deterioration of the brain as being chiefly the result of neuro-angio paralysis, which is the essential element in the production of the chronic inflammation of the cerebral cortex, so characteristic of the disease.

Taking into consideration, therefore, the preponderance of evidence in favor of the vaso-motor origin of paretic dementia, we should direct our researches toward the vaso-motor center on the floor of the fourth ventricle, hoping there to discover the primary lesion which produces this very fatal and distressing disease. When we add to this incentive the possibility of cure in the prodromal stage of the disease, as held by Meynert, the subject becomes still more important, and is worthy the treatment of abler pens than mine.
LUNACY COMMISSIONS.

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The general condition of the insane has doubtless been greatly ameliorated since our predecessors held their first meeting in this city in 1844. Psychiatry also has advanced pari passu with the other departments of medicine during the last fifty years; and yet no one of us claims that we have attained to an ideal system of administering it. Every one is daily conscious of personal and public limitations in the conduct of his work. These are much greater in some cases than in others, but are painfully real in the experience of all. Much still remains to be accomplished by us in our respective fields; and this may properly be regarded as a fit occasion to ask the question, By what additional measures, if any, can we reasonably expect to improve the present methods of caring for the insane?

Several suggestions have been offered by different members of this Association and others, as partial answers to this question within recent years. An ideal grouping of some of them was presented to us last evening. They all indicate that, as a body of physicians, we are alive to its importance and anxious for the highest success attainable. From these suggestions I have selected one which I regard as of special importance, especially at this time, and to which I beg to call your attention for a few minutes.

It is more than twenty years since some of our English con-frères suggested to us that, judging from the success which had attended their experience, much might be done to improve our methods of caring for the insane by adopting their plan, or something like it, of a board, or boards, of lunacy commissioners. The editors of the Journal of Mental Science, basing their statement upon a long period of observation, told us that the advantages of independent inspection of lunatic asylums by authorities who are not immediately concerned in their management, were so obvious and unquestionable, and its necessity so palpable, that they could not conceive any real argument against it.

Now, waiving for the time being any discussion which readily
suggests itself with reference to the different order of practice which exists in this country in caring for the insane as compared with that of England and Scotland, and which originated largely from our form of government, I am ready to admit the reasonableness of the above suggestions, and that they are practicable for some of our largest States. It can easily be understood how such a commission could, by its system of inspections, counsel and advice; by conferences with, and official advice to, individual patients, and to various classes of patients; by their yearly publications which would be presumed to contain more or less of information in relation to insanity and neurology; the administration of hospitals; the requirements of the insane, and the general subject of psychiatry; and, what is of special importance, by bringing into operation the stimulus of a generous rivalry among the superintendents and their assistants of all the hospitals of the State, in attaining a higher standard of excellence, be productive of a large amount of good to hospitals.

It is also easy to understand that a properly constituted commission, holding a position recognized by the government, and of a fairly permanent character, outside of those having the immediate management of hospitals, would be able, by means of publications, to exercise a large influence both on the public and professional mind, and inspire confidence in reference to the utility and importance of hospital care and treatment; also that its work might be in harmony with, and rather supplemental to, that of the officers who are in the immediate charge of institutions, and in this way serve the interests both of the public and of the system (of caring for the insane) which has been inaugurated at so great public expense.

In every large State there exists also a sphere of activity for such a board outside of hospitals. In few, if any, of the States are all the insane provided for in hospitals or asylums. In most of them there are many such persons who are either in their own homes, or with relatives, without any form of systematic treatment, and greatly to the annoyance and detriment of these homes. Others are in poor-houses or jails, or are left to the tender mercies of such persons as will assume the responsibility of caring for them for what may be realized from their services. All acknowledge that such arrangements are far from desirable. Every person whose reason needs to be supplemented by that of others should be under
some form of guardianship. Here, then, is a field of the first importance for such a commission. This would relate to securing hospital care and treatment for those who, either for safety or recovery, most urgently require it; providing the best attainable homes and attendants for those who could not be received into hospitals; arranging and tabulating such persons in reference to their legal status, the forms of disease with which they are affected, their medical histories and inheritances, etc. By such a procedure some degree of uniformity in the data of cases throughout the State could be secured. It would also extend to that large class of the chronic insane whose mental states are periodically changing. Periods of considerable duration occur when it may be possible, and conduce to their happiness and usefulness, to be provided with homes outside of hospitals; while at other times, and when in less favorable states, they should be in hospitals. It is important that properly constituted medical authorities outside of hospitals and in no wise connected with town authorities, should have the supervision of any method of caring for such patients.

Such a commission would also be in a position to study at the best advantage those conditions of modern civilization, if any such exist, which have a special tendency to increase insanity and crime. These would relate to the methods of public education and the laws which provide for and regulate it; to the kinds of education which are best adapted to qualify persons of both sexes to earn a living and support families with the least degree of friction and worry, in the complicated and competing conditions of society which prevail at the present time, and are yearly becoming greater. This would include a study of the effects of physical education upon growth and development, and especially that quality of it which can be obtained only by learning how to execute plans and make things; and also the effects upon the nervous system, of the different forms of labor as represented in those occupations which necessitate indoor and outdoor life.

Statistics, based upon the results of studies in reference to these present elements of civilization and others closely allied to them, may prove to be of the highest importance to the future of society by opening a door to the initiation of effort toward the prevention of insanity and crime.

These few brief sentences may possibly serve to outline a field of activity for a commission in lunacy, which has an important rela-
tion to the administration of hospitals, and also to the large number of the insane who are not cared for in them. It is also a field of service which, from its character, can not be occupied to any considerable extent by the regular officers of hospitals, while commissioners clothed with the requisite authority and professionally qualified for such labor may do so.

This seems to be so plausible and reasonable that the proposition of a commission should at once commend itself to our approval. Moreover, the experience of our English and Scotch confrères with a similar system of commissioners has been so favorable during the last thirty or forty years that they unhesitatingly commend it. I shall, therefore, say nothing more in its favor at present, but proceed to another view of the subject.

All that we or our friends across the water have claimed for the advantages of such a system of commissioners may be essentially true under certain ideal or actual conditions, and not equally true under other conditions and professional relations. Indeed, the whole outcome of such a plan of inspections, studies, and duties as outlined above, in its relation to the existing order and government of institutions, must depend largely upon conditions favorable to its operation, and the laws by which it is authorized. These may or may not be such as are essential to a successful operation of the system to be tried.

It should be borne in mind that the present system of establishing, managing, and governing hospitals by a board of governors or directors dates back to their establishment, and necessarily takes precedence in all that relates to their management. The plan of administration, which is evolved in every such institution after years of experience, acquires the force of law, whether it is placed on the statute book or not. Executive officers in charge of institutions—the larger portion of them during many years—have earned and won the confidence of the governing boards by their high personal character, professional acquirements, loyalty to and service in the cause of psychiatry. It certainly does not betray any spirit of egotism to assume that these officers, by their experience and studies in the specialty of insanity and its treatment, are better qualified than others of their professional brethren in either medicine, law, or affairs, to devise and administer a system of routine service essential to the highest success in conducting the life of every hospital for the insane. It is a service in which experience counts, or
should count for much, and none can deny that under its operations the general conditions of hospitals have greatly improved during the last twenty years.

Now a board of commissioners, clothed with the requisite authority, in coming into relations with this system at once introduces, or may introduce, a new order of procedure, or greatly modify existing ones. It implies inspections, supervision, and reports by officers not resident in hospitals, who have never been in any wise related to, and, it may be, are in no degree of sympathy with, the present management. It may be that the laws under which such commissioners perform their official service permit not only supervision and inspections, but also direction, change of methods and practices, treatment, and care; or in other words, revolution.

This bald statement of the relations into which the two sets of officials may probably be brought, serves to indicate how difficult it will be for them to act together in harmony. Indeed, it would not be easy to conceive of a combination of relations which would more easily and, I may add, more certainly invite to confusion and misunderstandings with unfavorable sequences. A struggle for existence might be anticipated from the earliest period of organic relations as probable in the natural order of events (if any such exists in a State), with no very uncertain result as to the survival of the fittest. And this large danger of friction does not arise necessarily from any imperfections in the laws or practices of hospital organization or conduct as they now exist, but simply from the peculiar relations into which such a board of commissioners is brought with the existing officials of hospitals in the discharge of their respective duties.

It becomes evident from this view of the subject that something more than mere professional ability will be required that favorable results may be anticipated from their coöperation. These can come only through wise concessions and liberal views concerning these mutual relations. Unity in purpose and harmony in action are essential to a successful issue. The whole subject must be regarded from a high professional standpoint. The object to be obtained must be continually in the foreground, while personal feeling must be subordinated. The relations existing are those of consultation and coöperation, and in such circumstances the question of authority has no place. Certainly no thought of abrogating or essentially curtailing the present duties and responsibilities of physicians in
charge of hospitals can for a moment be entertained; nor can any commission, with a proper appreciation of its legitimate functions, desire it if it were possible. In all relations with these officials the purpose should be that of supplementing and extending their influence and professional services, so far as it is good, not only in the hospital but beyond it. I think such a service which pertains so largely to the interests of the State becomes of the highest importance, and demands personal and professional equipment and executive ability of no ordinary character. Is it attainable in this country?

That it may become both practicable and desirable certain prerequisite conditions are necessary. The first relates to the number of hospitals and patients with which such a commission is to be identified. The *sine qua non* for its success is a large field of operations—one large enough to occupy the chief attention of the members. The comparatively insignificant numbers of the insane in the large proportion of the States at the present time do not constitute such a field or specially require such a service. In these States, therefore, whatever attention in addition to what is now rendered in hospitals may be required, must be provided by some charitable organization, medical visitors, or other means. Only in the largest States is the number of the insane sufficient to warrant the expense or require the service of such a board of commissioners as we have been considering.

The second relates to the professional qualifications and business tact which should characterize the members of such a commission. Officials are required who have not only a high professional reputation in their several spheres of action and some special knowledge of psychiatry, but also a large sympathy with whatever relates to the welfare of the insane and the interests of the public. It is impossible for persons to pass immediately from the general practice of medicine, law, or affairs to such a field of service, and accomplish anything of special value. The means and methods in operation in the treatment and care of the insane, and which have been adopted after a long experience, must be understood before one can be in a position to improve them, or suggest others which have not been tried. Persons whose chief interests are concerned in the details incident to the general practice of medicine, or law, or are in any wise much identified with commercial affairs, while they may render a service not wholly worthless, yet from the nature of the case will
be unable to accomplish much for the successful result of the work of a lunacy commission.

Another qualification consists in tact and genius for such a work. A horse may enter a china store in short order, but rarely with desirable results.

The organization of such a board, too, must be a fairly permanent one. The members should have a term of office as little likely to be disturbed as that held by officers of hospitals. Frequent changes, or the yearly introduction of new members, would speedily render it useless and greatly injure the present service of hospitals.

But it must be admitted that our form of government is not an ideal one in its relation to a system of civil service. This is true, not only in national, but in State governments. These are administered by political parties, which in many of them are so equally divided as to numbers, that the officers who make and execute the laws remain in office only during short periods. The same is true also in relation to nearly all who are employed in the civil service. This frequency of change, and the facility with which it occurs, opens a wide door for the entrance of the inexperienced and incapacitated. It fosters the spirit of partisanship and tends to lower the dignity of office. The two shibboleths, "to the victors belong the spoils," and "office is a reward for political service," have demoralized the public service, and constituted a threat to nearly every competent official, however high his position or difficult his work may be. Some incompetent always stands ready and with full confidence in his own sufficiency for any position which may become vacant or to which he may aspire. If the question which Shakespeare asked so long ago, "Who can minister to the mind diseased?" should be asked now, the answer in some places would be, "The political 'heeler,' who is first at ward primaries and peddles votes." Doubtless the exceptions are numerous, but such a spirit is in the air. Its presence is felt everywhere. It penetrates nearly every public edifice; it creeps stealthily or stalks boldly into the offices of those who administer affairs. It speaks smoothly and softly, or coarsely and loudly, as occasion may seem to require. Its demands have become potent, not only at the ends of Pennsylvania Avenue, but at almost every State capital in the country.

Now, under such conditions, I do not say that an efficient board of commissioners can not exist, but that the problem of how to have one is not easy of solution. They may be obtained, but will they
be of such a character as is required? Perhaps one can answer this question as well as another; all will agree that there are likely to be many failures with the successes. Possibly incompetent boards may be better in some States than none, while in others they will be infinitely worse than none.

When we see the grand success which has attended these boards in England and Scotland, and hear the high testimonials which all who are competent to pass an opinion, bear to the greatness of their service, we desire to have something like them. But the conditions and practices in the two countries are unlike. There only two boards exist, one each for England and Scotland, and the members of them are appointed by the crown. They have a permanent tenure of office, and are above the influence of parties or personal bias. The great dignity and honor attaching to the office render it inaccessible to the incompetent. The laws which define the nature and sphere of duties are of a restrictive rather than an aggressive character. The members have little actual authority over the officers of hospitals, and this relates largely to statistics and outside affairs. Their duties in reference to hospitals relate mainly to inspections, findings, and reports. These constitute a most potent factor of influence, and no other is required. Indeed the exercise of actual authority would lead to petty wranglings, disagreement, crimination, and, in the end, failure.

It will be observed that nothing has entered this discussion concerning the relations which a commisson might sustain toward the economics of hospitals. This has not seemed to be germane to this paper. Any such relation is so impracticable and foreign to the duties of any properly constituted board that it needs no discussion. If the superintendent and executive officers who have the immediate charge of patients do not understand what is required in this department, and how best to obtain it, for the care and treatment of several hundred acute and chronic cases, whose mental and physical states are frequently changing, better than is possible for those who see them only two or three times a year or not at all, and consequently can know nothing whatever from a medical point of view about them, they are not suitable persons to have the charge of institutions. Nor can any reason be assigned for the supposition that the economics of hospitals would be more wisely managed if they were subject to the supervision and approval or disapproval of commissioners, than they now are. On the contrary,
the control of a monopoly in providing or regulating the supplies for several thousand of patients might easily lead to most unfortunate results. The centralization of authority in this respect in the hands of two or three persons in a large State would open a door for Tammany practices on a large scale and utterly disqualify them for any service of a high order in improving hospitals or advancing psychiatry. Indeed, I believe that any radical change of this nature in the department of economics, as it is now conducted, would rapidly tend to so degrade the service as to destroy professional comity and shortly ruin the influence for good of any commission.

And yet in the vision of psychiatry, both in and outside of hospitals during the coming fifty years, I see a large place awaiting the coming of commissioners in lunacy. And when that time shall have passed and our successors shall gather in this city on soil sacred to this Association and review the past, as we, in some measure, have done, they will wonder, and possibly smile, in view of our groping in the twilight, and our stumbling, halting progress.

My conclusion, therefore, in view of the present conditions, is that, until a brighter day dawns upon our system of civil service, and a higher appreciation of the possibilities inherent in commissions is realized, we must look for advances in psychiatry mainly along those paths, some of which have already been outlined and entered upon by the physicians who have had large experience in the very limited conditions which have existed during the past half century;—rather than from any service likely to be rendered in the near future by boards of lunacy commissioners.
LUNACY COMMISSIONS.

BY EDWARD N. BRUSH, M. D.,
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It seems quite fitting and proper that at the fiftieth anniversary of this Association the subject of Lunacy Commissions should be discussed. It is almost fifty years ago that the first permanent Commission of Lunacy was established in England. It is just fifty years ago that Lord Ashley, better known by his later title, Lord Shaftesbury, in again urging the measure whose inception and successful operation will be inseparably connected with his name said: "The House possesses the means of applying a real and speedy remedy; these unhappy persons are outcasts from all the social and domestic affections of private life—nay, more, from all its cares and duties, and have no refuge but in the laws. You can prevent by the agency you shall appoint, as you have in many instances prevented, the recurrence of frightful cruelties; you can soothe the days of the incurable, and restore many sufferers to health and usefulness."

In the following year, August, 1845, the bills which he introduced received Royal sanction, and from that period date the labors and the glories of the English Lunacy Commission. These acts, as Tuke says in his "History of the Insane in the British Isles," have been well called the "Magna Charta of the liberties of the insane."

The subject of lunacy administration and the inspection of the insane under public and private care had been persistently agitated in the British Parliament from 1815 down to the passage of the act in 1845, but so indifferent were the law makers, and so thoroughly were the proprietors of private asylums and licensed houses intrenched that nothing was accomplished save the appointment of temporary commissions of inquiry, commissions with little or no power and but limited duties.

It is a curious feature of this whole subject and a sad commentary upon our humanity that the crying evils which attracted the attention and sympathy of philanthropic individuals were connected with the private care of the insane. There existed then, and there exist now, men who were willing and anxious to coin
money from the tears, blood, the groans and cries of their fellow beings.

In the earlier days of the agitation but few patients were in charge of public institutions, the pauper insane, when not neglected wholly and permitted to wander at large, were confined in jails and almshouses, where little was done to promote recovery, but what was done being under the direction and supervision of public officials seems to have been in a large measure free from the horrors which disgraced the private mad-houses of Great Britain.

What a terrible indictment is contained in the words of Sir Andrew Halliday, who, in 1827, wrote in criticism of the act of 1774: "This act, the inadequacy of which has long been ascertained and fully exposed, is still the only law by which mad-houses are licensed and regulated in England and Wales. * * * That it has remained so long upon the statute book must hereafter excite astonishment; and that even now there should exist so much difficulty in having it altered and amended is a fact scarcely to be credited. Yet such is the fact; and thousands of our fellow-men have been hurried to an untimely grave in all the horrors of raving madness or helpless fatuity without its being possible to get their condition altered or amended merely because certain (we hope mistaken) prejudices were entertained by an exalted individual whose voice was long paramount in the Senate; and we had almost added through the influence of those who have realized immense fortunes as wholesale dealers and traffickers in this species of human misery." If this "exalted individual" were permitted to see the reforms which he delayed, if he were given a glimpse of the misery and suffering which his action maintained, I am sure those words must have given him many uncomfortable moments. And those others, whose influence, it is hinted, produced the prejudices which stood in the way of reform, surely they could not have grown so callous that they, too, were not made to blush with shame, and we hope feel some twinges of remorse.

Lord Shaftesbury lived to see his reforms not only put under way, but for more than forty years directed, as Chairman of the English Lunacy Commission, its work and policy.

Upon the model of the English Lunacy Commission have been erected all the Commissions and Boards of Control or Inspection.
that have been called into existence in this country and the purposes of these Commissions and Boards have been practically the same as those of their prototype, though happily the causes which necessitated their appointment have not been the flagrant abuses which the first Lunacy Commission of England had to correct.

These causes have had relation to the commitment, detention and treatment in asylums of insane persons or persons alleged to be insane; the management of asylums and hospitals for the insane; and covering both of the foregoing, the demand on the part of the public for wider knowledge and more exact information concerning these points.

In an inquiry concerning Commissions of Lunacy or a discussion of their work and function one naturally considers them with relation to their value:

1st. To the patients in asylums, and to the insane in general, whether in institutions or in private care as "single patients."

2d. To the institutions and their managers, medical officers and the nursing staff.

3d. To the public—both in the relation which the public bears to the patients in institutions or elsewhere—and in its relation to institutions through levies raised for their support.

When this subject was first presented to me I wrote to the legal members of three Boards of Lunacy suggesting the foregoing points for their consideration.

From two of these gentlemen I have received replies which show a broad and liberal comprehension of the subject and from those replies I shall quote during the course of my remarks.

Upon the first point one of these gentlemen, the efficient legal member of the Pennsylvania Board, prefaced what he has to say with such wise and appreciative remarks, that I cannot pass them without quotation. He says: "Treatment has become allied with care and detention and thus it is that Courts of Law are coming to recognize treatment as a principle, that out of the asylum has merged the hospital. The old rigid rule that no person can be legally restrained of liberty, in an institution for the insane, unless dangerous to himself or the community is being relaxed. Lunatics who are neither dangerous to themselves nor to the community are being sent or remanded to hospitals for treatment. * * * Now it is proper that commitments should be made upon the authority of medical examiners and it is impossible to prevent occasional sensa-
tional publications, therefore the solution of the problem how to secure and retain the confidence of the public in our institutions and to remove groundless fear as to their internal management, becomes of the deepest concern to all who are associated with the care and treatment of the insane. When entire public confidence is secured, the number of voluntary commitments will increase and the prevalent hesitation in early commitments of curable cases will pass away. 'Home care' will as effectually disappear as has disappeared home treatment of capital and important surgical cases."

Continuing, this gentleman says: "I believe the answer to the problem I have suggested has been found. It has been found in my view in the establishment of supervisory public bodies called Committees or Commissions of Lunacy, Boards of Control and the like."

I am confident that the body of my hearers will agree with this gentleman. The patients in asylums have in such bodies a court of appeal which reaches their complaints of improper commitment or detention or of unjust or harsh treatment without the delay and publicity incident to courts of law.

As the Honorable Attorney General of the State of Maryland, ex officio one of the members of the Lunacy Commission of the State, says in a letter to me on the subject: "An intelligent supervision by an official body authorized to make a thorough inspection from time to time at their pleasure must be frequently most beneficial to patients. They may discover cases where the patients are the victims of gross error or worse in being confined at all and may be the instruments of securing their release. They may find that patients are being detained who are sufficiently cured to be discharged. They may in conversation with them ascertain that all is not being done for them that should be and may suggest different and improved treatment * * * They may have opportunity to hear and inquire into complaints, which, but for their visitations, would never be heard or inquired into."*

A scrutiny into the papers upon which patients are committed, an inquiry into the propriety of commitment or of further detention,

* The reference to "gross error or worse" which may be discovered in the commitment of patients should not I think be passed without quoting the remark of Lord Shaftesbury who, in his long experience extending as I have said over forty years, never found a case which showed any evidence of ulterior motive in the commitment of a patient, which is also the testimony of Dr. Ordronaux and his successor Dr. Stephen Smith in N. Y. State, and the legal member of the Penna. Board who says "I have never known a case of fraudulent commitment."
an examination into the treatment pursued and a careful investigation of all causes of complaint comprise the personal service which a commission may and should render patients—to these may be added, as from these would flow in a measure, a constant attempt to instill into the mind of the patient confidence in and respect for those having him in charge and directing his treatment.

But there are large numbers of insane not in charge of institutions, patients in family care, or residing as single patients, occasionally in larger numbers with physicians, in retreats or sanitariums, who do not commonly come under observation of commissioners or inspectors. In this field there remains a great work. The commission in Pennsylvania has found numerous instances of neglect and abuse of patients thus cared for, and will doubtless discover others. It should be as much a violation of law to restrict a patient of his liberty in a private house or in a sanitarium as in an asylum or hospital and the facts are that in these instances the patient's liberty is much more curtailed than in institutions. Every Asylum Board is in itself a Commission of Lunacy and its powers of discharge, of redressing wrong, of correcting improper treatment are really larger than a Commission of Lunacy which is, or should be, supervisory and inspectory in its work, making all its orders operative through local boards of Managers or Trustees.

The patient in private care has nothing of this kind to rely upon. His own family, with the best intentions but through ignorance of a better way, may shut him in a garret or out-house or immure him in a cellar and there is none to whom he may appeal. It is very firmly my opinion that as the State reserves the right to, through its courts of law, administer the property of those declared insane by judicial process, it should, through other proper officers, see that the persons of all these unfortunates, whether in public institutions or private charge, whether cared for for hire or maintained at home, are protected from indignity and that a certain proper standard of care commensurate with the means and position of the patient be maintained.

I am not an advocate of paternalism in governmental affairs, but the insane have something not in common with the rest of mankind—a something, which according to John Stuart Mill, should everywhere make them proper objects of the care of the State. That something, as Bucknill puts it, is their helplessness,
their dependence and their incapacity to give evidence regarding themselves.

If a parent may not do what he thinks proper with his child, but must afford him opportunities for education, must not expose him to the association of the vicious and degraded and must treat him without cruelty, certainly these irresponsible beings, these, in many instances, children of a larger growth, deserve equal protection. This protection can best be exercised through the Lunacy Commission, and upon their recommendation, after proper hearing the courts should have the power of applying in necessary instances the proper remedy.

Upon this point a quotation from a report of a committee appointed by the Lord Lieutenant of Ireland on lunacy administration is apropos. This report, to which reference will be again made, was presented in May, 1891, and is largely the work of Sir Arthur Mitchell, the Chairman of the Scotch Lunacy Commission. The report says in advising a Board of Lunacy for Ireland: “The control and supervision of the state over insane persons in Ireland should, as far as possible, be entrusted to this board, and should extend to such insane persons whether they are rich or poor, whether they are in asylums or out of them. So far as the State thinks it proper to exercise control and supervision over the insane, it should do so through one board which derives its powers from and is responsible to Parliament.” The relations which a commission should bear to institutions and officers of institutions is a matter of great importance. Such a commission is presumably appointed, and if its work is to be of any value in the lines which I have already pointed out, must be so appointed, as the agent of the legislative body and the courts of law. Its function it derives chiefly from the legislature. It is in a large sense judicial in character and yet it appertains in some degree to the police powers of the state in that it is not only to hear and determine the justness of complaints, but that it must spy out wrong-doing in its work of inspection.

A commission of this sort is charged with seeing that the laws regarding lunacy are executed—not with executing them. It may properly make rules and regulations to aid the more orderly and regular performance of its duties and establish uniformity of statistical and financial reports that it may lay before the legislature and the people systematic and intelligent reports of the
work accomplished by institutions, comparative tables regarding census changes in the insane of a state and community and matters of a like kind.

How much power should such a board have to see that its orders are carried out? In 1877 Lord Shaftesbury before the Dilwyn Committee said: "I am sure the success we have had with county asylums has been entirely because we have done everything by persuasion, by the force of experience and constant observation and we have never exercised any authority." At another time he said before the same committee that the commission did not want more power. The report of the committee appointed by the Lord Lieutenant of Ireland, to which reference has already been made, says in speaking of the experience of the Scotch Lunacy Board: "It is not believed that if it had enforcing powers of a very strong character more could be accomplished than is at present accomplished by the force of publicity, reason and good sense.

"So long as this force is found to be sufficient it is not seen that anything could be gained by the introduction of other powers of enforcing. It is seen, however, that something might be lost, because it is a common experience in such matters that what is done from a conviction that it is right is likely to be done more thoughtfully and liberally than what is done under compulsion."

The writer further doubts whether a board could exercise enforcing powers unless in a position to show that what it wanted was for the good of the insane and the public and that a reasonable amount of time had elapsed since a full explanation of its wishes had been given.

An active member of a lunacy board writes me in answer to my inquiries: "It is an error to give committees of lunacy radical powers. The internal economy of institutions should be left to managers or trustees." He further says: "I think it can be safely said that lunacy committees with large executive powers have less influence than those whose power is merely advisory and inspectory. Trustees and managers of hospitals are much more easily influenced by advice and counsel and their co-operation and confidence more easily retained by example than by military orders. Reforms that remain are never forced. Reform is another word for education and new ideas cannot be driven in with violence."
It seems to me wholly absurd and unreasonable for a legislative body to place or be asked to place in the hands of Boards which are to inspect and report upon the lunacy systems, the management of those systems.

As Sir Arthur Mitchell says, this "would place them in a false position, because they would then have to report on the condition of institutions in the government of which they took a part and shared responsibility."

A Board of Lunacy visiting from asylum to asylum sees points in one institution adapted to the work and method of another, and can easily advance the whole asylum administration of the state by wise suggestion, by exciting a generous rivalry, by wise and discriminating commendation and encouragement. On the contrary it can easily awaken distrust and open opposition or half-hearted obedience.

Moreover, Boards of Management act under powers given them by legislative enactment and these powers cannot be taken from them except by the same body—neither can another power supplant these Boards even temporarily until it is alleged or shown that the Boards have violated their own statutes.

The doctrine of all the decisions of courts touching upon these points is that the only recognized power of visitors or inspectors of charities is to redress and remedy wrongs, but these visitors cannot take the control of the charity out of the hands of its managers and proceed to administer it themselves because they cannot become visitors or inspectors of themselves. Upon their relations with institutions and their officers the Attorney General of Maryland says: "The knowledge on the part of officers in charge of institutions that a competent, experienced, just and independent Board of Public Commissioners would regularly visit their institutions, inspect their management, detect and expose neglect, inefficiency, incompetency, cruelty, disregard of the law and the like, must of necessity have a most wholesome stimulating effect upon them. The approval of such a Board will be eagerly desired and sought, their censure will be dreaded. The result will be practically to keep the institutions up to the highest mark of excellence within their power. The patients will be the first and principal beneficiaries of this supervision."

One point which I trust I may be excused for mentioning is often forgotten by commissioners. They are appointed to main-
tain justice and equal rights in the administration of lunacy laws and their experience has taught them, if they have not been exceedingly indifferent, that the public is extremely suspicious of institutions and prone to believe all that is charged against their officers. The commissioners should be as prompt in protecting officers of asylums from unjust suspicion by correcting false and sensational charges as they are in defending the insane from maltreatment. This is due not only to the officers, but it advances the public estimate of the institutions, increases the feeling of security which the friends of the insane should have and thus directly benefits the insane by dispelling a fear which hinders prompt and early treatment.

One word to the officers of asylums who may have thought or do think that their prerogatives are unduly trespassed upon by commissions. Unless you are wholly unlike your fellow asylum officers you have many patients who would be made happier and possibly more contented by frequent appeals—often upon matters of great importance to them—to a power higher than you and outside your jurisdiction. This certainly is a legitimate and proper field for commissions to cultivate. Encourage therefore these patients to seek the commission’s aid, advice and protection. You will relieve yourselves and keep the commission occupied—if it does its duty. I believe that each patient, as far as possible, where commissions exist, should be made to feel that the commission is called into existence for that patient’s individual good and should be encouraged by a free and certain means of communication with the members of such commission.

As to the relations of the commission to the public. If the members do their duty, inspect frequently—not semi-annually or quarterly—but at frequent and irregular intervals, they will be the means of awakening respect and confidence in the work of asylums and will bring to the taxpayer the satisfaction of knowing that his money is well expended.

This confidence is necessary to a public approval of asylum work—and can only be brought about through the fair, discriminating and full reports of an independent board of lunacy charged with the duty of inspection and inquiry.

In conclusion I can only say that all of my hospital work in New York, in Pennsylvania, and my present work in Maryland has been under the supervision of commissioners of lunacy. My
relations with the various commissioners have been intimate and pleasant. In all things I have sought to carry out their suggestions and always have felt a safety and comfort in the knowledge that between me and unjust or unreasoning criticism there was a court of appeal. Opinions differ and no two persons would attempt to bring about an end in the same way and naturally I have not always agreed with the methods and opinions of the commissioners, but I am perfectly willing to admit that in many instances time showed that I was wrong—in others the kindly and considerate attention given my protests have occasionally secured a reversal of opinion by those in authority.

I fully believe that commissions and managers and medical officers of asylums can work side by side and for the common good of the community and the insane—but that can only be accomplished when the sphere of action of each is independent in a measure. Asylum boards are bound by the exactions of the law and by the call of duty to select as their medical superintendent the man whom they consider best fitted for the duties and responsibilities of the case. It is then his duty to select the best subordinates both in the medical and nursing staff he can find. Unless these things are done both the managing board and the medical superintendent can justly be held accountable for any ill that may befall a patient which under better arrangements might have been prevented. The medical staff is charged with the medical and general internal administration of the institution with which it is connected, while the board of managers conducts its business affairs through proper agencies.

At this point the work of a commission of lunacy comes in—to inspect and to either assure the public that the charity is being properly conducted, or to suggest such improvements as may seem necessary, or in case of grave neglect of duty or abuse of power to call the attention of the body charged with administering the remedy.

When a commission dictatorially directs methods which are at variance with the judgment of those charged with either the general or medical administration of an institution, the responsibility for the result should not surely rest upon the asylum officers and a court of law ought certainly to excuse them from the consequences of their acts if a suit should follow, if it were shown that they were acting under directions of a higher body.
It will thus be seen what grave responsibility commissions assume when they attempt to "regulate the treatment of the inmates of hospitals for the insane."

There is enough work in the field of lunacy for all who engage therein. From 1815 to the present time is within the memory of men now living and what changes have been wrought! If lunacy boards will take a broad and liberal view of their duties they can awaken in the public an intelligent and growing interest in institutions for the insane. They can discourage sensationalism and disarm unjust and unfeeling criticism and in doing these things their time will be very largely occupied. The little petty details they can well afford to ignore. In avoiding being autocrats let them beware less they become bureaucrats. Let them beware that in looking after the "mint, anise and cummin" they lose sight of the weightier matters of the law "judgment, mercy and faith;" "judgment" as between the garrulous complaints and faultfinding of the chronic scold, the sensational story of the press and the sometimes well-founded charges of some unfortunate; "mercy" toward the insane no matter where found, and "faith" in those who are laboring along the same line of work. The managers and medical officers of our institutions for the insane, public and private, are the men who have suggested many of the reforms which have been accomplished in lunacy administration and who have cheerfully, as they saw the way, worked out the reforms instituted by others.
CONFUSIONAL INSANITY.

BY WILLIAM L. WORCESTER, A. M., M. D.,
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The matter to which I wish to call your attention for a few minutes is a question of classification. The classification of insanities is confessedly, at present, far from satisfactory, and is likely to remain so until our knowledge is much more complete than now. Those who find the etiological principle sufficient for their needs—to whom, for instance, puerperal insanity, pubescent insanity, masturbatic insanity, and the like, are distinct clinical forms of disease—will probably see no utility in the distinctions which I shall draw. I, for my own part, am unable to use such a classification with any satisfaction. I find very different symptoms in cases due, apparently, to the same exciting cause, and strong clinical resemblances in cases excited by different causes. Doubtless, when we get to the bottom of things, like causes always produce like effects, and the circumstances which I have mentioned lead me to think that the divisions in use in the etiological classifications in vogue are really of minor importance, and that the essential cause is something which is ignored in such systems, and which can not, with our present knowledge, be satisfactorily defined, although we must assume its existence—the defective organization of the patients.

Pathological anatomy, likewise, seems to me to fail in furnishing a satisfactory basis for classification. After giving a good deal of attention to the subject, I have failed to find definite and uniform changes, gross or microscopical, associated with the various forms of insanity that make up the bulk of the population of our institutions for the insane.

I am, then, for my own part, compelled to fall back upon the symptoms and course of disease as the most satisfactory principle of classification now available, and, judging from the reports of our hospitals, I conclude that I have with me, in that opinion, the majority of this audience. In those reports I infer that in most cases the acute, and presumably curable, cases of insanity are generally classified under the two titles of mania and melancholia. I presume, however, that the experience of others is not altogether
unlike my own in meeting, not infrequently, with acute cases which do not fall naturally under either of these heads, and with others which show, at different periods in their course, more or less of the symptoms of both, and with which it is a matter of chance, depending on the stage in which they may happen to be at the time of admission, to which of these categories they shall be assigned.

In a large proportion of such cases the most prominent symptom seems to be mental confusion, and since I have become impressed with the fundamental importance of this symptom, it has, to my own mind, greatly simplified the classification of my cases.

Neither English nor American writers have, so far as my reading has extended, laid much stress upon this symptom. It can not, of course, fail to attract the notice of any one who has much to do with the insane, but, with few exceptions, writers in the English language have treated it as an incident in cases which were classified without reference to it. Spitzkna, in his work, has a brief chapter on confusional insanity but speaks of it as a rare condition. The only writer in this country, so far as I remember to have noticed, who has paid very much attention to the subject is H. C. Wood. In the American Text-book of Medicine he defines it as follows: "An acute insanity produced by nervous shock or exhausting disease, without distinct constant emotional depression or exaltation, with marked abatement of mental power (ranging from a mild mental confusion to complete imbecility) often, but not invariably accompanied by hallucinations and great mental excitement; with loss of physical power; usually disturbances of temperature; the whole commonly ending in complete recovery. Synonyms.—Primary curable dementia; stuporous insanity; stupidität; delusional stupor; mania hallucinatoria; wahnsinn; surgical insanity; puerperal insanity; post-febrile insanity; mania following typhoid and other acute fevers."

German writers, on the other hand, have of late years, given a good deal of attention to this subject, although with rather a confusing variety of nomenclature, and considerable difference as to the extension which they have given to the application of the terms which they have bestowed upon it. I will not take up your time with citations, but will mention that the most satisfactory treatment of the subject with which I have met is by Schüle, in his "Klinische Psychiatrie," under the title of "Acute Wahnsinn."

The definition given by Wood, and quoted above, is, in the-
main, satisfactory to me, although I should not lay so much stress as he does on the etiological factor. Cases excited by the causes which he mentions usually, in my experience, have taken this form, but I have also seen pretty numerous cases, evidently belonging, as it seems to me, under this head, in which neither these nor any other obvious exciting causes could be ascertained.

The fundamental symptom, to which, in my opinion, all the other mental disturbances are subordinate, is mental confusion or bewilderment. There is a failure in the natural association of ideas, and, as a consequence, the mind is occupied with vague, inconsistent, and ever-changing delusions. Sensible objects fail to awaken their natural associations, and thus places and persons are not recognized. In a large proportion of cases, hallucinations add to the bewilderment of the patient. Incoherence of speech, very commonly present, is evidently due, not, as in uncomplicated mania, to an overwhelming rush of ideas, crowding upon the mind too fast for expression, but to incoherence of thought—to a failure of natural logical connection between the ideas to be expressed. The most absurd actions are done without any feeling of incongruity.

In such a condition of mind it is easy to understand how the emotional tone, imparted by the indefinite and shifting delusions and hallucinations, may vary between elation, depression, and indifference. We may, I think, gain some insight into the feelings of such patients by reflecting on what occurs in our own minds in dreaming—a condition which is usually characterized by mental confusion, with hallucinations, and in which our emotions take their tone from the delusions and visions of the dream. In the early and incomplete stages of anaesthesia, by ether, chloroform and nitrous oxide, again we have a state of artificially produced mental confusion, in which the patients may be elated or depressed, frightened or furious in accordance with their natural disposition, or as suggested by their feelings at the commencement of the administration of the drug, or by some trivial circumstance when coming under its influence. No one would think of calling the elation and depression occurring under such circumstances distinct pathological conditions, and there would seem to be no occasion to do so in the various emotional states of a waking dream. We find, accordingly, that the emotional condition may be as inconstant and variable as the delusions from which it takes its rise. Sometimes the patients wander about, appearing neither elated nor depressed, but
evidently comprehending very little, or not at all, their surroundings. They may denude themselves, disarrange furniture, throw things out of the windows, evidently without any intention of indecency or mischief, but in obedience to impulses originating in delusions. There may be a lethargic or stuporous state, which may be accompanied by cataleptic rigidity, or by constrained and extravagant postures and movements, as in Kahlbaum's katatonia. In a majority of cases I think there is, at some time, a condition of motor excitement, with tendency to violence, destructiveness, noise, and loquacity, but it is apt to be lacking in the elation characteristic of mania, and the violence is unprovoked and senseless—evidently due to delusions. Apprehensiveness, even to the most abject terror, may be manifest, but there is not usually the sense of personal unworthiness found in melancholia. It is infrequent, I think, for either excitement or depression to persist throughout the whole course of the attack. Most commonly there is, at different periods, an alternation of the one with the other, or with an emotionally indifferent state. A patient who has sat for days in a lethargic condition, perhaps with symptoms of catalepsy from time to time, may suddenly make a violent and unprovoked assault on the person who happens to be nearest to him, or commit some senseless and apparently purposeless act of destruction. A very common symptom is a vague apprehensiveness, leading the patient to resist everything that is attempted with him—dressing and undressing, feeding, moving from one part of the ward to another.

As to the etiology of this condition, the most important thing, in my opinion, is the constitution of the patient. The nervous shocks, mental and physical, which seem to be its starting-point in a large proportion of cases, have no such effect on the majority of those subjected to them, and it has not been very uncommon, in my experience, to meet with cases of this kind in which no obvious cause could be assigned. Still, this form of mental disturbance seems more likely than any other to follow influences which make a profound impression on the nervous system. So far as I can recall them, all the cases of puerperal insanity which I have seen, all cases following fevers and other acute illnesses, and most of those in which fright, grief, and mental distress seemed to be the exciting causes, have been of this sort. Cases following bodily injuries and surgical operations are, so far as I can judge, strictly analogous to puerperal cases. Most of my cases occurring in young people during
the period of sexual development, whether with or without obvious exciting cause, have been of the same character, as well as a large proportion of those occurring in women at the climacteric period.

Having indicated the class of cases to which, in my opinion, the name of “confusional insanity” is properly applicable, it is, I presume, hardly necessary, before this audience, to dwell on the accompanying bodily symptoms, which must be familiar to us all. The patients are apt to be debilitated at the start, but, however this may be, the nutrition uniformly suffers during the attack; the patients become thin, and more or less anæmic. In cases in which stuporous or cataleptic symptoms develop, the circulation is feeble, and the hands and feet blue and cold. Menstruation is usually suppressed in women.

Coming to the subject of diagnosis, the question first arises, whether it is necessary or advisable to differentiate this from other forms of acute insanity, or whether its symptoms should be treated, as has been customary in this country and England, as incidents in the course of melancholia and mania. As I have already said, there is a considerable group of cases in which there is no evidence of emotional disturbance or tendency to motor restlessness, and in which the mental symptoms, so far as manifested, are all comprised under the head of mental confusion. That there should be some designation by which such cases as these can be separated from the forms of insanity with which they have practically nothing in common, seems to me hardly to admit of discussion. The case is somewhat different in regard to those patients who, along with the mental confusion, present symptoms such as are found in mania and melancholia, and it will, I presume, be proper for me to state, a little more fully than I have done, my reasons for thinking the intellectual, rather than the emotional, feature the more important for purposes of classification.

As I have already intimated, I believe that a large proportion—I may say, a majority—of the cases which it has been customary to class as mania would be more appropriately placed under the head of confusional insanity. Whether this is correct or not, no one, I think, can have failed to notice that there are two very distinct classes of cases, which have in common the symptoms of motor restlessness, loquacity, destructiveness, and violence. In the one, there seems to be, at the outset at least, an exaltation of some of the mental faculties. The patients appreciate perfectly their surroundings;
perception seems preternaturally acute; memory appears to be quickened, so that long-forgotten circumstances are related with the utmost accuracy. The patients show an extraordinary quickness in repartee, and often a diabolical ingenuity and cunning in mischief. They are always ready with an ingenious and plausible explanation of their extravagant conduct. The elation which is present is the natural reflex of the feeling of unbounded, unimpeded energy. Hallucinations are seldom, if ever, present; delusions may be entirely wanting; and if they exist, they are the natural expression of the emotional state. In the other class, on the contrary, there is from the beginning, evident intellectual impairment, which may exist in any degree, even to an entire failure to rightly recognize any of the persons and things about the patient. Memory is impaired, or practically abolished; the acts of mischief and violence are done without any apparent purpose, and when any explanation of them can be obtained, it is utterly irrelevant, or evidently founded on some preposterous delusion. Hallucinations are extremely common, and, with vague, incoherent delusions, dominate the whole conduct of the patient. As a rule, there is no evidence of any feeling of elation, and when it is present it is plainly the effect, not the cause, of the pleasant nature of the delusions.

Now, I can not help feeling that the difference between these two classes of cases is a fundamental one. In the former, the essential thing seems to me to be a failure of physical and motor inhibition; in the latter, a disorder of the intellect. And when we find, as is a matter of every-day observation, that the symptoms of the latter group develop out of, or run into, those of a condition of quiet, unemotional mental confusion, it seems to me that we are warranted in thinking that the two conditions should be classed together as episodes in the same disease.

The distinction between melancholia and confusional insanity with depression is of the same sort. The disorder in melancholia is primarily emotional. The patients appreciate perfectly their surroundings, they recognize persons and things; they can reason correctly on topics indifferent to them, if their attention can be fixed upon them; their delusions are the expressions of the overpowering feeling of impending evil, which makes everything inconsistent with it seem incredible. In confusional insanity, on the contrary, when there is the feeling of depression, it is the result of the delusions, which are vague, incoherent, and illogical. There is but little chance
for confusion between cases of this sort and of simple melancholia, but I incline to think that many of the cases that are classed as agitated melancholia, and a majority of those classed as melancholia with stupor, are really cases of confusional insanity.

I presume it is not necessary to occupy your time with histories of cases, which, if I have made my meaning clear, each one will be able to supply out of his own experience, nor to dwell on the treatment, in regard to the general principles of which we are probably all in accord. I will only say, in conclusion, that I do not fail to recognize the fact that I have been describing merely a group of symptoms, which may arise from a great variety of causes. The delirium of fever, or of inanition, for instance, is a confusional insanity, essentially similar, so far as mental symptoms are concerned, to what I have been describing. Mental confusion is the most conspicuous symptom of many of the mental disturbances of epilepsy, and is usually present in senile insanity dependent on vascular degeneration. I will not maintain that I may not have grouped together the results of various pathological conditions, nor that it is impossible, though it seems to me unlikely, that there may be more analogy between the pathological states in mania and melancholia, and confusional insanity, than in their symptoms. But as symptomatic states they seem to me to be clearly distinct, and worthy of separation in any system of classification based on clinical facts.

DISCUSSION.

Dr. C. B. Burr: It seems to me that so valuable a medical paper as this should not go without some discussion. I have been extremely interested in it and I regret that a paper which supplements it to some extent and would be of interest, I think, to members of this Association, cannot be read because of the plethora of the programme. The paper is one prepared by Dr. Christian of Pontiac, Michigan, and was read before our local medical society. Its title is "The Unity of Mania and Melancholia." The title suggests the views of the author of the paper as to the similarity between these two conditions, and the paper deals with the difficulties which stand in the way of properly classifying certain cases. I have never experienced difficulty to the same extent as Dr. Worcester in grouping these confusional states under one or the other heads of mania or melancholia. At the time Dr. Christian read his paper I took issue with him in reference to it and could not agree with his conclusions.
As to Dr. Worcester's suggestion to introduce confusional insanity into our nomenclature it seems at first glance bad enough to be dependent upon a symptomatological classification;—to multiply forms of disease seems worse. A case recently came under my notice however which set me hard a-thinking. It was one of a patient who before she came to the institution had been suicidal or was said to have been. She refused food and was difficult to get on with. After coming to the asylum I thought her mental characteristics were those of mania. She did not display the emotional depression of melancholia. Her physiognomy, her attitudes, her manner and her conversation were indicative rather of mental excitement and exaltation. She was restless and mischievous and annoyed other patients by her attentions. I should have classed the case as one of mania had I been making up statistics at the time she came or soon after. She has cleared up within the last two weeks and her account of her mental operations during excitement is of great interest. She says that she was all the time harassed by the most painful ideas, although one would not have dreamed it from her facial expression. She speaks of having had hallucinations of vision which gave her the impression of snakes, and of seeing things of green hues which led her to refuse her medicine because she thought it poison. The same delusion caused her to decline food. She had a girdle sensation about the waist which also confirmed the idea of a snake and her being in its toils. All of which leads me to think that possibly it is desirable to have in our system some form of disease which shall be intermediate as it were, between mania and melancholia. I cannot agree with the author of the paper that a large proportion of cases would fall under this grouping. In my opinion but a small number would naturally be placed there.

Dr. C. K. Mills: This question is one which interests me quite a little. It seems to me that while Dr. Worcester has very well made his point as to the existence of certain cases in which we have confusional conditions as a dominant feature, yet I think the evidence is hardly sufficient to enable us to say that we shall erect confusional insanity into a type, coequal with mania and melancholia, with paranoia and the other great types. This subject has been presented to my mind on a number of occasions since the first appearance of Dr. Spitzka's book in which I first saw it ranked as one of the varieties of insanity. At the most perhaps, we can make of
confusional insanity a sub-type. Undoubtedly we have acute confusional dementias, and undoubtedly we can properly use the term secondary confusional insanity, owing to the prominence of general mental confusion in paranoiacs, who are in states of incipient dementia, and indeed in similar cases of mania.

Dr. Worcester makes the point that melancholia and mania are emotional rather than intellectual disorders, but the very essential element of melancholia is delusion, the presence of an insistent idea which is dominating the individual and everything he does or thinks—which is coloring his life and conduct. The peculiar emotional manifestations which are present in such a case are secondary to this condition or are outcomes of it. The same remark would be applicable largely to the other forms of insanity to which he alluded. The long series of synonyms quoted from Wood indicate much confusion in the method of introduction of "confusional insanity" into our terminology and classification.

We have, for instance, "stuporous dementia" given, I think, by Wood as one of the synonyms. What we need is a classification that will lead us and help us, and it must be a mixed classification. The old clinical method is a good one, but the new book on insanity must have a classification that will give us the pathology of insanity so far as it has been determined in its relation to symptomatology; and then we shall need etiological varieties. One of the best classifications was made by a member of this Association, Dr. Bannister. Some years ago, in one of the journals he published a classification of insanity in which he arranged his classes into teratological and pathological and into mixed types. Under the teratological and pathological varieties, using these terms in broad senses, we can range many or most of the forms of insanity, and we can then subdivide them again, and I would say that confusional insanity would come in as a sub-type under one or the other of these great classes.

Dr. A. B. Richardson: In the classification of insanity we should always keep in mind the practical operation of this classification on treatment. The old classification of mania and melancholia has held its place largely because it does indicate a distinction in the pathological changes in these states and consequently a distinction in the treatment. Confusional insanity, which the Doctor undoubtedly does establish, and which every alienist will recognize as being illustrated by a distinct group in his own ex-
perience, is possibly so indefinite, nevertheless, that its introduction would be of doubtful utility. It strikes me that with more distinct limitations than the Doctor has placed upon it, it may be useful; and yet it is a question whether it is not already covered by some such term as acute dementia or stuporous insanity—that form which we naturally get from auto-toxic processes and which consequently leads to and necessitates special methods of treatment distinct from those employed in exaltation or depression. I can recall several cases following severe attacks of typhoid fever, other cases following sudden shock, of that general type of cases which, I would think, answer very well to the Doctor's general description of confusional insanity, and which have undoubtedly a different pathological condition at their base from that which is usually found in cases of exaltation or depression. In so far as this describes such a type and assists us in fixing a distinction in the pathological basis from those of general exaltation or general depression, it is of unquestionable advantage to us.

I think the doctor's delineation was an admirable one and that the paper will be of advantage to us in the way I have mentioned, and yet, as Dr. Mills has said, it is a question whether it is of advantage to introduce these refinements.

Dr. Worcester: I only wish to make my meaning clear and then let the matter stand or fall on its own merits. I must take exception to what Dr. Mills has said that delusion is the fundamental thing in melancholia. I think it must have fallen to the lot of many of us to meet with cases of melancholia in which there was no definite delusion, only a vague feeling of general distress, in which the delusions developed subsequently, if at all, to this. The subject matter of the delusions in melancholia is something which varies very much with the circumstances and the previous habits of thought of the patient. But, letting that matter drop, the point which I especially wish to call to the attention of the Association is the fact that, in my own experience at least, there have been a good many cases which ordinarily would be classed as mania at a certain period, which have not presented that symptom at all during a pretty long course of treatment while under my observation, or in which that symptom has been very transitory. I have, for instance, two cases in mind of middle aged women who were under my treatment at the time I left the Arkansas State Lunatic
Asylum. Both were quite violently excited at the time of coming under treatment, although without any appearance of elation. Both in a short time became quiet. Both appeared confused during a number of weeks (as long as they remained under my observation); one was apprehensive, she imagined we were all going to be burned and had other vague delusions of apprehension. The other would not talk at all but usually would wander aimlessly about the ward, evidently in a state of perfect bewilderment. Now, in this condition, under the ordinary classification, the cases might, perhaps, be classed as cases of acute dementia, but they had previously shown symptoms of active excitement. I have had other cases in which melancholic symptoms were at one time a prominent feature of the cases, maniacal symptoms at another and symptoms of quiet bewilderment at still another, but the symptom of mental confusion ran through the whole. Now when we have a symptom or group of symptoms which is transient and another which persists throughout the whole course of the disease, the disorder can more properly, if we are going to adopt the classification based upon symptoms, be named in accordance with the symptom which is persistent than the one which is transient.
FREQUENT DISORDER OF PNEUMOGASTRIC FUNCTIONS IN INSANITY.

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It would not be within the appropriate limits of this article, even on this semi-centennial occasion, to mention to my hearers by way of preface the anatomical and physiological researches which have within the last fifty years so vastly increased our knowledge of the functions of the pneumogastric nerve.

Suffice it to affirm that this knowledge, taken in connection with pathological facts, is now such as to account for certain symptoms not infrequently present in cases of insanity.

An attempt will be made, therefore, within the brief scope of this paper, to offer some scientific rationale for certain clinical phenomena familiar to observers of mental disease, and consisting chiefly of functional disorders of organs within the region of distribution of the pneumogastric nerve.

A momentary review of the anatomical facts of the subject is first in order.

The deep origin of the vagus or pneumogastric nerve is in a tract of gray matter beneath the lower and outer half of the floor of the fourth ventricle; its surface origin is by eight or ten filaments emerging from between the restiform and olivary body and uniting to form the trunk of the nerve which, springing from the medulla between the glossopharyngeal above and the spinal accessory below, passes out of the cranium through the jugular foramen and down the neck in the sheath of the carotid vessels into the thorax and to the upper part of the abdomen.

During this extensive course from above downward it gives off branches to the pharynx, larynx, trachea, esophagus, heart, bronchi, lungs, stomach, spleen, liver and intestines. Its functions are in the main motor and sensory, and, to avoid repetition, it is stated broadly at once that most of its motor fibers are to be traced ultimately to spinal accessory sources.

The pneumogastric both inhibits and accelerates circulation and respiration and has also vasomotor and trophic influences. The
anatomical division of this whole topic is as simple as any, and the subject will be presented therefore in the order of the original distribution of the pneumogastric branches from above downward, beginning with the disorders of its pharyngeal functions as witnessed in cases of insanity.

The pharyngeal branch of the pneumogastric nerve supplies the principal motor fibres to the muscles and constrictors of the pharynx, and to loss of the motor influences which it conveys is due the paralysis of the pharynx both partial and complete, found in certain forms of insanity.

In dementia paralytica some or all of the muscles and constrictors above mentioned may be paralyzed, and the degree of difficulty in swallowing varies accordingly, and the pathology in these instances is doubtless degeneration of the pneumogastric and spinal accessory nuclei. A like pathology of nuclear changes also holds good for the dysphagia of certain cases of insanity complicated with locomotor ataxia or with bulbar paralysis, but in dementia syphilitica the paralysis of the pharynx may be due to syphilitic growths involving the roots of origin of the pneumogastric and upper roots of the spinal accessory nerve. In certain forms of organic dementia with central brain lesions and hemorrhage, softening, or pressure of medulla, or pons pharyngeal paralysis may also be present.

There is also loss of function of the pharyngeal and of other branches of the pneumogastric nerve in typhomania and other forms, with acute encephalitic and meningeal inflammations, and also in cases with effusions of fluid exerting pressure in the fourth ventricle. The pathological diagnosis in these cases is important and they often require artificial feeding, and the dysphagia may be mistaken for voluntary rejection of food.

The changes in respiration and in cardiac rhythm in the above cases will be referred to later. They are to be regarded as further evidences of pneumogastric lesions, like the failure of action of the soft palate in instances with nasal intonation, and passage of food into the posterior nares in deglutition, as the palate muscles are in part innervated through the pharyngeal branches of the pneumogastric.

There are other cases presenting minor degrees of paresis of pharyngeal muscles and varieties of dysphagia, due doubtless to vagal disorder of some kind, but not traceable to organic central lesions, like those first mentioned.
Spasm of the pharynx is a manifestation of functional pneumogastric disorder not uncommon among the insane. It may take the form of globus hystericus, or attend hypochondriacal cases with persistent delusions of inability to swallow, or it may constitute the motor aura of epileptic insanity.

It may render artificial feeding very difficult, and in one case under observation it was an absolute impediment to the use of the ordinary nasal tube for the purpose of alimentation.

It may possibly furnish some reasonable basis of explanation of a symptom encountered occasionally in hypochondriacal patients who are unable to swallow in the presence of others, as in a case mentioned by Gowers. In this same class of patients delusions of foreign bodies in the throat are due to paresthesia of the pharynx.

There are numerous and interesting affections of the larynx in insanity, due to disordered functions of the pneumogastric nerve or of one or both of its laryngeal branches. The superior laryngeal nerve gives sensation to the larynx above the vocal chords, supplies the cricothyroid muscle, conveys inhibitory impressions to the respiratory center, and causes glottic closure and arrest of the diaphragm in deglutition.

To heightened irritability of this nerve in hysterical and hypochondriacal insanity are due reflex and paroxysmal cough and persistent laryngeal hyperæsthesia. The latter affection is so pronounced that an attempt at forced alimentation in one of these will provoke violent cough, or vomiting, or inhibition of respiration, carried often to a most alarming degree.

Paresthesia in the region of distribution of this nerve also accounts for the familiar delusions of hypochondriacal cases with imaginary foreign particles in their larynx.

There is also anaesthesia of the larynx in several forms of insanity, and in general paresis it is often complete before paralysis of the pharyngeal constrictors begins, and to it is to be attributed the deglutition pneumonia of the early stages of paresis.

The fact that cough, as an objective sign of pulmonary affections, is often absent in insanity may in some cases be explained on the ground of suspension of the sensory innervation of the superior laryngeal nerve and of impressions from the different fibers of other vagal branches.

The inferior or recurrent laryngeal nerve furnishes motor innervation to all the muscles of the larynx except the cricothyroid.
Varying degrees of paralysis and of spasm of these muscles are common symptoms in insanity. This whole group of laryngeal affections, like all pneumogastric disorders in mental diseases, has a varied pathogenesis, though as a rule positive organic lesions are to be found. Thus in general paresis these disorders are due to progressive degeneration of the pneumogastric and spinal accessory nuclei—in alcoholic dementia to central sclerotic changes—in acute toxic insanity to neuritis of the vagal nerve trunk—in syphilitic dementia to luetic growths involving the roots of origin of the pneumogastric—in phthisical insanity to tubercle or pleuritic adhesions exerting pressure on the nerve at the apex of the lung—in delirium acutum to intense encephalitic and meningitic diseases with ventricular effusion and basal pressure, and in tabetic and bulbar-paralytic cases to progressive central and nuclear lesions.

There are also in insanity functional forms of paralysis of the larynx. Thus the adductor paralysis in hysterical insanity with resulting complete aphonia is a pneumogastric disorder which may vanish and reappear, or may be so constant as to be mistaken for insane mutism. Another form of functional adductor paralysis is to be seen in shouting cases of mania from laryngeal overstrain, from which complete recovery may not follow for weeks or months.

The lowered tone and monotonous and husky character of the insane voice in general is in itself often only an indication of defective pneumogastric innervation.

Spasm of the muscles supplied by the laryngeal branches of the pneumogastric is also a frequent symptom in insanity.

The preliminary scream in the convulsions of epileptic cases and the laryngismus stridulus in hysterical insanity are of this nature, and spring from laryngeal adductory spasms.

The laryngeal crises in tabetic cases are to be classed in this same category, and severe attacks of spasmodic glottic closure may constitute one of the earliest symptoms of general paresis, and some years ago a case of this kind was recorded by the writer in an article entitled "Laryngeal Hyperkineses."

Symptoms of disordered function, referable to the cardiac branches of the pneumogastric, are frequently to be observed in mental diseases. Physiological experiments as well as clinical and pathological observations show that the pneumogastric is regula-
tory of the heart’s action and inhibitory of the general vaso-motor center in the medulla.

The intracranial lesions, involving the vagus at its origin in paretic, epileptic, syphilitic, alcoholic, and other toxic forms of insanity, are attended by remarkable cardiac disorders, and in certain forms of insanity without demonstrable organic lesions of nervous centers the disturbances of the heart are still to be regarded as neuroses of the cardiac branches of the pneumogastric nerve. One of the most common of these heart symptoms is tachycardia. The frequency of the pulse varies from one hundred to one hundred and fifty beats per minute for hours or days together, without any corresponding rise of temperature, so that the use of the thermometer, of auscultation and percussion and the search for disease of internal organs are in vain, as the real diagnosis is cessation of the cardiac inhibitory action of the pneumogastric. It is of interest to note here also the physiological reason for the rapid change in pulse rate, corresponding to a quick succession of violent feelings in acute mania through the extensive central connections of the pneumogastric nerve with emotional cortical regions, and it may be added that the emotional depression of dyspeptic disorder may be produced through this same reflex channel.

The inverse affection of tachycardia, namely bradycardia, is also to be found, more especially in cases of primary dementia, melancholia attonita, epileptic stupor, and the final stage of general paresis with a pulse rate of from thirty to sixty per minute, and often accompanied by diminished arterial tension, general vaso-motor paresis, dilatation of cutaneous capillaries and cyanotic extremities.

Other symptoms of pneumogastric disorder in insanity are the frequent changes in the cardiac rhythm with various forms of irregularity, intermission and palpitation of the heart. Under this head come the sensory cardiac neuroses—the painful and suspended heart’s action of hysterical and hypochondriacal cases, the severe cardiac aura of epileptic insanity, the complete momentary stasis of the heart and feeling of impending dissolution of acute melancholia, and the precordial panic and pseudo-angina pectoris of completely developed forms of mental depression. It is also of clinical interest to mention here the weak and imperfect heart sounds—the frequency of venous throbbing in the neck and of
arterial pulsation in epigastric, abdominal, and other distant parts.

The cardiac crises of ataxic, paretic, and alcoholic cases are of a more serious nature, and spring from degenerative changes of the vagal and accessory nuclei. There are also various incidental cerebral lesions in insanity which may affect the heart's action by irritation or suspension of pneumogastric functions, such as basilar meningitis in phthisical cases, or softening and cerebral hemorrhage in organic dementia, syphilitic gummata at the base of the skull, cerebellar abscess or meningitis with effusion into the cerebellar fossa, or, as in two cases in which the writer made an autopsy, meningitis following otitis media.

The pulmonary branches of the pneumogastric give sensibility to the bronchial mucous membrane, and convey both motor and sensory fibers to the trachea, bronchi, pulmonary lobules, and air cells, and probably supply also vaso-motor and trophic influences to the lungs.

The symptoms of disorder of the functions of these pulmonary branches of the vagus are so frequent in insanity that they merit a thorough study on the part of alienists.

There are certain general facts that are so suggestive in this connection that they deserve to be stated. In the first place there is the fact that phthisis pulmonalis is vastly more frequent among the insane than among the sane. Moreover, there are undoubted vicarious relations between pulmonary consumption and insanity.

The total general mortality from other pulmonary disorders is considerably greater in the insane than in the sane population. From a review of a large number of reports of hospitals for the insane, it appears that large mortalities are nearly always due to pulmonary diseases, and this fact is confirmed by my own observation for the last twenty-five years among more than ten thousand cases of insanity that have been under my charge.

Now, of late years, the theory that all pulmonary consumption is due in the first instance to defective pneumogastric innervation has gained certain intelligent adherents, who claim with some plausibility that all are exposed to the germs of disease, but that bacilli only multiply and thrive in lung-tissue of lowered vitality. This theory, though not here endorsed, is of some significance in this connection. There is also the very important fact that a very large proportion, probably not less than 50 per cent of all paretics, perish finally from phthisis, pneumonia, œdema, or some like affection
of the lungs. Now disease of the nuclei and trunk of the pneumogastric nerve has been found in so many cases of general paresis that it is evident that there must be a causative relation between the pneumogastric and pulmonary lesions in these cases. Degenerative changes in the pneumogastric nerve have also been recorded in epileptic, alcoholic, and other toxic cases, and now that attention is turned in this direction there will doubtless be additional pathological observations recorded. Even in the absence of evident organic lesions it is to be borne in mind that nutritive and circulatory defects of central nuclei would fully account for disorders of pneumogastric functions.

Special attention is here called in epileptic, alcoholic, paretic, and some other forms of advanced dementia, to a very frequent type of lung disease, due to pneumogastric lesions, as above mentioned. The lung affection is initiated with moist rales and signs of serous effusions in the lower lobes first. Respiration becomes labored, and the pulse rate greatly increased, but there is seldom high temperature. One or both lungs may be involved, and edema is present before death, which usually occurs in the course of the first week. The typical auscultatory signs of pneumonia are wanting, and the autopsy reveals bloody serum and occasional pus cells throughout the lung instead of hepatization following a frank inflammation of pulmonary tissue, as in pneumonia.

In the status epilepticus, and in serial paretic convulsions the interesting phenomenon of respiration of ascending and descending rhythm, known as Cheyne-Stokes respiration, is due to central pneumogastric lesions. The insane often complain of want of air—they have acute feelings of suffocation—they tear the clothes loose about their neck and rush to doors and windows to breathe. They also suffer from pseudo-asthmatic attacks. These and other like symptoms are often only manifestations of a pneumogastric neurosis.

There are also in mental disease forms of hastened, retarded, and variously modified respiration from disordered centrifugal and centripetal influences proceeding through the pneumogastric nerve. These affections were fully described last year by the writer in the Journal of Nervous and Mental Diseases, under the head of "Modifications of Respiration in the Insane," and time and space will only permit a passing reference to them here.

The esophageal branches of the vagus convey both sensory and
motor fibers, and symptoms of their disorder in insanity arise chiefly from central nuclear lesions.

In general paretics paralysis of the œsophagus is sometimes present, and the food may accumulate and by distention of the tube exert pressure and cause signs of suffocation or even syncope. In a sudden death from this cause the writer found the œsophagus completely distended with soft food and as there was complete anaesthesia of all the parts the first sign of distress was fatal syncope.

The gastric vagal branches give sensibility to the mucous membranes of the stomach, impart motor influences, and control in a measure gastric secretion, digestion, and absorption.

Symptoms of functional disorder of these gastric branches of the vagus are very common in insanity.

The gastric crises of ataxic and paretic cases arise from central degenerations or irritations of the vagal and spinal accessory nuclei. Spasmodic contractions of the stomach sometimes occur, and may interfere with artificial feeding or lavage of the stomach. In hysterical cases contractions of the cardiac sphincter of the stomach or of both sphincters with distention of gas may arise.

Reflex or nervous vomiting is also in some cases a most persistent and troublesome symptom, which may be caused by arachnoid intraventricular effusion or meningeal inflammations at base of skull or irritations of the trunk or nucleus of the pneumogastric nerve.

Other motor neuroses here to be mentioned are the reverse peristaltic actions of the stomach, the eructations, the regurgitations, and the ruminations of the insane, since the centrifugal impulses for these movements proceed through the reflex influence of the pneumogastric.

Stomachal vertigo and unsteady gait may also be a reflex symptom through central vagal connections.

Numerous sensory gastric neuroses of the insane are likewise to be cited among functional pneumogastric disorders. Such are anorexia in melancholia—bulimia and acoria in general paresis—various forms of gastralgia, the painful epigastric aura in epileptic cases, also feelings of heat and of cold, of fullness and emptiness of the stomach, and various kinds of nervous dyspepsia.

Insanity from the abuse of tobacco also has in some cases well-marked neuralgia of the terminal fibers of the gastric branches of the vagus with irregular cardiac action.
In epidemic influenza among the insane the gastric symptoms are often very severe, and it is likely that the pneumogastric nerve becomes involved in the general inflammatory processes of this disease.

The abdominal branches of the vagus influence the glycogenic function of the liver and intestinal digestion, but knowledge is not yet sufficiently definite in this direction to admit of its application in mental diseases. After section of the intestinal branches of the vagus purgatives fail to act, and it is likely that this physiological fact may afford some explanation of the obstinate constipation among the insane who manifest other symptoms of pneumogastric disorder.

There is also a dearth of positive knowledge as regards the action of the pneumogastric on the kidneys, though irritation of this nerve is known to produce diabetes. The frequency of kidney diseases in the insane may some day be in part explained through pneumogastric irritation.

Much future research will be necessary in order to clearly show the full history of vagus diseases in insanity, but sufficient positive points have already been given, it is hoped, to excite an interest in this subject, and to fully justify the belief, that there is frequent disorder of pneumogastric function in insanity. The existence of these pneumogastric affections in mental diseases is in accordance with our knowledge of experimental physiology and of pathological law and is confirmed by clinical observation of insane patients, and is proved by autopsical examinations in the insane, showing both macroscopical and microscopical lesions of the pneumogastric nerve and of its central nuclei.
THE UNITY OF MANIA AND MELANCHOLIA.

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There is much in the various systems for classifying cases of insanity that is unsatisfactory and disappointing; and to none does the realization of this come more vividly than to those who are the most frequently called upon to engage in the work. In grouping cases of mental disease under the various forms in some one of the many tables in use today, the tabulator finds himself hesitating, now and then, in his decision, or meeting with a name, here and there, already figuring in tables of past years which now reveals itself to him in different light. These occurrences are frequent enough to give rise to the desire for some more comprehensive system than any we now possess. The difficulties met with, however, are such as are inherent in any system founded upon groups of symptoms rather than upon pathological changes productive of those symptoms. In the absence of data for a pathological grouping we must classify symptomatically, with results quite as satisfactory, perhaps, in the treatment of the disorder.

One might naturally suppose that in mania and melancholia, at least, we have forms of mental disease so distinct in their manifestations that doubt and hesitation would be eliminated in classifying cases falling in one or the other of these forms. To many these terms stand as distinctive appellations for pathological entities—diseases of the mind. So we find them in textbooks, and in use in clinical teaching, and so they will continue to be used, because of their convenience.

I desire to call attention to some points of resemblance between these two manifestations of mental disorder. Are they distinct forms of disease? Can we discover any common pathological basis for them? I do not refer in this latter query to those many different structural and functional disorders of the various organs of the body, which may indirectly bring about one of these forms of mental perturbation; but to state the question again, what is there in the domain of mental pathology which lies at the bottom of mania and its apparent opposite, melancholia?
The thought that comes into my mind, and which I desire to make plain if I can, is, that these apparently opposed states are not so alien to each other as they seem; that they have something in common—a something which may perhaps at some time form a basis for a better system of classification than we now have.

To make myself clearer I present two propositions—first, that mania and melancholia are not diseases but mental states, and, second, that the psychical basis of both mania and melancholia is to be found in alterations in the personality. Now, the individual's personality is not such an intangible, metaphysical conception as may at first appear. It is a something which has material existence, in the nervous elements of the body, and which is demonstrable to the reason. Its seat is in the ganglia of the sympathetic and of the cerebro-spinal nervous systems, and in their centrifugal and centripetal filaments. It manifests itself in the operations of these organs with the cortical brain cells which register and reproduce impressions.

This is not so abstruse as it may seem. Every organ of the body is constantly sending to the brain nervous impulses, only a small portion of which become part of the individual's conscious life. In health he takes little or no cognizance of most of them; but let these impulses proceed from viscera whose natural operations are deranged, and there comes at once into his consciousness a vague discomfort; a malaise so difficult to define or locate. It is the sum total of these incessant centripetal impulses, the "common sensation" the coenesthesia, as it has been called, registered in the organic memory which furnishes the physical basis of the personality. This common sensation is ebbing and flowing from day to day; a fluctuation within certain limits is normal to every individual, upon it depends his half conscious sense of well-being in health, as well as the vague discomfort experienced at other times,—in other words his "spirits"; at its flood we have a buoyancy of spirits, an enjoyment of living and a corresponding stimulation of activities in all lines. The perceptions are quickened and mental operations are carried on with a minimum sense of effort. Overflowing its normal confines, there result the busy restlessness and the loquaciousness of a mild maniacal disturbance. Carried still further there ensue the too rapid registration of sense percepts, the running of them together into a jumble of incoherent concepts, which are expressed in language equally incoherent. At its ebb
come the depression of spirits, the malaise, the introspection, the magnifying of all subjective impressions which constitute the essence of a mild melancholia; and later the appearance in the mental life of erroneous judgments or delusions—incorrect inferences drawn from perverted sensations.

Mania and melancholia have their origin, then, in opposed mental states, both of which depend upon either an exaltation or a depression of constant vital activities, and which manifest themselves chiefly in an increase of the object or subject-consciousness. Accepting this common origin of these troubles, it becomes easier at once to understand some of the difficulties encountered in the classification of certain cases of mental disease. It is generally supposed, so far as the purely intellectual processes are concerned, that we have in mania a quickening of the object-consciousness, percepts from without coming into consciousness chiefly and mental operations reflecting themselves outwardly; that in melancholia there is an exaggeration of the subject-consciousness, subjective percepts crowding out the objective and the attention becoming fixed upon the individual himself. In the affective or emotional region we are supposed to find pleasurable feelings in mania with a corresponding painful state of the emotions in melancholia. This would seem to furnish a sufficiently easy basis for classifying such cases. But in practice we find cases, and they are by no means infrequent, where with the most terribly painful state of the emotions object-consciousness predominates. Many such cases are easily placed in the category of melancholia with frenzy. But where shall we place those cases where these antipodal characteristics are displayed as different scenes in the progress of the disease? I do not refer now to distinctly alternating attacks of excitement and depression where the mental experiences in one state seem to bear no relation to those of the ensuing state, but to such a case as the following one where there is no break in the mental experiences but a gradual transformation in the conduct of the individual.

A young man after close application to work and to other pursuits breaks down suddenly while attending church services. He confides to the clergyman ambitious plans. He sends telegrams and writes letters in profusion. He challenges Robert Ingersoll to a joint debate. He talks in an extravagant strain about the Panama canal and converses on intimate terms with both God and the
devil. On admission to the asylum he recognizes promptly certain former acquaintances, but applies wrong names to them. He removes his clothing and when reproved by his attendant he impulsively strikes him. Ten days later he displays noisy excitement, imagining himself a noted pugilist and making frequent assaults. At the same time he is mischievous, untidy and exasperatingly annoying to other patients, wearing constantly a smile of self-satisfaction. At the beginning of the second month we find a reversal of the picture. The change though complete was not altogether abrupt. The patient's hands and feet are cold and swollen. He refuses to talk. His head is lowered upon his chest and he permits saliva to flow from his mouth. At times he throws himself to the floor in the attitude of crucifixion and seeks to denude himself. Occasionally he strikes himself by way of penance. The religious delusions which at this time prompted him to acts of self-punishment were but a transformation in those which existed at the time of his reception and which gave then a picture of religious exaltation. On his admission he was counted a case of mania. One month later he was a typical picture of profound melancholia. Had the patient subsequently alternated between these two conditions, his case could properly have been denominated one of circular insanity, but in the five years which have since elapsed the circular feature has been wanting.

With the disappearance of the acute stage he passed into a state of moderate dementia with fixed delusions not easy to classify—a terminal dementia not characteristic in its features of any previous acute stage.

There are several forms of relapsing insanity which spring indifferently from primary attacks of mania or melancholia. In the typical circular insanity we have alternating periods of profound melancholia and active elation, with or without an intervening quiescent stage. In neither of these extremes does the symptom picture presented differ from mania or melancholia simple. The individual, however, passes through a cycle in which his personality undergoes radical changes, and when once this cycle becomes established the victim passes the remainder of his life floating helplessly backwards and forwards between happiness and despair. In many cases the intellectual forces are disturbed only in so far as they may be quickened or weighted down by the state of the emotional centers; delusions making no appear-
ance and the logical faculties continuing unimpaired. We find simply a general good feeling or depression as mysterious and inexplicable to the patient as to those who watch for the turnings of his mental life from without. The victim discovers himself leading two existences. He finds that his personality is no longer uniform, but that in some way it has undergone a schism.

Every asylum carries on its records the names of individuals who return again and again for treatment after more or less prolonged periods of apparent health at home. In these individuals the equilibrium is so unstable, the tendency to relapse so strong, that we no longer feel justified in regarding them as ever cured. In some the law of their organizations brings about through contributing agencies the recurrence of maniacal attacks, in others of melancholia. But whether it be a recurrent mania or a recurrent melancholia, we find back of it all the same determining influences at work—faults of ancestry and defects of organization as predisposing causes, and the same set of agencies to act as exciting causes. Here again, then, we find points of resemblance between these two opposed states. The mere form which the disease may assume seems to be but a matter of accident in the molecular constitution of the individual's nervous system.

Other illustrations bearing upon this same point might be made. My only idea, however, has been to indicate the resemblances between these two states generally regarded as distinct diseases of the mind.
A NEW DEPARTURE IN MEDICAL JURISPRUDENCE.

BY JOHN B. CHAPIN, M. D.,
Pennsylvania Hospital for Insane, Philadelphia.

The majority of offenses committed against society and individuals are actuated by the domination of evil passions that exist in the human breast. While they are manifested in so many diversified ways, and crimes result from so many complex conditions that every new offense may be said to be a separate problem in human weakness or depravity, the courts adhere with such decorous tenacity to rigid methods and uniform rules to determine the guilt, or innocence, or the degree of responsibility of the offender, that one looks in vain for novelties in judicial proceedings. Doubtless the conservative tendencies of the courts find a supporting response in every community that looks to a uniform, wise interpretation of laws and their impartial execution, as the prop and buttress of human society as it is constituted. Every departure from established methods, whenever it occurs, is likely to be scrutinized with some critical spirit, and before it can have a standing as a precedent must be shown by experience to be a readier way to reach better results.

It is probably true that members of our profession sometimes come to attach to expert testimony about the same value at which it is reckoned by the legal profession and the community, and we may even deplore the lack of accord between science, so-called, and the common-sense that is said to inspire the interpretation of law. Expert testimony must, however, continue to be regarded as indispensable, and whatever may tend to appreciate the value of the opinions of physicians should be a proceeding to be welcomed by both professions. The present lack of confidence in expert testimony results in part from the manner in which experts are expected to present their opinions, in order to conform to the established usages of the courts, and partly from other reasons, so that the problem still remains to place the medical witness upon the stand that he may there give his opinion free from all bias or considerations likely to interfere with absolute independence in forming a conclusion.

It seems appropriate that any departure from the usual proceedings in trials, involving the question of the existence of insanity,
might have a place in a meeting of this kind, rather than that an incident of unusual occurrence in a court of justice should pass wholly unnoticed.

Howard J. Schneider was indicted for a double homicide committed in the city of Washington, January 31, 1892. His trial commenced on the 3d day of March and closed on the 9th day of April, 1892, when a verdict of guilty was rendered. On the 4th day of May succeeding he was sentenced to suffer death. A new trial was refused by the trial judge. On an appeal, the Supreme Court of the District of Columbia, in general term, affirmed the judgment and sentence of the court below. The defense was that the homicides were committed in self-defense. No suggestion of insanity was made at the trial, nor subsequently thereto until about the time of the imposition of the sentence, when the defendant's conduct began to change, and the medical interest in the case dates from that time.

For sufficient reasons the appellate court granted a stay of proceedings; also, an application on behalf of Schneider for an inquiry into his alleged insanity to begin January 31, 1893, the hearing to be held before the full bench, without a jury. The court was composed of Chief Justice Bingham, and Justices Hagner and Cox. The following is a copy of the order of the court:

This court, to assist in ascertaining truly the mental condition of the said Schneider, desires to obtain the opinions of competent medical experts in mental diseases, in the most reliable manner; and to that end this day

ORDERS:

1. That Dr. Allan McL. Hamilton, Dr. John B. Chapin, and Dr. C. L. Dana, be and they are hereby constituted and appointed a commission to report to this court, at as early a day as may be convenient, for the consideration of this court, their professional opinion as to the mental soundness or unsoundness of the said Schneider; the said report to be given in writing, and verified by their oaths thereto appended, taken before the clerk of this court.

That the said experts shall make a careful examination of said Schneider personally, both together and by each one of said commission separately at the said jail, in such manner as to them shall seem best, and they are also authorized and empowered to make proper examination of the employés and officials of said jail in their discretion, under oath, to be administered by a justice of the peace.

2. It is further ORDERED that the counsel of the prisoner may procure the services and attendance of skilled medical experts in mental diseases, not exceeding three in number, who are also authorized and empowered to make a personal examination of the said Schneider, either together or separately.
3. It is further ordered that on Wednesday, the 1st day of February, 1893, at 10 o'clock A. M., this court will enter upon an examination of the said allegation of insanity of the said Schneider in the court-room of the general term, at which time and place the members of the said commission shall attend, for the purpose of hearing the testimony there taken, and of further observing the said Schneider. And in behalf of said Schneider the said medical experts to be produced in his behalf (as provided in clause No. 2 of this order), together with a reasonable number of other witnesses to be produced on his behalf (in the discretion of the court) and a reasonable number of other witnesses to be produced on behalf of the United States (in the discretion of the court) shall be examined, on oath, in the presence of the court.

4. After the conclusion of the testimony so to be taken before the court, and of the personal interrogation of the prisoner by the court, if the justices shall see fit to make such interrogations—all in the presence of the said commission—the members thereof shall return their report and opinion for the consideration of the court, in form as is provided in clause No. 2 of this order.

By the Court, E. F. BINGHAM, C. J.

The court verbally permitted and instructed the commission that they might interrogate and cross-examine any one of the sixty-three witnesses who subsequently appeared and gave testimony. The commissioners frequently availed themselves of this privilege, partly for the edification of the court, and partly to determine how far the experts who were called by the defense agreed upon what are recognized as results of experience derived from observation of the insane.

The hearing having terminated on the 10th of February, the court took a recess until the 20th of the same month, to enable the commission to prepare a report. In the report which they presented, the opinion and conclusion were expressed that the defendant was not insane.

After the report had been presented and read, counsel for the defense were granted permission to prepare a number of questions to be submitted to the commission, provided the questions tended to further enlighten the court in the matter at issue. Counsel for the defense thereupon submitted eighty-four questions in writing, which Chief Justice Bingham announced would require time to pass upon intelligently. Upon reassembling after a recess, Chief Justice Bingham stated the court had carefully examined the questions, and explained that the commission had been selected to throw light on the question at issue, viz.: the present mental condition of the prisoner. The commission had been appointed as an
advisory body, to better enable the court to reach a fair and just conclusion. But the commission had not been brought into court as witnesses open to cross-examination, and the court believed that it would be both an unheard-of and unthought-of procedure to permit counsel for the defense to cross-examine the commission. The court found that the eighty-four questions that had been submitted were each and every one of them in the nature of a critical cross-examination of the report. To allow them to be asked would indefinitely prolong the inquiry and open up the case anew. The court would, however, permit the commission to read the questions and if, on reading them, they desired to add a supplemental report they might do so.

The commission submitted, with their report, a psychical chart prepared by Dr. Charles L. Dana of New York, a member of the commission.

The decision of the court, composed of Chief Justice Bingham and Justices Hagner and Cox, was rendered by Judge Hagner in writing. In the opinion of the court the prisoner was not insane, and the court declined to interfere. In may be of further interest to state that application was subsequently made to the Supreme Court of the United States for a writ of error, which was refused. Application was also made as a last resort to the President, who declined, after a thorough examination of the proceedings, to interfere with the execution of the law.

It has not been the purpose to do more than present an outline of the proceedings of the court in disposing of this case. To undertake to do more would be a re-trial of the case. The chief interest in the case to us lies in the action taken by the court in the creation of a commission, and whether such a proceeding may become such a precedent as to be followed in the interests of justice for the enlightenment of a court, and one more likely to secure greater independence of judgment by the medical expert in forming his opinion than by following the usual course. The refusal of the Supreme Court of the United States, and the President, to take any exception to the action of the court might imply that in their judgment no error had been committed. The Hon. Jere. Wilson, of counsel for the defense, when asked if there were precedents that warranted the proceeding which had been taken, replied that he knew of none, and "that it was evolved from the inner conscience of the court." There is some analogy in the action of a judge who, sitting in
admiralty cases, may ask a captain or navigating officer to sit with him as an assessor in a complicated case of marine navigation.

A question has arisen whether the order of the court directing that experts be called in a hearing or inquiry similar to this can be of any aid. I am in doubt, but can not decide. It must be borne in mind that the case had passed beyond the trial stage, and the inquiry was conducted by judges observing the rules of evidence, which medical men are not usually considered competent to decide. If an opinion of a commission is to be secured, which is to be free from bias, full and explicit, then its members should certainly be exempt from cross-examination as to the manner in which a conclusion may have been reached, and, in declining to permit the counsel in this case to cross-examine the commission, the court did right. If a cross-examination is permitted the opinion will neither be just, full, or explicit, but carefully guarded and defensive. A commission, it is true, may err in its conclusions, and the experts may also disagree, presenting the not infrequent spectacle of medical men reaching opposite conclusions from precisely the same statement of facts.

It may be alleged that in a questionable case doubts and differences are inevitable if two groups of experts sit in a case; also that the rights of the defendant must under all conditions be guarded. If the attorney for the people and the defendant can agree upon an equal number of qualified experts for submission to the court, from which say three may be selected, it would seem the proceeding would be perfectly fair, much simplified, and a satisfactory conclusion would be reached in any case where a medical commission might seem desirable, and in every case where experts are called, without prejudice to the rights of the defendant. The only pretext for introducing experts for the defendant, in a case such as has been presented, is that their views and testimony may enlighten the court and aid a commission, and a desire of the court to give the defendant every opportunity to show his mental condition.

The Hon. C. C. Cole, who was the district attorney of the District of Columbia, and engaged in prosecuting Howard J. Schneider on behalf of the people, and who is now a judge of a court in the District of Columbia, in a letter written to the writer, states: "I have no hesitation in saying that the investigations and report of the commission of medical experts were of the
utmost importance and assistance to the court in arriving at a correct conclusion in that case.

"There can be no doubt of the great value to the court of such a commission, where the court itself is charged with the duty of determining the question of present sanity as a fact, as in the Schneider case, where it was claimed that after conviction insanity developed and existed at the time fixed for execution of the prisoner and that the execution should be delayed until recovery. It would apply equally to a case where, at the arraignment of the prisoner, it should be claimed that he was then insane, and not capable of pleading or proceeding with the trial."

"Such a proceeding would have no proper application when the defense is insanity at the time of the commission of the alleged crime. Insanity as a defense to the alleged criminal act is a question of fact solely for the jury under the guidance of the court to determine."

"From my observation and experience in the Schneider case and other cases, I have no doubt but that the proceeding adopted in that case is the best possible to ascertain the mental condition of the party, and I am certain that the judges who heard and determined the case agree with me in that opinion, and they have each had great judicial experience in such matters."

The proceeding which has been presented, so far as I have been able to learn, is without precedent, but whether this statement shall prove to be correct or not, I have presumed to name it "'A new departure in medical jurisprudence' practice, and trust that it may be one step in advance toward the adoption of some practical plan that will enable the expert to appear in court in such a manner that his independent judgment may be secured, and that it may be presented free from bias, or the suspicion of its existence, for all of which service he should be paid, by an order of the court, a suitable compensation.

If it be alleged that the court erred in its conclusions; that danger may arise lest an insane person be condemned and punished; or that the court sought to be informed in an unusual manner, it may also be asserted the whole proceeding will tend to make human life more sacred, and exercise a wholesome deterrent influence against violence and criminal acts.
A NEW DEPARTURE IN MEDICAL JURISPRUDENCE.

BY W. W. GODDING, M. D.,
Superintendent Government Hospital for Insane, Washington, D. C.

The points in this judicial procedure have been so well presented by Doctor Chapin that it seems hardly necessary to add anything further.

I will say, however, that I am thankful for the departure. I feel that the United States' courts in the District of Columbia have taken a step in advance, and have established a precedent for humanity in every case where, after conviction and sentence, pending the infliction of the penalty, the question of the present insanity of the convict has been legally raised. It should hereafter be impossible to legally hang an insane man in the District of Columbia.

In this case the court properly held that a prima facie case of insanity must be made out before any action could be taken from the bench, and that the affidavit of the convict's counsel and of the physician of the jail to his insanity was not sufficient ground for an official inquiry, since the physician of the jail could not be presumed to be an expert in insanity. I was accordingly asked to examine the man, which I did, and added my affidavit that he appeared to have the belief that attempts were being constantly made to poison him, which belief, if is not feigned, of which I saw no evidence, was an insane delusion, and he was insane.

The court accordingly issued an order, appointing a commission of three well known experts in insanity to examine the condemned man in regard to his mental condition, also appointing a time for a hearing of witness on the subject of his sanity, witnesses who might be called both by the man's counsel and by the government, together with three medical experts in insanity, selected by the convict's counsel and called in his behalf. All this testimony was to be taken before the judges in the presence of the commission of experts, who should have power to ask questions, and who, after the examination was over, should make a written report to the court of their finding in the case. Later the court would render its decision.
A wide latitude was allowed in the testimony, the question of insanity not having been raised at the time of the trial when he was found guilty of murder. The testimony at this hearing went over the whole life of the convict, from the time when a demented father begot him, down to and including his nine months' residence in the jail, awaiting the coming of his execution. There was also the testimony of three medical experts who had, after examination of the man, pronounced him insane.

The hearing was patient and exhaustive. The commission of experts unanimously reached the conclusion that he was sane. The court declined to interfere, and the man was properly hung for his crimes.

I think this judicial proceeding was most salutary. The court was relieved from the possible imputation of having permitted the execution of one who, by reason of the loss of his mind, had been rendered incapable of comprehending his punishment; and the community was relieved by finding that the wretch, against whom the popular feeling was most intense, had not, by feigning insanity, been able to escape the gallows he so richly deserved. The criminal seemed also to have entered into the spirit of the occasion, and appeared as stolid and indifferent at the hanging as if he did not know what was taking place.

A few words of comment on the procedure, from the standpoint of the expert, are proper here. It seems unfortunate that the court allowed three experts in insanity to be called in behalf of the convict. It goes without saying that if their testimony was that the man was sane, they would not have been placed on the stand by his counsel. The man, having been convicted and having exhausted every chance for a new trial, had no right in the premises. The rights were simply those of a common humanity, which permits no punishment where there is no mind. Evidence of his former life, his heredity, and his conduct was properly introduced, as it might help both judges and commission of experts in arriving at a correct conclusion in regard to the mental state of the man. But what earthly use had they for the opinion of these quasi-or (as it proved in this case) pseudo-experts? Had they chanced to agree with the commissioners, this would have added nothing to the enlightenment of the judges, while disagreeing, their weight with that tribunal was lighter than the vanity that might have deceived them into thinking that they were of some importance there. A
commission of three impartial experts, who were the "amici curiae," afforded the man all the protection that he needed, and the introduction of the other three only served to detract from the solemnity of the commission's responsibility, and to still farther weaken the faith of the public in medical expert testimony. I trust that the order of the court in the next case will omit the pseudo-expert.

But while regretting this one "fly in the ointment," I can not think the procedure has "lost its savor" thereby. Hereafter, I say again, no condemned man who is really insane needs to hang in the District of Columbia. When three able and impartial experts have passed upon his sanity, we have a right to claim that the wretched convict has had all the protection which is possible, or that a reasonable philanthropy has any right to demand. Even if he should appear a little strange at the scaffold, it would be far more reasonable to attribute his conduct to his eccentricities than to suppose that we, as experts, had made any mistake.
When physicians attempt to talk or practice law, and explain its many and often inexplicable mysteries, they may, as a rule, be expected to leave the domain, what our legal friends term the "common law," and to stray into the fields of very uncommon jurisprudence.

Aside from its own particular points of interest, the Schneider case, which I have been invited to discuss, possesses, in the legal procedure which terminated its relations with the courts, features of such interest, and, so far as I am able to gather, so wholly unique that I assume the risks involved in trespassing upon the domain of another profession in speaking of those features from my point of view.

Howard J. Schneider, of Washington, D. C., was tried for and convicted of murder and, on May 4, 1892, was brought to the bar of the criminal court of the District of Columbia for sentence. For an account of what steps were then and subsequently taken, leading up to the procedure I am about to discuss, I quote from a letter from one of his counsel, Mr. A. A. Hoehling, Jr., of the bar of the District of Columbia:

"Immediately prior to the passing of sentence, counsel for the prisoner (by reason of certain information which has been brought to our attention) made a suggestion to the court that there was doubt as to the sanity of the prisoner, and requested the court to postpone the sentence until some inquiry might be made in regard thereto.

"This the court refused to do. Thereupon the court proceeded to and did sentence the prisoner to be hung on Friday, January 20, 1893. Then occurred the scene in court which was testified to at the recent hearing, unnecessary for me to here re-state.

"As an appeal was taken, on the merits, to our court in general term, and moreover, as we considered that, if the prisoner were really insane, his condition would become more exaggerated and
pronounced in time, we decided to take no further steps in the insanity investigation until after the hearing of the case on appeal.

"Neither of his attorneys saw the prisoner from the time of his sentence until after the decision of his case on appeal, on the 7th day of January, 1893. In the meantime, however, we were repeatedly requested by Doctor McWilliams, the jail physician, to take some steps looking to an inquiry into the mental condition of the prisoner; further that he considered him insane, etc. This belief was shared in by the warden of the jail, and so reported to us.

"After the decision of the case on appeal, we immediately took active measures looking to an inquiry as to the mental condition of the prisoner.

"Our first move was to file with the court a communication addressed to the court and signed by counsel, suggesting to the court that we had been advised by persons having charge of the defendant, and competent to know, that the prisoner was insane, and we requested that the time of execution be postponed for such reasonable time as would enable an investigation to be made; and, further, that the court order such an investigation.

"This application was accompanied by an affidavit of Dr. McWilliams, the jail physician, who stated some of the delusions, as well as the manner and conduct of the prisoner, and further expressing the opinion that the prisoner was 'undoubtedly insane.' We also filed at the same time a letter from the warden of the jail, addressed to us, in which he described some of the delusions, the conduct, etc., of the prisoner, and expressing the opinion that the condition of the prisoner was one of 'mental apathy.' This application was filed by us, I think, on Monday, January 15, 1893, just five days prior to the date of execution, and was by the court refused, on the ground that we had not made a sufficient showing.

"We thereupon, on the same day, saw Doctor Godding, and had him go to the jail and make a personal examination of the prisoner; also Doctor Walsh (not an expert). This examination was made and we obtained the affidavit of Doctor Godding, who stated sufficient doubt existed as to the sanity to warrant an investigation being made. Doctor Walsh, who had known Schneider for many years, stated that he considered Schneider insane. These two additional affidavits were filed, and thereupon the court
granted our application and postponed the time of execution, and subsequently passed an order providing for the investigation.

"The order, passed by the court, was as follows, except that I have substituted the name of Dr. C. L. Dana for that of Dr. A. E. McDonald, which appeared in the original order, Doctor McDonald being unable to serve; Doctor Dana was called in his place."

It is difficult either from the order or from the experience gained by appearing for examination before the court and medical commission to comprehend exactly what method of procedure was in the mind of the honorable court from which the order was issued.

As the inquiry developed, it was observed that the law court appeared to regard the three commissioners as a court medical, and yet it appeared that the district attorney regarded the medical gentlemen as in a sense his assistants.

Another anomalous feature of the order is that portion which directs that the commission shall collectively and separately examine the prisoner, take the evidence of the guards and others, and then appear in the court to hear the other witnesses and the experts called by the counsel for the prisoner, after which they are to file their opinion under oath. The natural supposition is that a commission of this sort is composed of experts in the particular branch of inquiry toward which the commission is directed—and this was the case in this instance. This being true, why the necessity of experts called by the counsel for the prisoner? If the two sets of medical men agreed, such a concurrence of opinion was very desirable.

If, on the contrary, they disagreed, the commission, refusing to be moved by the opinion of the experts called by the prisoner, the judges would be in the position of receiving three verbal opinions from the witness stand upon one side, and the written opinion of the three medical commissioners upon the other side—and we all know the difficulties and dangers incident to a decision upon points whereon doctors disagree.

The whole question of the best method to be followed in obtaining in capital and other cases the opinions of those who, from experience, unusual means of observation, or other reasons, are supposed to be best able to aid in the solution of the problem, is a difficult one for solution, and presents so many sides that I may

*This order appears in the article by Doctor Chapin, and is not repeated here.
be excused, possibly thanked, for not attempting to touch upon more than one or two of the points.

Experts, so-called, are commonly summoned by one side or the other of the case at issue. If the plaintiff learns that the defendant is to call experts, experts are summoned to contradict them, and the non-edifying spectacle is presented of two sets of learned men, holding diametrically opposite views upon the same question. Why is this?—Is science so uncertain that her teachings can not be read by those versed in her mysteries? Is experience truly, as Hippocrates taught us, fallacious, and judgment difficult? I think not, at least not always. What, then, are the difficulties? Do they not partly lie in that peculiar mental constitution which all of us possess, but the weakness of which some are able to keep under, which makes us unconsciously see a case in the light in which a specious special pleader may put it to us, a psychological hemianopsia—a mental blindness yet to be examined, labeled, and classified by our neurological friends, who are so expert and so ready at that kind of work?

Unconsciously, always unconsciously, let us hope, experts bend theories, and cut down or pile up facts to suit the side upon which they are called, until the term expert has become a label, which some of us hesitate to wear. And then the lawyers. Few, I presume, of the members of this Association, have lacked the experience of a cross-examination by these ready-witted and nimble-tongued gentlemen, who put alternative questions, and lead you to think they expect an affirmative or negative answer, who delve in the literature of a forgotten past, and calmly ask you questions upon matters as foreign to the case in hand as the Behring Sea controversy to the claims of the Tichborne claimant; who look at you with mild-eyed surprise or pitying sympathy if you, on any subject connected with medicine or the allied sciences, presume to answer "I don't know;" who ask your opinion, and then, dramatically thunder at you, "I don't want your opinion, sir, I want facts." If none of you have had this experience, I advise that you gain it in some way; it is a liberal education in the art of how not to do things. And then, after you have left the stand, and think over the answers you have made, how the attorneys on the one side or the other have obtained from you, by cunning devices and well-concealed pit-falls, admissions and theories, which make you wonder why you ever attempted to express an opinion on the most simple
truth in creation, and which permit the able experts on the other side to say that Professor—who repudiates any such theory as you have advanced, and Herr Professor Von Something-else long ago exploded the opinions which you enunciated, and that, in fact, there is not a single nail upon which to hang your views of the case, you will hide your diminished head, and wish for some Du Maurier to illustrate for your delectation, "Things one would better have left unsaid."

It was once my pleasant experience to occupy the witness-chair for two whole days, the direct examination lasted twenty-minutes; the remainder of the time was taken up by most interesting cross-examination made by a very brilliant attorney who had read medicine diligently for six weeks to prepare for this case. At the close of the second day, the cross-examiner said to me over the dinner-table at the hotel, "Doctor, I don't know much more about the case than when we commenced." I replied that I was sorry if he were disappointed, but that I was in a worse condition, I did not know as much.

On another occasion one hundred and ninety questions in the anatomy, physiology, and pathology of the brain and general nervous system were brought into court for my particular pleasure. After assuring the learned counsel in answer to a few of them that I could not gratify his search for knowledge—the judge kindly came to my relief by suggesting that I had probably been examined at college—and intimating that some questions upon the case at issue might elucidate some opinions worth hearing. Then there is the jury. Well, jurors are supposed to be the peers of the individual on trial, and if, of the case, dementia is alleged, they commonly are. Then the judge with wise saws and learned precedent, sums up the whole matter, and from out the confusion of ideas and complexity of theories—a verdict is rendered.

Sometimes upon one side or upon each the attorney has at his side a member of the medical profession, to suggest questions and add variety to the torture of his medical brother on the rack, and out of all this, as is witnessed in many of our courts of law, is evolved something at which gods and men may wonder.

It was doubtless to escape just these things that the honorable judges in the Schneider case took the course which has been pointed out.

I think I voice the sentiments of all my associates called as
experts by the counsel, by the prisoner, that never has it been our experience to have a more fair, considerate, and, touching the case at hand, more intelligent examination than in this case.

The prisoner's counsel asked each his opinion, with the usual preliminary questions, and the questions naturally drawn out by the opinions, and then turned us over to the district-attorney for examination. This gentleman, instead of permitting himself to be coached by medical assistants—relegated the cross-examination, with the consent and concurrence of the court, to the commissioners. This examination was undertaken in a dignified manner, and attracted the closest attention of the court. It was undertaken not with the intention of producing contradictions, or of surprising the witnesses into making faulty or questionable admissions, but to get at the facts of the case and the processes by which the witnesses reached their conclusions. In these respects the inquiry was satisfactory and admirable.

The opinion of the commission did much, possibly did all, to form the opinion of the court. It was clearly expressed, and with no hesitating or doubtful phraseology. It was an opinion by a commission, a commission which sat with the court, and was to all intents and purposes part of the court. It was not the verdict of a jury, but an opinion.

I am not an attorney, neither have I submitted the point which I am about to make to one, but it seems to me, that, being an opinion, it was subject to examination and review, and that the attorneys for the prisoner were entitled to appeal from it.

Herein, it seems to me, lies the weak point of this procedure. The opinion of a similar commission may not in a future case be found to stand without examination and review, and therefore it may not always simplify the present cumbersome and unsatisfactory methods.

The experts called by the counsel for the prisoner, while clearly within his rights, were, I think, unnecessary, and in the presence of the able commission added nothing to the elucidation of the problem.

If this case had been one which upon the point at issue could have been submitted to a jury, and the judges could have summoned for the "information of the court" three or more men of judgment and of experience with the insane, I believe the ends of justice would have been as well met.
In a malpractice suit which I once reported for a medical period-
ical, the question turning upon a point in surgical diagnosis, the
presiding judge issued upon his own motion four subpoenas, three
to eminent surgeons, one to a physician of large general practice
who, when they came into court, were directed to examine the
plaintiff, and report upon the witness-stand the diagnosis. These
witnesses were subject to cross-examination, but their testimony
satisfied judge and jury and terminated the trial.

Is there not here a suggestion in criminal and other trials out of
which our courts and law-makers could evolve a plan which shall
supplant the unseemly contests between experts, and the unfortu-
nate exhibitions which are too often made by those willing to lend
their aid to bolster up doubtful pleas.

DISCUSSION.

Dr. Richard Dewey: I would be glad in this connection to
present to the Society a draft of a bill which has recently been
passed upon by the Illinois State Medical Society with the recom-
mandation that a bill of this nature be introduced for the purpose
of improving, if possible, the character of expert testimony or of
securing unbiased testimony in addition to the testimony which
may be submitted by the two sides in any criminal case. It does
not contemplate interference with the existing rights of prosecu-
tion and defence to have all the witnesses they choose, but is
something supplementary. The projected law is worded as fol-
ows:

A bill for an act authorizing the judges of criminal jurisdiction in the
State of Illinois to appoint persons to act as expert witnesses.

Be it enacted by the people of the State of Illinois in the General Assembly
represented, that the judges of the Circuit and Superior Courts in the
State of Illinois be and the same are hereby authorized to appoint in the
month of January of each year . . . persons who shall act as expert witnesses
in the medical and other sciences in giving opinion upon the evidence as pre-

cented in a hypothetical form of criminal causes that may be in hearing in
the courts presided over by the said judges.

Such expert witnesses shall hold their said appointments for one year or
until their successors are appointed and qualified. They shall be entered
as expert witnesses upon a list of such witnesses kept by the Circuit Clerk,
and the said clerk shall issue a certificate of appointment as such expert
witness to the person appointed as above.

Such expert witnesses shall be citizens of the State of Illinois and shall be
known in the communities where they reside for their professional com-
petency and personal probity, and, if physicians, they shall have been at least five years in regular and active practice.

Where expert opinion is desired in any cause pending in a criminal court, the trial judge, presiding in such cause, may, at his discretion, summon for duty under this act such expert witnesses to the number of three.

Such expert witnesses shall be paid for their services by the county in which the trial for which they are summoned is held, in such sums as may be named by the judges.

Such experts shall be subject to cross-examination by both the prosecution and defence, but such cross-examination shall be limited entirely by the subjects embraced in their opinion.

In criminal cases previous to trial, if the States Attorney deems it advisable to have expert opinion, he shall so state to a court having jurisdiction of the cause and the judge receiving such a statement may summon expert witnesses to serve under this act.

Dr. C. K. Mills: I arise with some hesitation to discuss the subject which has been brought before us in so interesting and able a manner; particularly I hesitate because I feel like disagreeing with some of the ideas advanced by gentlemen who have spoken. Certainly this, if not an absolutely new departure in the medical jurisprudence of insanity, is a departure that we are to be thankful for; we should be thankful for anything that can be gained in this direction. It was better that this man should have had this opportunity of having his case heard by this court of experts than that he should have been hanged without any such opportunity; but as attractive as this plan is, it does not seem to me to be one that will be generally adopted. It has weak points in it, which, indeed, were pointed out by the gentlemen themselves in presenting the facts in reference to this commission. I would rather be inclined to disagree with those who believe that these commissioners should not have been subjected to some sort of cross-examination. These "pseudo-experts," referred to by Dr. Godding, were two of the ablest members of this Association, and a neurologist of ability and position. This was a chance by courtesy, granted to a man in peril of his life, but it is not a practical method of solving these questions in all or in many cases. Various factors enter. The Court, however unbiased and unprejudiced it may be, as we all know from experience, is likely to be inclined to sustain the verdicts already given in cases of this kind. What would have been the result if these gentlemen had reported otherwise than they did? I suppose the court did not agree to abide by their decision. I suppose it was by agreement with the district attorney, or counsel of the
district attorney, that this commission was appointed. Now I have known in this State a strenuous effort to be made to have a commission appointed under very similar circumstances. The matter came before a lower court, and soon again before a higher court, and both courts decided that the procedure could not be allowed under any circumstances. The essential objection to any plan of this kind is that it is contrary to the spirit of Anglo-Saxon jurisprudence. If this was a legal procedure at all, to have legal and judicial force, it should have been submitted to the same processes and methods which prevailed at the time of the man’s trial. It was, after all, simply a means of gaining opinions and information, which might or might not be acted on in accordance with the views of the commission.

I never have believed that the appointment of experts by the courts would settle or much help such questions. This is an old proposition, constantly renewed. It has been tried and will be tried again. It might lead to serious injury in cases of this sort. Who would these experts be? They might be eminent men and highly fitted for the purpose; but in a little while, perhaps, they would be political appointments, or, at least, personal if not political; and they would have no weight; and counsel for the defence would refuse to abide by any decision they would come to, and would demand the right of cross-examination to the full. I am heartily in favor of anything that will put matters of this kind in better shape. My experience is, that in the prosecution of cases where the plea of insanity is entered the tendency is to curtail or refuse even the recognized methods of proving the insanity of the prisoner in trial by jury. A law in this State allows the man to be tried on the plea of insanity before a jury before he is tried for the offence of homicide. On several occasions strenuous efforts have been made to have persons alleged to be insane, and who in some cases were insane, tried by this method; but this has always been prevented in my own experience. I recall a “Commission” experience: Five men were appointed—two of them members of this Association, three of them not members of the Association, but men competent in their lines—to examine a person who was alleged to be insane and who was waiting for the execution of his sentence. When this commission by courtesy reported—one held the prisoner was sane, and the other four that he was insane. The decision of the one was
adopted, and that of the four was thrown aside. This subject must have full discussion and consideration before we arrive at definite conclusions.

Judge Mason of Geneva: I am obliged to you for giving me this opportunity to address you, but I had not anticipated saying anything on this subject. It is a subject in which I feel some interest, belonging as I do to a different profession from most of the members here, and I will occupy your time for a few minutes in referring to one or two of the questions raised by the papers and discussions.

Now this proceeding really is not so very new except in its application to a peculiar case. It is a matter of common usage in the courts of justice, upon the civil side, constantly to refer questions which are brought before the court to a referee, requiring him to take the testimony which may be produced by counsel representing either side under oath and to present that testimony afterward to the court with the opinion of the referee thereon. This is simply to advise the court, first, of the evidence which exists for and against the contention to be decided, and, second, of the opinion of the referee who has been present and seen the bearing of the witnesses as well as having transcribed their testimony. You will see an analogy between this procedure, which is constant in our courts on the civil side and the procedure adopted by the court in the District on the criminal side. In that case there had been a conviction of the person upon the criminal charge made. Upon his trial the question of insanity was not raised. After his trial and conviction, that question was raised. The question then was, shall the sentence of the court be executed against a man as to whom it may be said that he has lost his reason, and the court properly said, no, we will make an inquiry as to his condition of mind. Now there is no provision of law either in the United States courts or in the State courts for the trial by jury of such a question as that. There would never be an end of trials by jury if such a trial as that could be had or such an issue of fact could be had. Therefore the court said, we will inquire whether this man be or be not possessed of reason, and to do that they resorted to similar procedure to the one already sketched. Practically the commission selected by the court was a body of gentlemen possessed of superior or expert knowledge upon the subject in hand and that body was sworn to take the tes-
timony of such witnesses and to report to the court such testimony as was produced, with their opinion as to what it established, and they did so. The court was at no time a party to any of this except to authorize the procedure. It was not bound by any finding the commission should render. If it rendered a finding which, on the whole, seemed to be based upon, and justified by, the evidence as it heard it, they would adopt it, and if otherwise the court would reject it. This seems to be in the present state of our laws about the only method by which a question of this kind, arising after conviction, can be determined. I think it was a wise procedure, a humane procedure, and if in the State courts as well as in the Federal courts it were adopted, this would be in the line of improvement. The opinion of intelligent expert men upon the facts in such a case is certainly as reliable, as just to the prisoner, as likely to protect all his rights, considering our instincts in favor of innocence rather than of guilt, as the verdict of the average jury which would be selected in this country.

There was one other question which occurred to me, and it arose, I think, upon the suggestion of Dr. Godding. It was the question whether after all it was wise for the court under the circumstances to have suggested and permitted the selection of experts on the side of the defense. Let us bear in mind that upon all trials, upon questions of science, upon questions of value, upon questions which are to be decided by opinion, men as we are constituted will constantly differ. They may be equally wise, equally honest, and may have had, as near as we can tell, the same experiences in life and they may be possessed by nature of like judgment and yet they will differ upon the same statement of facts in their opinions as to what the value of a thing is or what the state of a man's mind is. This is one of the conditions we have to meet. We have to do it through human agents and human agents are fallible. We can only say, if we employ the best methods we can devise in human reason and judgment, that we have done justice to our fellow man. When the question of the credibility of a witness is in hand and an attempt is made to impeach the witness on the ground that his character is bad and his neighbor will not believe him on oath, the court will tell you that you can limit the number of witnesses on this subject to six on each side. This is done for convenience. Accordingly so many men are summoned. His neighbors who like him and have any method for forming an opinion
that he is an honest man come into court and say so. Those who have had dealings in which he appeared to be a dishonest man, appeared to be a man who did not tell the truth, or a man who trifled with the truth, under circumstances where self-interest intervened, will tell the court that they will not believe him on oath. This is still a question of fact. The jury weigh the testimony and if they conclude that his word is worth something they will take him as testimony in the case. So it is in insanity.

Perhaps the opinion of the court would be that the experts called in the case were the men whose judgment was most to be relied upon as to the truth in the case, and the judges would say that, notwithstanding our respect for the commission, yet we believe that the experts have, on the whole, formed the most just conclusion in the case, and we adopt the opinion reported by the experts called for the defense.

This is all advisory to the court; these are all means by which the court possesses itself of all the facts and the conclusions which learned gentlemen form on the same facts, and then the court sifts out of it all the best judgment it can form upon it. This is the way of administering justice, through human tribunals, and though infected with that liability to error that attaches to everything human, it would seem to shield innocence with every practicable safeguard.

Judge A. J. Mills, of Kalamazoo: I do not know that I can add anything to what has been so well said by the learned Judge who has just preceded me. I congratulate myself, however, that I find myself in the company of at least one lawyer in this large assembly of doctors. I should dislike to stand here alone. I think that I should want to examine this jury for cause before I should be willing to accept it as a jury.

Now, as has been said by the gentleman who last addressed you, there is nothing very strange in the procedure which was adopted by the court in the District of Columbia. In the State of Michigan we practice under what is known as the common law system; modified somewhat, but not essentially. It is the old practice that the State of New York got along with very satisfactorily for many years. We have, as a part of that practice, the equity side of the court. You know that it is not usual in equity cases to take the verdict of a jury, yet a jury may be summoned by the court in an equity case. The difference between
the verdict of a jury in an equity case and in a court of common law is, that in equity the verdict of the jury is only advisory upon the conscience of the court. The court can adopt the finding of the jury or reject it entirely and base its decree upon its own findings, so that there is an analogy between the practice in equity courts and that taken in the case in the District of Columbia.

Then again, in Michigan, in mandamus matters before the Supreme Court, as well as in equity causes, it is not an unusual thing to refer questions of fact to a commissioner or to an inferior court to take testimony and report the conclusion to the court in which the primary jurisdiction is vested and such finding is sometimes merely advisory.

Now, in the case in Washington, as has been said, the man had exhausted all his rights to a trial by jury. He had had an opportunity at the outset to refuse to plead to the indictment and set up his insanity. He could have been tried upon that plea, undoubtedly. Upon pleading "not guilty" he could have insisted upon the plea of insanity; and upon the trial of the case as a whole that question would have gone to the jury with the rest of the questions of fact under proper instructions by the court. If the question had arisen upon the trial of the case, the court would have called no commission but would have been compelled, in obedience to the constitutional rights of the accused, to permit the people to introduce testimony after he had presented testimony upon his part and the question would then have been solved by the jury under proper instructions by the court at the close of the trial.

Now it is probable that, during the course of the investigation upon that trial, the experts, both for the people and the prisoner, could be examined by the State's attorney as well as by the prisoner's attorney and the range that the direct and cross-examination would have taken would have been largely within the discretion of the trial judge; and judges, like doctors, do not always judge aright.

I think it may be truthfully said that judges have been known to allow an unlimited cross-examination in such matters unwisely; and other judges have limited the cross-examination of experts within proper bounds, and in those cases, as a rule, little difficulty has been experienced.

You know that doctors, and indeed witnesses of all classes,
chafe a little under cross-examination; and yet cross-examination, after all, is the sifting process by which the truth is ascertained. When the judge rules that a question must be answered in such a way by an expert witness or must not be answered at all, the presumption is that the judge is right and that his ruling is based upon some well settled law or rule of evidence.

Now, gentlemen, if you are going to change present methods and practice, if you are going to sweep that away, you must change the Constitution and the whole method of disposing of civil and criminal cases in courts of justice. I do not say that it would not be wise, when revising the constitution of a State, to make provision that would remedy and obviate many of the difficulties that are experienced with expert testimony, but you can not do it by the appointment of commissioners under the present state of the law and our present Constitution.

The matter as submitted by the judges to the commissioners was one of favor. The man had been properly convicted and sentenced. In the District of Columbia he was no longer entitled to have the question of his sanity submitted to a jury as a question of fact and appealed to the court, by affidavits, (the most unsatisfactory testimony that can be presented to a court) for relief and the court said, that is not sufficient. We cannot act on that, but, for the purpose of advising ourselves, we will assign three gentlemen to sit with us or to act for us and upon their finding, coupled with our own opinion of the matter, we will dispose of this question. The testimony and the finding of the commission was reported to the court and seemed to coincide with the opinions of the judges who adopted and acted upon it.

The refusal to permit the prisoner's experts to be cross-examined was right because that would have amounted to a cross-examination of the court itself and would have been like a cross-examination of a jury as to the basis of its verdict.

If the case had occurred in the State of Illinois nothing of the kind would have happened. You are well aware of the course pursued in the Prendergast case. It is novel. Prendergast is allowed to try the question of his sanity after his conviction before a jury. It is not novel in any other respect because ever since the common law was firmly established it has been the law that, if a respondent shall become insane after conviction and before execution, he is to have a hearing; and if it is determined that he is insane, he is not to be executed.
Judge Chetlain, who granted the order in the Prendergast case, has been severely criticised in some quarters; but fair men, reading the statutes of the State of Illinois and being disposed to attribute just and not vicious methods to Judge Chetlain, will see that the statute says, that upon proper proof being adduced satisfying the court prima facie of the insanity of a person convicted of crime and sentenced to execution, a jury shall be called to inquire into the matter; and Judge Chetlain could only do what he did do.

It is matter for regret that the question should have to be retried before a jury in Illinois, especially as the question was so fully gone into at the trial as part of the defense of the respondent who was probably insane then, if he is now. It looks, in that case, a little too much like a resort to sharp practice to try to save Prendergast’s neck but, gentlemen, a lawyer may be pardoned for that in a capital case.

You gentlemen insist upon very careful measures in dealing with your patients whatever their disease and whoever they may be. You won’t take any chances but will do everything that you can to cure and care for your patients. Surely, a lawyer is not to be blamed too much if he does everything he can to save, not a sick patient, but an insane man from the halter.

It is true that a good many guilty men escape punishment, but, after all, the old doctrine of the law is just and humane. It is better that ninety-nine men who are guilty should escape than that one insane man should be convicted and lose his life. To hang an insane man would indeed be a disgrace.
Patrick Eugene Joseph Prendergast was born in Ireland in 1868 and was 25 years old when he shot and killed Mayor Harrison. His parents came to America while he was an infant, leaving him behind, and when he was five years old brought him to the United States. Some evidence given by his mother at his trial, brought out by the prosecution, tended to show that he had an injury of the head when four years old by falling from a bench about four feet high, which rendered him unconscious and thereafter ill for some weeks with nausea and vomiting. It was alleged the effects of this injury lasted three months.

The parents of Prendergast came to Chicago. His father died of consumption while Prendergast was still in school. A paternal uncle died insane in Ireland. His mother is living in fair health at the age of about 63. The boy attended school from 7 years of age till about 16. He was rather dull and backward in his studies. At the period of puberty he became peculiar and fond of solitude. It was doubtful whether he was given to onanism.

During adolescence he appeared to be threatened with consumption and went to New Mexico for his health. He came home in a destitute condition, "looking like a tramp," but his bodily health appears always thereafter to have been good. He took an interest in study of law; read a book called "Easy Lessons in Law," and when the "single-tax" theories of Henry George began to be agitated he eagerly espoused them. He enjoyed argument on this subject and (his mother and many others testified) wearied all the people around him with discussion of this matter. His principal work from the time he left school seems to have been carrying and delivering newspapers, though he started a laundry at one time which was a failure. He was irregular in his hours and ways but his habits do not appear to have been vicious. He smoked a little, used alcoholics but little. He stated he had
slightly practiced onanism and had been otherwise sexually abstinent. It was shown at his trial that he was quarrelsome and contentious, having frequent disputes and occasional physical conflicts with the boys he came in contact with. He had on one occasion disappeared for a time, and it was afterwards found he had been in a rural part of Wisconsin, and apparently thought he was engaged in a religious mission. He took up his abode in a vacant building and engaged in preaching or haranguing on the highways to children and others who were attracted by his peculiar appearance. He had frequently called at the Catholic school where he was educated and engaged in arguments with the religious brothers. He had, when about 20, written out a form of prayer which he claimed was miraculously given him and he sent it to a priest recommending its use as capable of producing miraculous results. Several Catholic priests and brothers who had known the prisoner well testified they had thought him insane for a number of years. He wrote letters and postal cards to the Pope, to Cardinal Gibbons and to the archbishop, offering advice and suggestions. He insisted that the “single-tax” doctrines should be taught in the school which he had attended and became so unreasonable that he was forbidden admission to the school. Among other things, he insisted that certain prayers should be used. He also wrote giving advice to Secretary of the Treasury Carlisle about the finances of the country and to various other Washington officials.

Shortly after the election of Carter Harrison as Mayor of Chicago, in the spring of 1893, the prisoner told his mother that his influence had elected Harrison, and that he (Prendergast) was to be corporation counsel of Chicago. He was angry with his mother for not believing him, and said he knew as much law as the present officials. It seems probable that in a joking way Mayor Harrison may have encouraged Prendergast to expect some office and the city corporation counsel had had a call from Prendergast who informed him he was to have his place, and that official had in sport surrendered his office to Prendergast and introduced some of his subordinates to the “new boss.”

It appeared in his trial that one reason of the prisoner for desiring the position of corporation counsel was an opinion of his that he could accomplish the elevation of the railroad tracks. This was a subject which had been bitterly agitated in Chicago for many
years, the city, the greatest centre of railroads, being gridiröned
with tracks in every direction. The 18 or 20 separate trunk lines
have each their many times multiplied miles of tracks and switches
all running to the heart of the city, intersecting its most thickly-
thronged and populous districts—all except one upon the same level
as the city streets, and the result that might be expected occurs,—
annually hundreds of human beings are slain at these grade-cross-
ings. The agitation due to this monstrous abuse had no doubt af-
fected powerfully the mind of Prendergast. The denunciations of
the press, and the indignation meetings of the people on the one hand,
and the indifference of the corporations and the venality and su-
pineness of the city government, on the other, had aroused such a
state of public feeling as to furnish a brain like that of Prendergast
with a motive strong enough to engender fanaticism. He con-
ceived of himself as one who could correct this abuse by being made
corporation counsel. He built upon this foundation of vanity, im-
becility and the political ambition to which his race is so prone, a
vision of himself as a great reformer and deliverer of the people.
He had visions of fame and power with himself as the central
figure, all the more vivid and splendid because unlimited by any
appreciation of their impracticable and impossible nature. While
the world looked upon him as an insignificant, even pusillanimous
creature, he regarded himself as a hero and a genius; even more
than that; as a sacred messenger from God, soon to be applauded
and hailed as a deliverer by the very newspapers he was now humbly
carrying from door to door. Hence his demand upon the Mayor
for office, and the bitter disappointment of continued failure. The
hope-deferred which maketh the heart even of the common, every-
day office seeker sick, was intensified in Prendergast by a grow-
ing feeling in his weak mind that a divinely-conferrèd mission was
being prevented in its accomplishment and that the Mayor, by his
indifference was not only breaking faith with an important political
supporter, but was an obstacle to the execution of the divine will,
and must therefore be removed out of the way. About 7.30 p. m.
on October, 28, 1893, Prendergast called at the residence of Mayor
Harrîson and asked to see him. The Mayor was resting, having
been busy at the World's Fair all day, and Prendergast was told to re-
turn in half an hour, which he did. He was then admitted to the pres-
ence of the Mayor and left alone with him. He had been with the
Mayor but a few moments when shots were heard and it was after-
wards shown that Prendergast had with him a six-chambered revolver loaded with five cartridges. He fired at and hit the Mayor three times. The family coachman, hearing the shots, entered the room and later testified that on seeing him enter, Prendergast leveled the revolver at him, (the coachman), and then, seeing the coachman retire, turned his aim again at Mayor Harrison and fired, and then stooping down and skulking, made his way to the door, and, going out, fired back as if to prevent pursuit. The prisoner when this testimony was given denied that he fired back or skulked, though freely admitting the shooting of the Mayor.

From the Mayor's house Prendergast went to the police station and surrendered himself and announced that he had shot Carter Harrison. The next morning he asked for the newspapers, and being given the supplement of one, stated that was not what he wanted, but the front page with an account of the shooting of the Mayor.

In my visits of examination to Prendergast at the request of the State's Attorney, I found a young man, shy in his demeanor, yet with an air of self-importance, lean and ill-favored, of stooping shoulders and shuffling gait, with a sinister expression of face imparted by grimly set lips, the upper thin, the lower large and full. A "canine" expression was given to the mouth by a frequent lifting or curling of the upper lip, which showed the teeth and produced a decidedly vicious effect. There were numerous wrinkles of the face around the angles of the eyes and mouth, stiff hair of a decidedly red color, and certain malformations of the cranium and facial bones to be presently mentioned.

Dr. E. S. Talbot, of Chicago, has kindly supplied the accompanying portrait of Prendergast taken from his photograph, and the following is his description of his physical condition and abnormalities taken from his recent work:* 

"Height, five feet, seven inches. Weight, 132 pounds; hair, red, coarse and stiff; very little upon face. Nose fairly normal, thin at bridge, broad at alae. Ears large and projecting; lobes short and broad; tragus both well developed; helix broad, with typical tubercles at the upper and outer border of the ear. [Morel: degenerate ear.] Lips, upper, small and thin; lower excessively developed, more prominent because of undeveloped upper jaw. Face,—arrest of development of the bones of the face, especially at the alae

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of the nose. Zygomatic arches normal, but appear prominent owing to the arrest of the bones of the face. Lower jaw normal. Forehead receding. Head sunken at the bregma; occipital portion excessively developed; circumference 22.3 inches (57 millimeters); antero-posterior, 7.75 inches (20 millimeters); lateral 6.36 inches (16½ millimeters); lateral index, 82; therefore extreme brachycephalic. Feet large; hands normal; fingers long and skinny. Width outside first permanent molar 2.25 inches; width outside second bicuspid, 2 inches; width of vault, 1.25; height of vault, .75; antero-posterior, 2.

I am aware that many attach no significance to cranial measurements and deformities of the osseous system—or rather, claim that we do not know what significance to attach to them, and indeed we must all admit that we are not in a position to say how much any one or more osseous deformities mean in any given case. It is true that some mentally and morally normal individuals present as great deformities as any member of the defective classes, and the deformities among the normal impress themselves more powerfully in proportion to their number; but the more powerful impression produced upon the mind by the exception leads perhaps to an exaggerated idea as to the prevalence of exceptions and to undue doubt as to whether any rule exists, since we have no full or reliable data as yet upon this subject.

The outline of the circumference of Prendergast's head as shown by a "conformateur" such as hatters use, gave a decidedly
simian type of skull. The index of the biparietal and longitudinal diameters was 82 while the normal is 75 to 80. This shows a deformity of excess in the parietal and occipital regions, while an even more marked deformity of deficiency exists in the frontal region. This deformity means that the occipital lobes of the brain are over-developed, while the frontal lobes are contracted and deficient. The regions of the higher faculties are narrow and contracted in this subject and there is in this case undoubtedly a corresponding inability to reason.

The prisoner when examined with reference to his mental state, exhibited an intensely self-satisfied and egotistical character; full of self-importance and cynical consciousness of fancied superiority. Intolerant and fanatical where that superiority was not recognized and grimly bent upon enforcing his opinions against the world. His supreme confidence in his own ability and authority was so much at variance with his ignorance, logical weakness and puerility as to amount to imbecility.

He said to me, "I have firmly believed there was something wrong with the world ever since I was fifteen. I have loved solitude more than society." When questioned about religion, he stated he was a Catholic but so deeply grounded in religion that he did not need ordinary religious forms or aid of priests. He spoke of having helped men and causes by his prayers. His definition of a good Catholic was as follows: "A good Catholic is merciful and believes in the single tax." He said he "lived to do good." When questioned about killing the Mayor he said he knew his act was contrary to law and knew what the penalty for taking life was, and could have refrained if he had chosen, but "Christ's laws were the only laws to obey." Asked if Christ told him to kill Carter Harrison he said, "You talk to me now like you thought I wasn't sane." He denied at this time acting for revenge, though he had previously stated that Carter Harrison had not kept faith with him—had promised him the position of corporation counsel and then refused it, and this was one reason why he had to die. When asked what plea he would make he said he had not seen his attorney yet and added, "I don't know whether you are for or against me." He spoke in a low, mumbling tone, and rambled from subject to subject, continuing to talk on as if scarcely conscious of his auditor or surroundings. He manifested some excitement at this interview, appearing to realize
when his crime was spoken of that his position was a critical one. His pulse at the beginning was 88 and at the end was 112. When asked whether he had attended the meetings held by the Rev. Father Kelly to agitate the subject of track-elevation, he replied "No," with an air of superiority and said that Father Kelly's scheme of track elevation "did not amount to much," as if he felt himself to be the original and only elevator of tracks. I asked him if he felt it his mission to elevate the tracks and he replied, "I do not think it shows I am mentally unbalanced if I say it was my mission." He said the Mayor was at peace now and he had felt better since the deed was done; that it was to him "like going through hell" for some time before. At the same time he stated he had meditated the act about a week, but had lost no sleep and no meals except that he did not eat dinner the day he committed the deed, but did eat supper. He had heard no voices commanding him to do the deed and had had no dreams or visions that had made any impression. His health had not been in any way affected and he had noticed no change in himself. [Physical examination showed his bodily health to be good in all respects three days after the homicide.] He stated he bought the revolver on the morning of the day he killed the Mayor. He would not tell where he got the revolver and it afterwards transpired that the reason of his unwillingness was that he had bought it at a second-hand shoe store and was ashamed of the humble nature of the business house that furnished the weapon. I asked him at one interview if he would justify his act of violence and he said "anything done in accordance with the will of God was not an act of violence." I asked, How do you know the will of God? and he said by prayer and by "losing peace of conscience until I obey." At this time I asked him if he had any enemies or had been persecuted in any way. He replied, "Yes, for a year," but could not give names of any one persecuting him. He thought the Mayor and his children had envy for him. It was shown indirectly he said when the Infanta of Spain was here, they tried to belittle her. He had no suspicion of poison.

The demeanor of the prisoner during his trial in court presented some striking features. He frequently interrupted the proceedings and insisted on addressing the court or expressing his opinion. One of his first interruptions was to insist that he should be spoken of as "Mister Prendergast." He did not wish his name
mentioned without a title of respect attached. He frequently re-
buked both his own attorneys and those of the prosecution and
sought to raise points which he thought important in his case.
He insisted that his plea was "justification" and would hear of
no other. His actions have often been compared to those of
Guiteau and there was considerable similarity, save that Prender-
gast was a man of much lower grade of intelligence.

The trial of Prendergast resulted in his conviction. A motion
for a new trial was overruled and he was sentenced to be hanged
on March 23d, 1894.

I will here give some extracts from Prendergast's speech in
court at the time sentence was passed upon him:

As I told your Honor before, they set up this infamous plea of insanity
against my will. But, your Honor, the issue is: Did I do right or did I do
wrong? Did I do my duty or did I not? Did I do the will of God or did I
not? This point has never been touched upon, and I say it is the only
issue before this court. Of course, if I did wrong I should be condemned.
But, your Honor, if I did right I should be justified and acquitted. **

Now, your Honor and everybody says that Harrison was a great and good
man. I deny this. A good man is generally faithful to his friends, and
Harrison was not. If he had been a good man he would not have been
hostile toward me. But this newspaper trust, your Honor—I have been
attacked by this newspaper trust, and if the sentence of this court is carried
out you will all be at the mercy of this newspaper trust. **

But the issue, your Honor, is whether I did right or wrong. If this
court wants to shirk the responsibility in this case it will not be my fault.
The most of the motions made by the attorneys for me have been overruled
by the court, and that was wrong. Then there is this great grade crossing
issue. If your Honor consents to my death, to my murder, you also con-
sent to take the lives of these people on the infamous grade crossings.
That is what caused me to shoot Harrison, although I had stood by him in
times of distress. **

I am feeling much better now, your Honor. My health is much better
than when I first went to the jail. **

I suppose these doctors, John and the others, really wanted to know
whether I was sane or not. They think they have done good, but as I go
to the scaffold they will be made infamous throughout all ages. It was the
most infamous thing in history to kill Christ on the cross, and it will be as
infamous to hang me.

Most strenuous efforts were made by the prisoner's counsel to
obtain a supersedeas from the Supreme Court of Illinois on technical
grounds, but the application was refused. The Lieutenant
Governor, in the absence of the Governor, was applied to but
refused the executive clemency. But the indefatigable attorneys who had undertaken his case from a belief that his execution would be unjust, late on the very eve of the day when he was to be executed, obtained a stay of proceedings on the ground that the prisoner had become insane since his sentence was pronounced. The stay was granted shortly before midnight on the 22d of March; first, for a week or ten days, but later extended to the 21st of the present month (May, 1894). When the trial occurs it will be simply on the question whether Prendergast is at this time insane. If he is found insane, he must then be sent to the criminal asylum, there to remain until he is "fully and permanently" recovered, in which event he will be discharged and the original sentence can be executed.

The diagnosis of insanity in Prendergast follows as a necessity from the facts proven in his case. Several of the alienists first retained by the State, who could not testify that they believed Prendergast sane, were subpoenaed and required to testify for the defense. Of the twelve or more physicians who testified to the sanity of Prendergast, all except two were men who had had little practical experience with the insane.

The form of mental disease existing is plainly a primary developmental insanity, the condition of degeneracy quite generally described under the term "paranoia." There is imbecility of mind, and there are delusions. Taken as a whole, Prendergast's ideas regarding his ability to fill an important public office, his belief in his extensive influence in politics, his religious mysticism, his title to express opinions on finance, education and government, and to give advice to the Pope and even to our own Secretary Carlisle—I say, these ideas, taken as a whole, may be regarded as systematized delusions, though some of them are difficult to separate from ordinary non-insane delusions growing out of ignorance, conceit, vanity and overweening ambition, such as are often met with among the sane.

The trial of Prendergast brought home strikingly to the public attention several points long familiar to alienists, but hitherto receiving little public attention. One was the question of proper disposition of insane criminals. Another was the fact that any and all persons are regarded by the law as equally competent to express an opinion as to the insanity of an individual. A third was the fact that persons may be insane and yet "know the
difference between right and wrong" and, indeed, be rational in very many respects. A fourth is the question of modified responsibility of insane persons and the fact that an individual, though insane, may be responsible in greater or less degree and a few words in reference to these points may be pardoned in this connection:

First.—The proper disposition to be made of insane criminals.—It is plain that the best means of disposing of these cases has not yet been attained. As the matter now stands a person acquitted of crime on the plea of insanity goes to the hospital or asylum, remains there a varying length of time, but may, and often does, either escape or secure release from custody, being discharged by the asylum authorities, or even securing release on habeas corpus. It is also undoubtedly a fact that one chief ground for the opposition of the general public to the plea of insanity in criminal cases is the feeling of insincerity with reference to dangerous insane persons, and if better and more certain regulation of criminally insane cases were secured there would be less opposition to the plea of insanity and less clamor for the hanging of homicidal individuals who are of unsound mind. All such persons when sent to the asylum should remain there and never obtain release except through the deliberate action of the highest executive authority of the State. They should not, as is now the case, be solely dependent for their release upon the superintendent who happens to be in charge, and the discipline of these institutions should be made as strict as that of the penitentiary, so that escape would be as little likely to occur as it now is from the penitentiary. Again the criminal asylum should be exempted from the operation of the habeas corpus law, as it now is in England, where the habeas corpus only applies for the purpose of showing that the individual was not properly committed as a criminal lunatic. One may have much charity for the public demand that such persons as Prendergast are better hanged than allowed to go about in the community; yet they are rendered dangerous solely by a dangerous disease. A victim of small-pox or tuberculosis or cholera is quite as likely to destroy the life of others as a paranoiac. The proper remedy is prevention by quarantine and strict police regulation. Hanging is also declared to be demanded in such cases for the purpose of striking terror to the souls of other "cranks," but hanging has no terrors for the majority of those
who are genuinely insane. They are more likely to glory in their fancied heroism and martyrdom. Prendergast, when the death sentence was passed upon him, compared his execution to the crucifixion of Christ.

Second.—The second point is the peculiarity of our law, which makes all opinion with reference to insanity of equal value, allowing nothing for experience or special knowledge. This anomaly arises from two circumstances: 1st, It is supposed by the people and even by courts that insanity is a condition so plain that any one can detect it. 2d, Mistakes have been made and false pleas of insanity so often urged that expert opinion has fallen into a certain degree of disrepute.

Third.—A case like that of Prendergast should help to make clear to the popular mind the fact that insanity does not by any means necessarily destroy all the mental faculties, but that in some cases, memory, the senses and perceptions and ability to think and plan within certain limits may remain intact, the insanity consisting almost wholly in one or a few delusive ideas or in morbid impulses. While the insane person knows perfectly what the law of the land is and deliberately violates it, but is governed either by an insane delusion which destroys reasoning power or in some instances even, by an insane impulse which is beyond control, the talk about an insane person knowing right and wrong contains much absurdity. Sir James Stephens, one of the greatest interpreters of English law, says, "Knowing the act is wrong means nothing more nor less than the power of thinking about it the same as a sane man would think about it," that is, of appreciating the effect of a wrong act in all its extent; the shame and suffering and loss and injustice to the victims and to the perpetrator himself, but it cannot be said that this power exists in many a criminal who is undoubtedly sane, as a professional burglar or thief.

Fourth.—The fact, (well understood by all alienists,) that responsibility often exists with insane persons to a certain degree has been scarcely appreciated by the public. Responsibility must be measured by knowledge and self-control and both of these exist among the insane, large numbers of whom even in the asylum know what is right. Some have and some have not, the ability to control their acts, and to do the right; but those who know what is right and have the ability to do it and do not act accord-
ing to their knowledge and ability, are responsible. Even Pren-
dergast had motives of malice and hatred and revenge. He knew
what the law was; he had no blind over-mastering impulse, but
could, if he had chosen, have stayed his hand when aiming the
revolver, as he himself stated; but to hold such a person responsible
in the same manner as the mentally sound are held responsible,
does not accord with the requirements of justice.

It only remains to add that Prendergast had a second trial to
decide the question whether he had become insane since his con-
viction or was insane at the present time, which resulted in find-
ing him sane and a second conviction in consequence of which he
was sentenced and hanged on July 13, 1894, after a strenuously
conducted defense in which many new witnesses were introduced
on both sides, and in which, as on the previous trial, the witnesses
most experienced in insanity and competent to judge, as a rule,
pronounced him insane.
INSANITY AMONG CRIMINALS.

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The determination of the relationship which the criminal bears to other members of the human race in regard to his mental development, his responsibility, and his proper treatment, is a matter which closely concerns every citizen, and is daily becoming a subject of more careful study and inquiry among educated men. It is a question which has for its object primarily the protection of society, and incidentally involves the education, reformation, and the safe and suitable custody of the individual so far as such incidental results subserve the main object in view. Criminology is a subject so intimately connected with psychology that it distinctly comes within the scope of the alienist and affords a field which may be profitably investigated. The criminal so often exhibits peculiar anatomical and pathological conditions that he is a creature of interest to the medical profession, and insanity and mental weakness are so commonly discovered in him that he should engage our special attention. The Government of Belgium within recent years has appointed three physicians, alienists of high repute, who constitute a commission of psychological medicine for the careful examination of the inmates of the various prisons of that country. Questions arising every day in our own courts concerning the mental condition of persons charged with crime indicate that there is a leavening of insanity which permeates the criminal class more largely than it does the general community. Acts are often perpetrated of such a nature as to create doubts concerning the mental condition of those who commit them, and the query arises, would it not be better in such cases for society, and for individuals themselves, if they should be by judicial order confined in hospitals for the insane until such time as in the judgment of a competent tribunal they are fit to be at large rather than to be repeatedly sentenced to penal institutions for short terms and then regain their liberty? A person disposed to crime who is mentally unbalanced should not be treated as an ordinary felon.

Unsoundness of mind in the criminal, whether exhibited in the
various degrees of imbecility or in the different forms of chronic cerebral disease, is very generally a mark of physical and mental degeneracy. It is well known that hereditary influences with this class are especially strong, and that unless tendencies toward defective development are corrected by early training and education, by proper methods of living, and by the avoidance of evil habits, individuals and families of degenerate ancestry will further deteriorate and injuriously affect the physical development as well as the intellectual and moral character of the race. Setting aside the inferior types of humanity exhibited in institutions for the care of imbeciles and idiots, there is probably no other special class of mankind wherein mental, moral, and physical degeneracy is more pronounced or wherein these general statements are more broadly applicable than among the convicted inmates of our various penal institutions who suffer from the different forms of mental disease. Taken as a whole, the criminal class exhibits defects both of morals and of intellect, and to an equal degree its members in early youth show evidences of incomplete and imperfect physical development. Forty-one per cent of the inmates of three great prisons in the State of New York, containing a population of over three thousand seven hundred men, were under the age of twenty-five years when convicted. So prominent is this matter of degeneracy that some distinguished students of the subject have asserted that even the sane criminal is a pathological product, and scholars have endeavored to establish a type, assuming by certain bodily signs and fixed anatomical relations determined by measurement to assign limitations within which a man is arbitrarily stamped a criminal. It is true, as a class criminals are defective, but it can not be admitted that there is any physical condition of which it can with certainty be predicated that every subject thereof is of necessity and without choice a criminal. Crime is a complex product, not only of heredity, with its entailed physical disabilities, but also of environment, including evil examples and bad training; and the subject of it, if of sound mind, bears a responsibility for his acts, and must suffer the consequences. Natural, spiritual, and civil laws all entail penalties for those who break them, and the violators must abide the results. Natural law is most remorseless in its operations. Civil laws, though not so certain retributive, are yet attended by penalties. The insane criminal suffers from all. A well-balanced mind in a healthy body is able to comprehend in a
general way the operations of law in its relation to society, and to grasp the consequences of its violation, not only specifically as relating to his own individuality, but from an abstract point of view in relation to others, and as a rule naturally refrains from infractions. Degenerate or defective man, from whatever causes his deficiencies arise, has less discernment, greater temptations, and less will-power to resist them, and consequently more often falls into the commission of crime and is deprived of his liberty. If we find such people leading an evil life, they should not only be placed in custody, but their degenerate condition should further operate as a bar to their discharge. The average convict in many ways, either physically, educationally, or morally, falls below the standard of normal man; many of them in fact become insane and many more walk on the border line.

The forms of insanity affecting convicts admitted to the Matteawan State Hospital are of peculiar types when compared with those found among the general admissions to civil hospitals for the insane. It is very seldom that acutely maniacal states are witnessed; such cases are exceptional. Usually the mental disturbance is of a quiet form, sub-acute or chronic in its nature, unattended with noisy demonstrations or exhibitions of motor excitement, and very often is associated with arrested physical or mental development.

As a class, patients received at the Matteawan State Hospital from penal institutions, although they often ask for work, dislike to apply themselves to labor continuously, or to practice self-denial in any way. They are seldom actively industrious, or capable of assiduous and intelligent labor. They are prodigal in their ideas of living, and, having very little foresight beyond the present, they are not thrifty. While they suffer as a result of their own acts, they are inclined to believe themselves wronged, and victims of injustice. The aspect of their mental disease, in many cases, seems to be a development along these lines, and is attended with an intensification of their feelings of personal grievance or injury. In prison, while undergoing sentence, they become secretive and suspicious, and soon come to cherish fixed beliefs that the officers are oppressing them, that their fellow-convicts are hostile to them and are conspiring against them, that their food is poisoned, and that they are to receive bodily harm or be put to death. Hallucinations of hearing and ideas of persecution are extremely common phases of their disease. While these delusions may be very
pronounced and fixed, and often provoke the patient to commit
attacks upon others, they seldom lead to maniacal outbreaks, but
are usually systematized, although in a primitive way, and are of
a quiet character. Such cases retain their reasoning faculties to a
large degree, and are apt to become incorrigible and rebellious,
and to make premeditated assaults in order to protect themselves
from fancied harm or to procure revenge for imaginary insults.
These assaults are both well considered and malicious, oftentimes,
as much so as the acts of the sane. In many instances this class of
the insane fraternize and sympathize with each other, and the old
adage that there is honor among thieves finds a quite general ex-
pression as well among the insane belonging to the criminal class, as
they are unwilling to inform against each other. It is this fact
which renders a large proportion of them dangerous, and their frater-
nal feelings account for the disposition of convicts who become in-
sane to combine and to conspire with others, and to promote vio-
lent attacks and cunning schemes to effect escape from custody.
The insane burglar, highwayman, thief, or robber is as fully
capable of exercising his natural propensities and his peculiar talents
as is the insane mechanic or artisan in the ordinary insane hospital,
who, in the pursuit of his trade, occupies himself usefully to his
own benefit as well as to that of the institution wherein he may be
placed. All those commendable qualities of the heart and mind
which are commonly found among the chronic insane are replaced
in the criminal by habits of thought and action of an opposite char-
acter, and which require on the part of officers in criminal asylums
constant espionage for their repression. Weapons of various
patterns and all manner of harmful instruments to do bodily injury,
as well as implements to aid them in efforts to escape, and which
they are very shrewd in concealing, are constantly found manufac-
tured from every conceivable material. There is a strong leaven-
ing of criminality in such a population, and unless carefully
watched its members are dangerous in their proclivities.

We have stated that the forms of insanity observed are generally
of simple types and they are accompanied with a paucity of ideas.
Delusions are not apt to be varied or to assume much complexity
or intricacy, and do not manifest themselves either ideationally or
pictorially to such a degree as among more highly educated and intel-
lectual people. In describing their hallucinations they usually com-
plain that fellow convicts jeer at them, apply opprobrious epithets,
or utter slanderous remarks, or that sounds are made to annoy them. Hallucinations of this nature and delusions of persecution based upon them are exceedingly common. A majority of these patients are of a low order of intelligence, in whom confinement in prison has developed their morbid condition of mind.

An important factor in relation to this subject is lack of education, even in the simple branches; and still another is the element of intemperance. The influence of degenerate parents of foreign birth is also a very potent cause in the production of insane criminals. Out of about twelve hundred convicted cases admitted to the Matteawan State Hospital during the past thirty-four years, the records show that 10 per cent were wholly without education; 6 per cent could read only, 45 per cent could read and write, and only 30 per cent had received a common-school education. In a certain percentage the facts were not definitely ascertained. The parents of upward of 65 per cent were both of foreign birth. In 46 per cent there was a history of positive intemperance. Many of these people have not sufficient intelligence to be susceptible of much education; in others there seems to be a lack of moral fibre or stamina which would preclude them from exercising the necessary application required to obtain an education, even were the opportunity offered. They have all had a trial before a jury, and it might be said have been judicially pronounced sane: and while this opinion may not formally have been declared, yet it has tacitly been implied from their having been found responsible for their acts and sentenced accordingly. The fact that a sentence has been imposed by the court after an examination both of the individual and of his offense, and after a fair trial has been granted, would indicate it was expected that after the expiration of his time the convict should return from the prison to the society of the outer world. The mild form of mental disturbance developed in confinement soon subsides after arrival at the hospital, but the inherent mental weakness is permanent. Both the patient and his friends consider that after his delusions have passed away he is as well as ever he was, and yet if discharged the result would probably be, and usually is, a return to prison, so that it frequently becomes a question, even after the patient has dismissed his delusions and apparently regained a condition normal to his previous health, whether he is a proper subject to be thus returned and to be placed in position to regain his lib-
They have been permanently detained as defective persons or, in other words, as lunatics. Some of these criminals, speaking from a medical point of view, are no longer insane, in the strict meaning of the term, but they are in a condition which is recognized as unsoundness of mind; that is, they are imbeciles or weak-minded creatures, easily swayed, prone to vicious acts, evil practices and habits, with little knowledge and little capacity for acquiring it. They are not amenable to prison discipline and are incorrigible. Solitary confinement in the dark cell of the prison soon unnerves them and unhinges their already feeble mental powers. Corporal punishment is said to be often corrective, without the evil effects upon the mind of solitary confinement. If discharged they become recidivists. Their lack of mental development should require that upon their second conviction they should be confined upon an indeterminate sentence at a reformatory or be placed, in many cases, as permanent inmates of a criminal asylum. One brief example will illustrate: A young convict whose short stature, facial expression, and cranial development, as well as speech and actions, indicated a degree of imbecility, was committed for epilepsy. He had previously been an inmate of poorhouses and penitentiaries, and came to us from prison to be treated for his convulsions. After he was received in the Matteawan State Hospital he was charged with shamming, and acknowledged that he had long practiced it. He has not now had an attack of epilepsy for two years. His intelligence is of low grade, he can not read or write, is disposed to petty thefts, hoarding miscellaneous articles and bulging his pockets with rubbish. Among other things he collected five or six hundred empty thread-spool, strung them and hung them in the hose tower. In certain directions he is useful, but in many ways he is a nuisance, and occasionally, in order to control him, has to be taken from his work and temporarily placed upon the ward. It is a problem often to know what disposition to make of such and similar cases. A brief sentence does not subserve any useful purpose. The subject receives but a short term at the utmost, which is often made still less by commutation, and is then allowed his freedom. His stay in prison is rather detrimental to him morally, nor does it act as a deterrent upon others. The feeling usually aroused is that a wrong has been done and justice scandalized in convicting him. In all such cases a judicial inquiry should be held and the character of the mental unsoundness of such offenders should be fully set forth, and by
order of the court they should be placed in some asylum, there to remain permanently. This would prevent an annual exodus from the prisons of men unfit to be discharged, and who only swell the criminal ranks when freed. A cursory examination of many of them would reveal their mental defects.

In the interests of good government there should be restrictions placed upon the personal liberty of imbeciles, of all grades, with criminal propensities, greater than that imposed by definite terms of imprisonment.

There is also a certain proportion of cases, not large perhaps compared with the total prison population, yet constituting a considerable number of those transferred from the penal institutions to the Matteawan State Hospital, who were naturally possessed of average endowments, both physically and mentally, but who were evidently insane at the time of their conviction, and whose crime was the product of their insanity. Such persons always have been, and instinctively would remain, law-abiding were it not for the promptings of insane delusions. The mental condition of these convicts is not taken into consideration with enough frequency at the time of trial. Cases often come to us from the prisons in which it is astonishing that the insanity could have escaped detection at the time of their trial, and who should have been committed to a hospital upon an order detaining them therein until sane. Instead of having been held responsible and sentenced for short periods, they should not have entered prisons at all. Many such cases occur annually; and although they can not be said to be numerous, yet they constitute a considerable number. They are not of the criminal class as a rule, although a few of them are. The contrast is striking between these patients of previous reputable character arrested and confined for crimes committed while insane, and those convicts who become insane after conviction and while undergoing sentence and imprisonment. This class distinction has been noticed and commented upon, not only in this country but abroad. Among the convicted cases these persons form an accidental group and their acts can hardly be called criminal. It is important from many points of view that the mental condition of every one who commits a crime should be thoroughly understood in courts of law. This would be plainly apparent in the majority of cases, but in many others it is evidently not the subject of inquiry. In some cases the conviction has been the result of incompetent or conflicting medical testimony.
Medical experts should be summoned by the courts and paid by the courts and thus be freed from any suspicion of partisanship. The antecedents of every criminal, particularly of foreigners, if not known to the police, should be thoroughly investigated. Even a plea of guilty should not be accepted until their past history has been ascertained. There are many imbeciles, people of defective mentality, and some who are even insane, arrested for various criminal acts, which are the product of their mental condition and whose history would show that they have been previously inmates of insane asylums, reformatories, jails, and prisons abroad, and who have either been aided to reach the United States by civil authorities or assisted by friends, with the connivance of similar officials, in order to rid their native land of the burden of their support. Some of them wander about this country for months and are arrested as tramps or for minor crimes. They should not be convicted or placed in our asylums, but should be at once transferred to their native soil; the authorities in their own country should be notified of such return, or such other proper steps be taken as would not only prevent their ever reappearing here, but preclude the occurrence, if not wholly yet so far as possible, of similar immigrations in the future. Our laws are gradually becoming so framed that it is growing more difficult, although the difficulty is not great, for such people to enter our ports; and it should be the duty of every American citizen, particularly those whose position enables them to obtain knowledge on this subject, to ascertain facts in the previous history of the insane and criminal classes which should exclude them from our public institutions and place the burden of their support upon their own country, where it rightfully belongs. A few criminal cases of this kind returned would give prominence to the fact that such immigrants are not desired here and would tend to dry up the source whence come not only themselves, but hundreds of other young persons whose cases are never reached by the law, who never enter our insane asylums and yet who procreate and fill our institutions with their children. Safeguards should be erected with great care so as to effectually exclude the insane, the feeble-minded, and those having criminal propensities. Only immigrants of thrift and character who are in good physical health should be welcomed, otherwise we must suffer from the results of their lives, which are often worse than death in their effects upon the mental, moral, and physical condition of
their offspring, entailing a vast burden upon society, upon the taxpayers and upon the government.

The mental condition of those condemned for capital offenses to either death or to life imprisonment, is an interesting one. It is not denied that many who are sane take the lives of their fellow-men; yet it is significant that among the "life men" in our prisons there is a very great proportion of insanity. The question arises as to whether in trials for such offenses the prisoner's soundness of mind was thoroughly investigated. It is true that the monotony of prison life and methods of discipline, the weight of a long sentence and remorse may have a tendency to develop insanity, and yet it can not altogether account for the wide prevalence of mental disease. In many cases the subsequent history shows that it must have been present when the act was committed. It is a fact that among "life men" insanity is exceedingly prevalent; out of 196 life convicts in the State of New York, thirty three, or 17 per cent, are inmates of the Matteawan State Hospital. As a rule their mental condition is either one of melancholia, with great dejection and depression of spirits, or a condition of mild mental disturbance attended with delusions of persecution. Many of them at the Matteawan State Hospital have now reached the stage of terminal dementia. This proportion would show a still larger percentage were it not for the fact that a few years ago, on account of overcrowding, and in order to create room for admissions, several such cases were pardoned and transferred to the custody of the county authorities, and by them committed to other State hospitals. As a class they are peculiar, and are superior mentally and physically to the average criminal. They are possessed of better morals, and naturally are freer from vicious propensities, and in many cases their misdeed was the single criminal act of their lives. A number of them were undoubtedly lunatics at the time of the commission of the acts for which they were convicted, but many of them become insane in prison, suffer from a hopeless regret for their crimes, and fall into quiet, subdued melancholia.

The public appears to sanction the opinion, erroneously I believe, that insanity is frequently pleaded as a fraudulent defense for crime, particularly in capital offenses. In only an extremely limited sense this may be so to the extent that a few isolated instances may have occurred. On the contrary, insanity in all classes of criminals is too often overlooked, or when recognized the popu-
lar desire is to hold them both sane and responsible. This is not a proper sentiment. Like the sequestration of contagious disease, the object sought should be the common welfare of the community. In the case of minor crimes, if it appears that the perpetrator is an imbecile, or what is popularly termed a "crank," let the grounds for such an opinion be stated in the commitment papers, and an order made forbidding his discharge so long as such conditions continue to exist. As it is now, a sentence definite as to a term of months or years seems to satisfy the people. The old idea of retributive justice prevails; an eye for an eye, a tooth for a tooth. The populace is, and always has been, anxious for blood. If, however, a careful determination of each prisoner was undertaken with a view to his proper disposition or his commitment to some permanent and safe custody, so long as he was dangerous to society, many insane and pauper aliens illegally landed would be returned to foreign countries; many other habitual criminals now sent to prison or penitentiaries for short terms would be adjudged insane or even pronounced incurable by reason of natural defects, and the judge's order might so recite, thus practically committing the latter class for life to a hospital for the insane, and permanently ridding society of many dangerous and undesirable elements.

DISCUSSION.

Dr. E. N. Brush: In connection with one point touched upon, the importation of pauper insane, etc., it may be interesting to the gentlemen present to know that in New York State, June 1st, 1890, the census showed that almost exactly one-half of the insane are of foreign birth and, of the remaining one-half, nearly one-fourth are of foreign parentage. Of the 17,831 insane in 1890, 8,642 were of foreign birth.

Dr. Walk, of Philadelphia: Defectives and insane are common amongst the wealthy classes as well as amongst the poor, but the wealthy classes take care that their defectives and insane do not get into trouble, whilst amongst the poor this care is not exercised and their defectives come into conflict with the civil authorities and they are sent to the prisons because there is no other place for them. In the Eastern Penitentiary perhaps 40 per cent of the inmates can be reckoned of this class of defectives; prisoners who come time and time again, are sent out into the community and are then re-arrested for some slight offense.
COSMIC CONSCIOUSNESS.

BY R. M. BUCKE, M. D.,
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Seventeen years ago I read at St. Louis my first paper before the Association and since then it has been my privilege to read several. All these, and all other original work done by me within the last twenty years, have dealt, directly or indirectly, (but generally directly) with one subject—namely— with mental evolution. In papers read in 1877 and 1878, and still more exhaustively in a volume published in 1879, I considered the evolution of the moral nature. In 1881 I read a paper on the evolution of the intellect and some of the sense functions, and in 1892 I dealt still further with these latter. I venture to draw your attention to these labors of mine because they have a direct bearing upon what I am to say to-day. The labor of twenty years has shown me clearly that the human mind has been slowly evolved by a species of unfolding or growth extending over millions of years. Not that the human mind has existed as long as that, but that the mind which we possess to-day in its human and its ante-human forms extends back for unknown ages and eons into the geologic past of the planet, sending its roots and drawing its sap to-day from the lives of tens of thousands of generations of our prehuman as well as human ancestors. And (it may be said in passing) it is apparently this almost infinite experience, treasured up and handed down the ages in the form of instincts—monitions of conscience—and delicate phases of emotion—that gives to the human mind of the present time many of its most profound and subtle qualities.

Be this as it may, the studies of the last twenty years have convinced me that the human mind as we know it to-day is a lineal descendant of a certain prehuman mind which could not have been very different from the mind of the higher animals of the present time and that this animal mind grew into the human mind by means of two closely related but distinct processes—first by the unfolding and expansion of its various faculties and second by the springing up within it from time to time of entirely new functions which in their turn unfolded and expanded as the generations and
the centuries succeeded one another. My volume on Man’s Moral Nature was intended to make clear whence proceeded and how from lower to higher planes advanced this important part of the human mind—my paper read in 1881 was intended as an exposition of the manner of growth of the intellect and that and another two years ago set forth reasons to believe in the addition from time to time of new faculties to the immense aggregate.

The process is (in short), as I have before pointed out, precisely similar to that of evolution in all other departments—a tree, for instance, both sends out new branches and all its branches both new and old increase in size—a language (like the original Aryan or the Latin) puts out as its branches dialects which grow into languages and put forth others in their turn—a species either animal or plant puts forth as its branches varieties which grow into species and in their turn put forth other varieties which later also become species.

Suppose then we admit (as I think we must) that far back in geologic time what we call mind had its origin in some very low organization in the form of mere excitability—that later on from this initial excitability was born sensation—from that again after many ages and generations and much experience simple consciousness—and again from that “when the time was ripe” self-consciousness—supposing we admit this to be a rough description of the trunk of our mental tree, then we have as its branches all the senses—each with its diverse and wide spreading congeries of functions—we have also as another vast trunk the moral nature, and as another still volition, without stopping to mention many another limb and twig of less consequence.

The centre of all is of course the trunk and upon this I want to keep your minds fixed for the moment—that trunk resting upon and rooted in inorganic nature may be divided from the ground up (as before said) into: Vitality, Excitability, Sensation, Simple Consciousness, Self-Consciousness—these being superimposed the one upon the other in the order in which they are named. The line between simple consciousness and self-consciousness is, of course, the line between the brute and the man since self-consciousness is the basis of language, of human faculty in general and of the methods and arts that constitute objective human life.

As vitality, excitability, sensation, simple consciousness and self-consciousness each one arose, in its turn, from anterior conditions which prepared the way for it and made it possible, so every other
faculty and function existing to-day had its own date of birth. For instance: The general sense of sight dates back many million years into geological time—the color sense only dates back about a thou-
sand generations. The sense of hearing is very old—the musical 
sense is just coming into being. The animal instincts which are 
the basis of it go back far behind the carboniferous era, but any-
thing we would to-day call a human moral nature is probably less 
than a hundred thousand years old.

How do we know how long any given faculty has existed in any 
given race? Chiefly by three indications:
1st. The average age at which the faculty appears in the 
individual.
2d. The greater or less universality of the faculty in the mem-
bers of the race as we see it at present.
3d. The readiness (or the reverse) with which the faculty is lost 
(as in sicknesses).

For the sake of illustrating the position taken let us briefly com-
pare almost any two faculties. Let us take for this purpose simple 
consciousness and self-consciousness.

1. Simple consciousness appears within a few hours or days of 
birth. Self-consciousness appears at about the age of three years.

2. Simple consciousness is absolutely universal in the human 
race. Self-consciousness is congenitally absent in all true idiots— 
i. e., in about one or two in every thousand individuals of the race.

3. Simple consciousness is only lost in the most profound dis-
turbances as in epilepsy and coma and only for short periods, a few 
minutes, hours or days. Self-consciousness is always lost when 
simple consciousness is lost and over and above it is frequently lost 
as in the delirium of fever and in insanity (simple consciousness 
remaining present) and it often remains absent for days, weeks, 
even months.

These three facts clearly show that simple consciousness is a much 
older faculty than is self-consciousness.

But why is it that the older a faculty is in a race the earlier it 
shall be acquired by the members of the race? The answer is not 
far to seek and has a most important bearing upon the subject im-
mediately under discussion—i. e., the existence or not of the new 
faculty in the race which I have named Cosmic Consciousness. It 
is briefly as follows: Suppose that a race is coming into possession 
of a new faculty—say self-consciousness, the moral human nature,
or color sense—it must be that the new faculty or sense will be first acquired by the foremost members of the race and at that time of life when these are at their best. The new faculty having been acquired by the foremost member of the race (foremost at least in that direction) is later acquired by any other member of the race who has in that particular line attained the position occupied by the member who first acquired it. As the race moves forward a larger and larger number of its members acquire the new faculty until it becomes, let us say, fairly universal. Then another process sets in—the race gains (as it were) upon the new faculty or upon the level upon which the new faculty rests, and whereas no member at first acquired it under full maturity, say thirty years of age, later certain members acquire it at twenty-five, then at twenty years and after thousands of generations at three years of age as in the case of self-consciousness.

In the light of this short resumé of a large subject I will now briefly set forth what I have to say on the real subject of this paper. And in the first place does it not seem pretty certain that a race which has been enabled by its own inherent growth to advance from excitability to sensation, from that to simple consciousness, from that to self-consciousness, that has been able to take on the human moral nature, color sense and a hundred other faculties—does it not seem pretty certain, I say, that this race, still as full of vitality as ever, will take on, as time passes, still other faculties? Have we any reason to think that a process which has been in full operation certainly for many millions of years and probably from all eternity will now cease? No rational being with the facts in his mind can suppose anything of the kind. To start with, then, we have the probability, if not certainty, that the human mind will advance beyond its present status and that the next step made will be comparable to those made in the past as from sensation to simple consciousness or from that to self-consciousness. Further, if the next step made in direct ascent is in the nature of a new consciousness it is reasonable to suppose that it will come per saltum as does self-consciousness and not by infinite, almost imperceptible degrees as came or is coming (for instance) the color sense.

I have next to say that the human mind is now in the very act of making this supposed step; is now in the very act of stepping from the plane of self-consciousness to a higher plane than it, which I call Cosmic Consciousness.
I have in the last three years collected twenty-three cases of this so-called cosmic consciousness and what little further I have time to say at present will be based on the actual facts belonging to them. But will you kindly remember that anything I may say in the brief time at present at my disposal will bear an exceedingly small proportion to the mass of facts collected by me on this subject.

First as to the age at which (if at all) cosmic consciousness is attained. In twenty-one of the twenty-three cases I have been able to fix this with considerable certainty and accuracy and I find that illumination took place:

In 2 cases at the age of 30; in 1 at 31; in 3 at 32; in 3 at 33; in 2 at 34; in 5 at 35; in 1 at 37; in 2 at 38; in 1 at 39; in 1 at 40.

Thus then the new consciousness obeys the first supposed necessary condition and appears when the organism is at its highest point of efficiency and excellence.

You will please keep steadily in mind that I claim that what I call cosmic consciousness is not simply an expansion or extension of the self-conscious mind with which we are all familiar but the superaddition of a function as distinct from any possessed by the average man as self-consciousness is distinct from any function possessed by one of the higher animals. It is my purpose now to attempt to give you some idea of what this new function is and show you (or at least give you some hints) as to how the cosmic conscious differs from the merely self-conscious mind. But I warn you that with the best intentions in the world I shall not be able to make this at all clear to you, and that if you desire enlightenment on this point you will have to seek it in the books that contain the explanations of these men themselves—in, for instance, the Upanishads and Sutras which gives us the experience of one of the earliest cases, that namely of Guatama the Buddha—in the Epistles of Paul—in the "Shakespeare" Sonnets—in Dante's Divine Comedy (especially in the Paradise)—in the works of Honore de Balzac (especially in Louis Lambert and Seraphita)—in Boehme's Aurora and Three Principles—in the works of William Blake—in those of Edward Carpenter and lastly in the Leaves of Grass and other works of Walt Whitman. But the great difficulty has always been and is still that the cosmic conscious and self-conscious minds are so far apart that words coming from the former are often strange and meaningless to the latter. They contain, as Paul expresses it "wise...
this world"—a wisdom consequently which is very apt not to be understood and for that reason to be accounted no wisdom at all but foolishness. I ought to say further (in the way of introduction) that though cosmic consciousness has certain fixed elements which give to it a clear individuality yet the range and variety of mind upon the plane of cosmic consciousness appears to be still greater than the range and variety of mind on the plane of self-consciousness—just as the range and variety of mind on the self-conscious plane is far greater than are those in any given species on the plane of simple consciousness. So that in all ways the men possessed of the new faculty are liable to differ and do differ enormously and in all directions one from the other: some of them being for instance supreme poets, others religious founders, prophets and apostles, others great artists, and so on. Also I ought to say that while some of them are so obviously great that they are accounted superhuman others are not to outward seeming strikingly different from their merely self-conscious contemporaries. Even a casual study, however, of the characters and lives of these great men will reveal the plain fact that both by the intellect and by the moral nature they are enormously in advance of their self-conscious contemporaries.

What now are these fixed elements belonging to cosmic consciousness to which I have referred? First there are certain phenomena connected with the onset or on-coming of the new faculty—which is usually, perhaps always, sudden—instantaneous. Among these the most striking is the sudden sense of being immersed in flame or in a brilliant light—this occurs entirely without warning or outward cause and may happen at noonday or in the middle of the night. In order to give some notion of this dazzling subjective light I will show you what a few of these men have said about it.

Paul (in his speech to Agrippa) said: "As I journeyed to Damascus I saw on the way a light from heaven above the brightness of the sun." Then he heard the voice and then was caught up into the third heaven and heard unspeakable words. But the initial fact was the subjective light.

In the night called by the Arabs Al Kader—in the month of Ramadan—in the fortieth year of his age—in the Cavern of Mount Hara, Mohammed heard a voice calling upon him, immediately thereafter or at the same instant a flood of light broke upon him of such intolerable splendor that he swooned away. On regaining
his senses he beheld an angel in human form, which, approaching from a distance, displayed a silken cloth covered with written characters. The angel said to him: "Read." Mohammed said he did not know how to read but immediately afterwards his understanding was illumined and he read what was written on the cloth.

In the first Canto of the Paradise, Dante gives an account of the on-coming of the cosmic sense in his case. And as descriptive of the commencement of the series of his experiences he has these words: "On a sudden, day seemed to be added to day, as if He who is able had adorned the heaven with another sun."

The report made by Whitman of the same occurrence is in very similar language. He says:

"As in a swoon one instant,
Another sun, ineffable, full dazzles me,
And all the orbs I knew—and brighter unknown orbs:
One instant of the future land, Heaven's land."

The dazzling, sudden, unexpected, subjective light, then, is usually the first thing known of the change that is taking place—it is usually succeeded by alarm—for a longer or shorter time the person fears that he is becoming insane—very often a voice is heard, and the form of the person speaking may be seen. These phenomena, (the light, the voice, person seen) soon all pass away and the essential elements of the new order dawn upon the mind. These essential elements are a consciousness of the cosmos—or in other words a consciousness of the life and order of the universe—not (you will please understand) a knowledge of this but a consciousness of it—just as self-consciousness when it comes gives the person not simply a hearsay or learned knowledge of himself as a separate and distinct individual but something far deeper—i.e., a consciousness of himself as a distinct personality.

With the intellectual illumination comes an indescribable moral elevation—an intense and exalted joyfulness and along with this a sense of immortality—not merely a belief in a future life—that would be a small matter—but a consciousness that the life now being lived is eternal—death being seen as a trivial incident which does not affect its continuity. Further there is annihilation of the sense of sin and an intellectual competency not simply surpassing the old but on a new and higher plane.

Let us hear now, in conclusion, very briefly, for my time is short, some of the words of a few of the men, having cosmic con-
consciousness, descriptive of this new state after they had fully entered upon it.

Guatama Buddha attained illumination at the age of about thirty-five years under the Bo tree since and hence so celebrated. In the Dhamma—Kakko—Ppavattana—Sutta he is reported to have said that the “noble truths” taught therein were not among the “doctrines handed down but that there arose within him the eye to perceive them, the knowledge of their nature, the understanding of their cause, the wisdom that lights the true path, the light that expels darkness.” This is an excellent description of the intellectual illumination that belongs to cosmic consciousness. In the Maha Vagga it is said that during the first watch of the night following on Guatama’s victory over the evil one—that is the night following upon his attainment of cosmic consciousness and his consequent victory over his old and lower condition—“he fixed his eyes upon the chain of causation, during the second watch he fixed his eyes upon the chain of causation, and during the third watch he fixed his eyes upon the chain of causation.” That is to say: the cosmic order became visible to him and he could not for a long time remove his mind from this the grandest and most entrancing of all sights. Again in the Akankheyya—Sutta is set forth, as taught by Buddha, the distinctive marks of Arahatship—that is of cosmic consciousness—the attainment of this condition he says will cause a man to become “beloved, popular, respected among his fellows, victorious over discontent and lust, over spiritual danger and dismay—will bestow upon him the ecstasy of contemplation—will enable him to reach with his body and remain in those stages of deliverance which are incorporeal and pass beyond phenomena—cause him to become an inheritor of the highest heavens—make him (being one) to become multiple, being multiple to become one—endow him with clear and heavenly ear surpassing that of men—enable him to comprehend by his own heart the hearts of other beings and of other men—to understand all minds—to see with pure and heavenly vision surpassing that of men.”

In Buddhism “Nirvana” which literally means “a blowing out,” as of a candle, is the word which stands for cosmic consciousness, the “blowing out” or “extinction” being not that of the soul as sometimes supposed, but of the desires and instincts which belong to the self-conscious mind and which are thought to stand in the way of the attainment of the cosmic sense.
The great Apostle Paul was (using the word in its medical sense) an admirable "case" of cosmic consciousness. His initial earnestness of character, his instantaneous illumination, his age at the time—probably a little over thirty—the subjective light, the voice which spoke to him, his consternation, the resulting intellectual illumination and moral exaltation—all these typical symptoms make the true nature of his "conversion" as plain as would be a case of typhoid fever with frontal headache, diarrhoea, ochre stools, characteristic temperature and rose spots. But still more absolute proof of Paul's entry into cosmic consciousness is his own account of his subsequent habitual feelings and convictions as given us by himself in those letters of his which have come down to us. He says for instance in second Corinthians: "I will come to visions and revelations of the Lord. I know a man in Christ fourteen years ago, (whether in the body or out of the body I know not) such a one caught up even to the third heaven—into paradise—and heard unspeakable words." Again in Galatians: "For I make known to you brethren as touching the gospel which was preached by me that it is not after man. For neither did I receive it from man, nor was I taught it, but it came to me through the revelation of Jesus Christ." Here Paul uses almost exactly the same words as above quoted from Guatama. There is only time to give one more short quotation from Paul, but all his writings may be read with very great advantage from the present point of view. He says in Romans: "There is therefore no condemnation to them that are in Christ Jesus. For the law of the spirit of life in Christ Jesus made me free from the law of sin and death. For they that are after the flesh do mind the things of the flesh: but they that are after the spirit, the things of the spirit. For the mind of the flesh is death, but the mind of the spirit is life and peace." That is to say: In cosmic consciousness there is no sense of sin or of death. The merely self-conscious man cannot by "keeping the law" or in any other way destroy either sin or the sense of sin, but "Christ" that is the cosmic sense can and does accomplish both.

In the case of Mohammed there was the same initial earnestness of character. The same instantaneous illumination. His age was thirty-nine. There was the intense subjective light. The voice which spoke to him. The same extreme consternation. The same intellectual illumination. The same moral exaltation.

In the case of Dante there was the same initial earnestness of
character combined with unusual spirituality. The same instantaneous illumination. He was of the typical age at the time, namely 35 years. There was the intense subjective light. The voice—that is the duplex personality that belongs to the condition, spoke to him. There was the same consternation followed immediately by the same intellectual illumination and the same moral exaltation.

The evidence of Dante’s illumination in his great work the Divine Comedy is overwhelming, but I have only space here for one short quotation, namely, the passage in which he describes the on-coming of the cosmic sense. He says: “Beatrice was standing with her eyes wholly fixed on the eternal wheels and on her I fixed my eyes from thereabove removed. Looking at her inwardly became such as Glaucus became on tasting of the herb which made him consort in the sea of the other gods. Transhumanization cannot be signified in words: therefore let the example suffice for him to whom grace reserves experience. If I was only what of me thou didst last create, O Love that governest the heavens, Thou knowest who with thy light didst lift me.”

Beatrice (i.e., “making blessed”) is Dante’s name for cosmic consciousness. He says that when his illumination took place he fixed his eyes on the cosmic sense and the eyes of the cosmic sense were wholly fixed on the eternal wheels (in the language of Guatama “on the chain of causation”—both expressions meaning the same thing—i.e., the life and order of the universe). Then he says: looking upon this new sense that had come to me I became transhumanized into a god. He says that of course this change that was wrought in him cannot be expressed in words and that no one will be able to understand it until he himself experiences it, and like Paul he does not know whether at that time he was in heaven or upon the earth, whether he continued during the experience in the body or whether for a time he left the body.

All these men recognize clearly three states or stages of mind, namely: Simple consciousness; self-consciousness; cosmic consciousness. And that there exists as clear and broad a distinction between the two last as between the two first. Thus Balzac says: “The world of ideas divides itself into three spheres,—that of instinct (simple consciousness): that of abstractions (self-consciousness): and that of specialism (cosmic consciousness). As an instinctive, man is below the level: as an abstractive, he attains to
it: as a specialist, he rises above it: specialism opens to man his course: the infinite dawns upon him, he catches glimpses of his destiny."

Balzac proceeds as follows. "There exist three worlds—the natural world, the spiritual world, the divine world. Humanity moves hither and thither in the natural world which is fixed neither in its essence nor in its properties. The spiritual world is fixed in its essence and variable in its properties. The divine world is fixed in properties and in its essence." In other words: Men who live almost entirely in simple consciousness float on the stream of time as do the animals—drift with the seasons, the food supply, etc., as a leaf drifts on a current not self moved or self balanced but moved by outer influences and balanced by the natural forces as are the animals and the trees. The fully self-conscious man takes stock of himself and is (so to say) self-centred. He feels that he is a fixed point—he judges all things with reference to this point. But outside of himself, we know, there is nothing fixed for him, he trusts what he calls God and he does not trust, he is a deist, an atheist, a Christian, a Buddhist. He believes in science but his science is constantly changing and will rarely tell him in any case anything worth knowing. He is fixed, then, on one point and moves freely on that. The man with cosmic consciousness being conscious of himself and conscious of the cosmos, its meaning and drift, is fixed both without and within—in Balzac's words: "In his essence and in his properties."

To sum up: The creature with simple consciousness only is a straw floating on a tide, moving freely every way with every influence. The self-conscious man is a needle pivoted by its centre—fixed in one point but oscillating and revolving freely on that with every influence. The man with cosmic consciousness is the same needle magnetized. It is still fixed by its centre but besides that it points steadily to the north—it has found something real and permanent outside of itself toward which it cannot but steadily look.

One word in conclusion: I have been searching three years for cases of cosmic consciousness and have so far found twenty-three. Several of these are cotemporary, minor cases, such as may have occurred in any age and no record of them remain. I have however found thirteen all of them so great that they must live. Of these thirteen cases, five appeared in the thirteen hundred years extending from Guatama to Mohammed—and include, of course,
both of these men. But including Dante and from him to the present time (a space of barely six hundred years) there have lived no less than eight cases—and these (so far as I can see) just as great as the five cases of the earlier thirteen hundred years. But eight cases in six hundred years is more than three and a half times as great a frequency as five cases in thirteen hundred years. I do not pretend to say that cases of cosmic consciousness are becoming more frequent in exactly this ratio. There must have occurred a large number of cases in the last twenty-five hundred years that I know nothing about and I suppose no man could say positively how many lived in any given epoch. But it seems to me certain that these men are more numerous in the modern than they were in the ancient world, and this fact taken in connection with the general theory of psychic evolution propounded by the best writers on the subject such as Darwin and Romanes points to the conclusion that just as, long ago, self-consciousness appeared in the best specimens of our ancestral race in the prime of life and gradually became more and more universal and appeared earlier and earlier until as we see now it has become almost universal and appears at the average age of about three years—so will cosmic consciousness become more and more universal and appear earlier in the individual life until practically the whole race will possess this faculty. I say the whole race, but as a matter of fact a cosmic conscious race will not be the race which exists to-day any more than the present is the same race which existed prior to the evolution of self-consciousness. The simple truth is that a new race is being born from us, and this new race will in the near future possess the earth.
IMPORTANCE OF LIBERAL ADMINISTRATION OF FOOD IN THE CURABLE INSANE.

BY ELI E. JOSSELYN, M. D.,

It is not proposed to discuss the propriety of forcibly feeding patients who from active delusions abstain from taking nourishment until life is in jeopardy or the attending circumstances which make such procedure necessary, but rather to consider the effect of an apparently excessive quantity of food in recoverable cases of mental disorder and the intimate relation which an improved physical condition bears to the permanent restoration of sound mental health.

It is hardly probable that the beginning of mental derangement often depends upon permanent pathological changes within the cranium save in paresis and senile decay, and doubt may be well entertained if the existence of insanity for some time can generally be made out without a knowledge of the mental symptoms. The absence of any constant abnormal condition in a sufficient number of cases and the frequency of recovery of recent cases under judicious medical care and treatment are enough to justify the assumption that degenerative changes of the intellectual centres are not the primary difficulty but secondary to unnatural conditions elsewhere.

In the incipient stage of a large majority of cases of threatened mental aberration there is a decrease in bodily weight which becomes more and more apparent if the disease progresses. The crisis of alarming cases of insanity is not infrequently accompanied by extreme emaciation. This loss of flesh is more constant than any other prognostic. Where there is a hereditary taint and where there have been one or more attacks of insanity, the continued or progressive loss of weight, however gradual, is significant of approaching mental disorder. In these cases its importance can hardly be over-estimated and should never be regarded lightly by the patient, friends or medical attendant. Whether in developed or incipient insanity, no hope of permanent restoration can be reasonably entertained without first restoring the physical
health. The only exception occurs in cases of phthisis where sometimes the mental symptoms disappear while the pulmonary disease goes on. It is indeed true that sometimes returning bodily health is not accompanied by corresponding mental improvement. Such cases will generally be found to be of much longer duration than at first supposed and that permanent change to the higher brain centres occurred before physical improvement commenced. A peculiar characteristic of some of these cases is the existence of delusions relative to the individual, rather than to surrounding objects and circumstances. The persistent hearing of false voices from a distance is also portentous of confirmed insanity. But whether mental disorder tends to recovery or not he has but poorly read the lesson who denies the ameliorating influence of the best possible physical health.

The dethronement of reason is such an appalling calamity that throughout the entire attack there is a tendency to think of the mind first and to give the body a secondary consideration. It is not uncommon to see the physiological action of chloral, hyoscine, the bromides or the different preparations of opium, either singly or in conjunction, mistaken for symptoms of the disease they were intended to relieve. These remedies have their legitimate use. They serve to tide over difficulties, not to solve them. They should be subordinate to medicines calculated to restore deficiencies, or to such remedies as counteract or remove poisons introduced from without or generated within the system.

However appropriate the medical prescription may be, the diet is equally important. Practically more depends upon quantity than theoretical quality and requirements. The sum total of nourishment in the large amount of ordinary food which some patients can be induced to take not infrequently far exceeds the very moderate amount which the same patient will take in a highly concentrated form. Such foods as my New England ancestors designated "hearty victuals," free from adulteration and absolutely sound, meet the requirements and are also as easily digested as alleged delicate dishes. Then again the appetite and capacity for digestion both increase by eating. The common articles of food, if properly cooked and attractively offered, are generally far more tempting than "prepared food" so much exalted by the proprietors who manufacture them. The salutary influence of pleasant environment, good ventilation and proper
amusement is too often counterbalanced by poor cooking. "God sends meat, and the devil sends cooks."

In many instances the natural desire for food is obtunded or almost completely abolished or else morbid suspicions prevent taking more than a meagre quantity. Frequent coaxing on the part of the attendant will usually overcome the apathy of the former class, while the latter often eat with avidity food that is not mistrusted if placed within easy reach. Fruit and eggs cooked without interfering with the shell are less liable to be distrusted than other articles of diet. There is a natural inclination to a diversity of food but it is not absolutely necessary in all cases. One patient took no food for 25 days save bananas. She voluntarily ate from 14 to 20 daily and meanwhile gained three pounds in weight. For fear of being poisoned an advanced case of phthisis took no food for six weeks save nine boiled eggs daily which she cooked herself. The greatest amount of nourishment is taken by patients who are coaxed to take liquid food after they can be no longer induced to take solid.

Digestion is so much influenced by conditions and individual peculiarities that we really know very little about it aside from the chemistry of the process and the quantity of nutriment contained in the food. Sometimes there is a demonstration of the fallacy of our ideas about these things. Recently a patient at home abstained from food because she imagined that she could not digest it. She made her first meal at the hospital largely upon boiled cabbage without any deleterious effect or discomfort afterwards. No amount of food should therefore be considered sufficient if the patient can be possibly induced to take more.

A case of melancholia with frenzy made a remarkable gain in weight with reciprocal mental improvement. A married woman, aged 36, of short stature and small frame, with dark, sallow complexion and a decided neurotic constitution, but without ancestral history of pronounced insanity, came under treatment greatly emaciated. For seven weeks she had been fed by nasal tube and had been mechanically restrained on account of suicidal and homicidal tendencies. Hallucinations of hearing and delusions of persecution were actively present. She accused her husband of unnatural crime and thought he was bankrupt and unable to support her. She imagined her children maltreated and they could only be made safe from injury by the death of some one else. Then
again she heard their voices crying in distress. She made repeated attempts upon her own life and also upon the lives of others. The following is an abstract from the full history of her case at the end of five months: “She made an excellent recovery during which she exhibited a truly wonderful capacity for food, amounting at times to between 11 and 12 pounds a day of liquid food which she seemed always to assimilate.” Her weight increased from 63 to 125 pounds, a part of which she subsequently lost but has continued well in body and mind since 1886.

A remarkable case of acute mania developed in a woman of medium height aged nineteen years. She had previously studied very hard in college and was valedictorian of her class. She was thin in flesh, pale and anemic and suffered with indigestion and constipation. The attack commenced shortly after graduation, with hysterical symptoms which quickly assumed a cataleptoid character. From this condition she soon passed into acute mania which in turn was followed by profound dementia. At this time she was silent and non-responsive and did not dress or feed herself. This demented state was followed by a second maniacal outbreak during which she was brought to the hospital in March, the tenth month of the disease from the beginning. She weighed 94 pounds. She was wakeful and noisy at night, untidy in dress and careless in habits. She was incoherent and unladylike in speech and talked almost incessantly. There was excessive muscular activity. When awake she kept in pretty constant motion. By the following May her weight had decreased to 86 pounds but by the middle of the next August it had increased to 102 pounds and continued thereabouts till May of the second year of the disease. Up to this time there had been no essential change in her mental condition, but she was less anemic and less restless as the spring advanced. She now began to gain in flesh and continued to do so steadily. She became passive, spent her time in a recumbent posture for several weeks, ate well and cleared up mentally. In August she weighed 132 pounds and was discharged recovered, but continued to gain physically till she weighed 165 pounds. She afterwards lost some 35 pounds but has continued well in every respect since 1887.

Of course the great bodily improvement in these cases is very exceptional, but the average gain, where there has been a systematic record of the weight kept of cases who have either recovered
under hospital care or have completed their convalescence at home, is found to be between 25 and 26 pounds in women.

Cases of extreme emaciation sometimes put on flesh very rapidly under a full diet. A man with melancholia gained 17 pounds in 17 days. A woman with acute mania gained 13 pounds in the first 13 days of treatment. In 1845 Dr. Kirkbride reported "one patient who became perfectly well, increased sixty pounds in his weight in less than two months, a part of the time having an average gain of more than two pounds a day. When most emaciated—weighing only 87 pounds" and when discharged "one hundred and forty-seven." A few weeks later he weighed one hundred and sixty pounds.

The illustrative cases presented have been selections from recoveries extending over a number of years, but the extraordinary daily amount of food and the gain in weight are equally true of the whole number of recoveries in a minor degree. The uncommon quantity of food consumed has been requisite and necessary to compensate for the rapid waste of old and the building of new tissue going on at the time; or else the supply of nerve force for assimilation has been diverted in other directions without interfering with the process of digestion. There is very little apprehension about the result in recent cases not dependent upon organic changes or hereditary tendencies as long as the increase of weight is one or more pounds a week. With such a gain the red blood corpuscles multiply in number, the haemoglobin increases, the capillary circulation improves, the complexion clears up, the depressed become cheerful, the noisy, boisterous and maniacal become quiet and physical and mental convalescence become established.

**DISCUSSION.**

Dr. J. T. Searcy: Dr. Josselyn has very happily given us one extreme of this subject of feeding the insane. I will simply make a statement or two at the other extreme. The Doctor has advocated the abundant administration of food in the treatment of the insane, and has very correctly shown cases in which it has done good. I take no exception to his paper.

I dislike to appear unusual in any statements I make; my hospital has already gotten itself noted for the fact of its having had no case of mechanical restraint for twelve or fifteen years, but I can
also say, in a population of about eleven hundred, there has been no case of forced feeding in over two years in our institution,—with a tube or otherwise.

We have starvation cases, of course, as in other institutions; but our policy is to let them severely alone—very seldom, indeed, to force them to take food. We find, in the very large majority of cases, this is the best practice.

The large majority of our patients, if left alone, in time return naturally to food, and we do not manufacture those cases that have to be tubed for weeks, months and sometimes for years.

The principle that backs us up in this practice is the fact that the forcible treatment of deluded patients, of all kinds, tends to fix their delusions rather than to cure them. Those starvation cases, who resist the administration of food, or refuse to take it themselves, almost always have such delusions as that their food is filthy or poisonous or the like; to force their food upon them tends to render what would prove a transient delusion a fixed one; and also, because will power, physiologically, is brain strength, the ability to hold to the deluded resolution not to eat weakens with the general weakening of starvation, and long before the danger line is reached, in the large majority of cases, the patient can be induced to eat, or will passively submit to natural feeding. We find the danger of leaving them alone without food is not so great as is usually supposed. Our patients go one, two, and, in extreme cases, three weeks, without food, and, in bed, keep up extraordinarily well; and we find that they come out of these periods of starvation in a more satisfactory condition than if we had forced them to eat,—with fewer relapses, and, as I say, without having them manufactured into the continuous cases where feeding with a tube has to be kept up for weeks, months and years, in its unnatural and often injurious way. I believe really the injury, in the majority of instances, because of its unnaturalness, is greater by forcing or tubing, than by letting such cases run their course.

I arise not to criticize, or to particularly comment upon Dr. Josselyn’s paper, but more to say something at the other extreme of the subject, and to intimate that every case, at and between these two extremes, will have to be considered and treated, with good judgment, on its own merits.
BODY WEIGHT AND MENTAL IMPROVEMENT.

BY DR. A. R. MOULTON,
Philadelphia.

Although defective nutrition of the body is well known to be one of the principal predisposing causes of nervous and mental disorders, I am unable to find in the books and monographs at my command a distinct discussion of the relation between bodily weight and mental condition.

In giving the clinical histories of their cases, few authors record the weight of their patients when well, and most of them make only a cursory allusion to the avoirdupois as affected by treatment, or to its significance as a desirable condition.

Full stress has been laid upon the harmful effects of overwork in general, the debilitating influences of disease, and the dangers attending privation and care; the subject of toxic agencies in the organism, and their action upon the brain, has been well-nigh exhausted, and the question of the effects of "organic sympathies" in causing mental breakdown, or continuing the subject of them in a state of mental disorder, is receiving its share of discussion; but, under the head of treatment, the importance of fattening patients before lasting improvement can be expected has not, to my mind, received the consideration it deserves. There is, however, testimony which bears out the writer's belief that improvement in the recoverable class of the insane depends upon improved nutrition, is usually preceded by gain in weight, and that successful treatment is along those lines.

Clouston speaks of one of his cases "getting very stout," after which he improved and returned to his family. To maintain this condition "every effort is made to keep up bodily health and stoutness." Again he says, "every pound of body-weight gained means a gain in nervous and mental tone."

One of his examples is of a man who "gained a stone in weight, and was well in six months," while another was discharged recovered at the end of five months, "having gained a stone and a half in weight," showing the hopefulness in some forms of melancholia, and giving a key to the line of the treatment pursued. Clouston
also records the case of a woman who got well after being five years insane, having become "very stout and healthy."

In another case the same author "did not give up hope, for the patient digested eleven glasses of milk a day, and gained weight," and as a prophylactic in one case, besides following certain set forms as to his daily life, he was advised to weigh himself every month and to stop work and take a sea voyage "when he found he had lost three pounds."

Macphail, in his chapter upon "Blood of the Insane," in "Tuke's Dictionary of Psychological Medicine," remarks that "there appears to be a close connection between gain in weight, improvement in the quality of the blood, and mental recovery."

Bucknill and Tuke long ago said: "Mental health depends so greatly upon physical health, that the physician will constantly be able to promote the prophylaxis by giving good advice as to the growth of a sound body." They truthfully assert that the brain must have a free circulation of arterial blood, and that "in the stage of acute insanity the treatment is physiological."

Stearns, in directing as to the treatment in melancholia, states a very important truth in describing a condition, frequently met with in all forms of insanity, and his conclusions are in accordance with those of other observers. He says "the tendency is to lose flesh and become emaciated; the nerve centres are imperfectly nourished and consequently have an insufficiency of energy; hence, when the patient once begins to increase in adipose tissue, it is a most favorable indication, and one looking toward recovery."

Doctor Chapin has frequently, in his hospital reports and elsewhere, shown that recovery from mental disorder is intimately connected with, if it does not depend upon, improved general health, and in his report for 1892 he says: "We continue to recognize that our acute and recoverable cases embrace a large number who have passed into a stage of various forms of mental disorder, preceded by nervous prostration and caused by overwork, illness, some defective nutrition of the nervous mass, some deficiency in the quality of the blood, or quantity of same. They have a chance to make a good recovery with improved sleep, nutrition, and an average increase of weight, usually amounting to twenty pounds."

The following cases treated in the department for men, Pennsylvania Hospital for the Insane, are illustrative of the thought herein expressed:
1. Is a lawyer, twenty-seven years of age, who was admitted to the hospital on April 28, 1893. Three uncles had been insane, all of whom recovered. This patient was intemperate, and had been in poor physical health for some years. He had been melancholy and suicidal for four months, and when admitted was confused, had hallucinations of hearing, a sluggish circulation, sub-normal temperature, was thin and anemic. He had suffered from insomnia; and chloral, the bromides, and caffeine had been given, which had had a stupefying effect upon him. For many weeks his mental reflexes were slow, and he suffered the usual dyspeptic symptoms of melancholia. He gained flesh, and on November 15th (nearly seven months after admission) weighed one hundred and forty-one pounds, which was increased by three pounds during the next month, when the records state that "he is quite bright, answers questions more readily, and talks freely with his friends." During the next month his weight fell off nearly twenty pounds, and his mental condition suggested approaching dementia.

Following this period, from the last of January, 1893, to the middle of the next November, the patient was in an unsatisfactory state, at first being dull, almost stupid, then he became exalted with violent tendencies. His weight varied from one hundred and thirty-two to one hundred and forty pounds, and when it was lowest he was wakeful and noisy at night, in addition to being opinionated and irritable.

In November, 1893, it was necessary to place him in the refractory ward, which is so constructed that patients may get an abundance of out-door air. This man spent nearly fourteen hours a day out of doors. Most nourishing food was continued, and from this time on the curves of mental coherence and of bodily weight were steadily upward. His delusions vanished, and there was the usual transformation seen in patients passing from stupor, with impulsive interruptions, to complete convalescence, when the weight was one hundred and fifty pounds.

This gentleman has no recollection of making the journey from his home in Cuba to the hospital, and occurrences at the institution previous to November, 1893, are vague and shadowy. His brother and sister brought him to the hospital, remained in the city and visited him twice a week for a year, yet the only remembrance he has of their presence is the impression that somebody used to call upon him, and that he called the gentleman "John," not his brother's name.
No. 1. *

<table>
<thead>
<tr>
<th>Month</th>
<th>Date</th>
<th>Weight</th>
<th>Month</th>
<th>Date</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov.</td>
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<td>Aug.</td>
<td>1893</td>
<td>134 lbs</td>
</tr>
<tr>
<td>Dec.</td>
<td>12, 1892</td>
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<td>Sept.</td>
<td>1893</td>
<td>136 lbs</td>
</tr>
<tr>
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<td>Oct.</td>
<td>1893</td>
<td>140 lbs</td>
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<td>23, 1893</td>
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<td>Nov.</td>
<td>1893</td>
<td>136 lbs</td>
</tr>
<tr>
<td>Feb.</td>
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<td>137 lbs</td>
<td>Dec.</td>
<td>1893</td>
<td>137 lbs</td>
</tr>
<tr>
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<td>136 lbs</td>
<td>Jan.</td>
<td>1, 1894</td>
<td>139 lbs</td>
</tr>
<tr>
<td>April</td>
<td>1893</td>
<td>140 lbs</td>
<td>Jan.</td>
<td>8, 1894</td>
<td>141 ½ lbs</td>
</tr>
<tr>
<td>May</td>
<td>1893</td>
<td>135 lbs</td>
<td>Jan.</td>
<td>15, 1894</td>
<td>150 lbs</td>
</tr>
<tr>
<td>June</td>
<td>1893</td>
<td>136 lbs</td>
<td>Jan.</td>
<td>22, 1894</td>
<td>150 lbs</td>
</tr>
<tr>
<td>July</td>
<td>1893</td>
<td>132 lbs</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

2. Is a young man who was twenty years of age when admitted to the hospital on July 23, 1892. There was a decided insane diathesis in his family, though no member had become actually insane. He had always been thin and delicate, and within a comparatively brief period he grew to be very tall, measuring six feet two inches. Four months previous to admission he had la grippe. He worked hard as a bookkeeper, and first showed signs of insanity four days before admission. When received he was in a furiously maniacal condition, and he was too sick to be placed on the scales until July 30th, when he weighed 118 pounds. Under nourishing food, tonics, cod-liver oil, the hypophosphites, etc., he did well, and his excitement was subsiding, when, in the middle of August, he was made much worse by the injudiciousness of his family; his mania returned with increased violence, and on September 3d his weight had fallen to 111 pounds. Food in the shape of milk, eggnog, chicken broth, strong beef tea, etc., was given every hour and a half (fully five quarts of milk or its equivalent being taken during the twenty-four hours), and as soon as he would masticate and swallow solid food it was pushed. By the last of October he had reached 132 pounds in weight, but, although his circulation was less sluggish and his blood had gotten richer, it was nearly another month before his excitement and incoherence had decidedly improved. Then he would sit down quietly, began to make up his sleep, of which he was very short, and he passed on to recovery, going home on December 10th. He weighed at the time 135 pounds, a gain of twenty pounds. He has remained well, and, as is not at all unusual after a patient resumes the active duties of life, has lost a little weight.

*As a convenience for the printer, the tabulations were substituted for the weight charts, as originally prepared.
No. 2.

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<td>Sept. 3, 1892</td>
<td>112 &quot;</td>
</tr>
<tr>
<td>Oct. 26, 1892</td>
<td>132 &quot;</td>
</tr>
<tr>
<td>Nov. 15, 1892</td>
<td>128 &quot;</td>
</tr>
<tr>
<td>Nov. 20, 1892</td>
<td>132 lbs.</td>
</tr>
<tr>
<td>Dec. 10, 1892</td>
<td>135 &quot;</td>
</tr>
</tbody>
</table>

3. Is a young man, a student, twenty years of age. He was admitted to the hospital on February 14, 1893. He had applied himself closely to his studies, and during the previous October he slept badly and became exhilarated; then he was melancholy for two weeks and began to lose flesh, when positive mania supervened, which increased down to the time of his admission. He was much excited for a few days, but under forced feeding and some stimulation, with the necessary remedies to encourage the excretions and aid digestion, he became quiet and soon slept well. On February 27th, thirteen days after admission, he weighed 154 pounds. The psychical storm through which he passed was followed by stupor, with imperfect circulation, cold extremities, constipation, etc. His weight went down to 147 pounds in April, rose a little, and by the last of May had fallen to 145 pounds, when he did not respond to the calls of nature, nor even seem to understand what was said to him. He was at times suddenly violent. During the next two months he received constant personal attention, was kept much in the open air, and, when the weather was suitable, under the direct rays of the sun; his circulation was stimulated by massage, walking, calisthenics, etc.; large quantities of nourishing food were given, and tonics administered. At the end of July he weighed 154 pounds, his circulation had improved, and, though passive, he was no longer violent. From this time on he gained flesh very rapidly, and his mental improvement was equally marked. He proved to be a fastidious young man, whose disposition was happy and mental reflexes responsive. When discharged on August 28th he weighed 171 pounds, a gain of twenty-six pounds.

No. 3.

<table>
<thead>
<tr>
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<tbody>
<tr>
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</tr>
<tr>
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<td>147 &quot;</td>
</tr>
<tr>
<td>May 22, 1893</td>
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</tr>
<tr>
<td>May 29, 1893</td>
<td>145 &quot;</td>
</tr>
<tr>
<td>June 19, 1893</td>
<td>146 &quot;</td>
</tr>
<tr>
<td>June 26, 1893</td>
<td>147 &quot;</td>
</tr>
<tr>
<td>July 3, 1893</td>
<td>149 lbs.</td>
</tr>
<tr>
<td>July 10, 1893</td>
<td>150 &quot;</td>
</tr>
<tr>
<td>July 24, 1893</td>
<td>154 &quot;</td>
</tr>
<tr>
<td>Aug. 7, 1893</td>
<td>160 &quot;</td>
</tr>
<tr>
<td>Aug. 14, 1893</td>
<td>165 &quot;</td>
</tr>
<tr>
<td>Aug. 28, 1893</td>
<td>171 &quot;</td>
</tr>
</tbody>
</table>
4. Was admitted on February 15, 1893, aged fifty-three years. His father had senile dementia, his mother was afflicted with lateral sclerosis, and he has a cousin in the hospital. The subject of this note had been intemperate many years, and he had lost nearly seventy pounds in weight during the previous six months. He weighed 144 pounds. Amnesia was extreme, and delusions of identity marked. He did not know his age, nor did he have a correct idea of time or plan. No weight chart that I have examined corresponds more nearly with one that might be made of the mental state than this. Starting with a patient whose mental powers had been very much broken, who had rapidly lost flesh, the ascent of the weight line has invariably been accompanied by improvement in memory and a lifting of the cloud of dementia. When the weight line has been horizontal, or nearly so, the mental condition has appeared stationary.

No. 4.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Feb., 1893</td>
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</tr>
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<td>March, 1893</td>
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<td>May, 1893</td>
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<tr>
<td>June, 1893</td>
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<tr>
<td>July, 1893</td>
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<tr>
<td>Aug., 1893</td>
<td>163 lbs</td>
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<tr>
<td>Sept., 1893</td>
<td>165 lbs</td>
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<tr>
<td>Oct., 1893</td>
<td>169 lbs</td>
</tr>
<tr>
<td>Nov., 1893</td>
<td>174 lbs</td>
</tr>
<tr>
<td>Nov. 20, 1893</td>
<td>176 lbs</td>
</tr>
</tbody>
</table>

No. 5 is instructive, not only because a quick recovery occurred in connection with rapid increase in weight, but it is one of those cases not infrequently seen where if the delirium is not occasioned by narcotic drugs it disappears upon their withdrawal and the substitution of means to hasten elimination and to nourish the sys-

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* A. B. has just passed through my hands. One month before admission he had pneumonia. For three weeks he had been delirious and wakeful, had refused food and lost flesh rapidly (fully fifty pounds, so his wife stated). His tongue was dry and furred, his pupils were moderately dilated, and did not respond to light. He slid down in bed, and replied to questions in a slow, rambling manner.

The evidences of excessive drugging being marked, no medicine was given, save a laxative. His skin was stimulated to action by bathing, friction, etc. Animal broths were freely given. He slept none the first night, two hours the second night, and ten hours the next, after which he had no delusions. He made a good recovery, and was discharged thirteen days after admission.

The wife of this patient felt that he had been over-medicated (he had three doctors—one a neurologist), and voluntarily brought me a copy of the seventeen prescriptions she had filled, some over and over again. The druggist indicated those that had been regularly relied upon, by which it appeared that 900 grs. bromide potassium, 150 grs. chloral hydrate, 30 m. tr. belladonna, 15 m. tr. nux vomica, 10 m. tr. digitalis, had been given daily: in addition to the above, co. spts. ether, morphine, alone and combined with chloral and the bromides, sulfonul, iod. potassium, quinine, and strychnine had been administered irregularly. Blisters to the back of the neck had not been forgotten, as the prescriptions showed and a dirty ulcer proved.
tem. The patient, who had been under the care of a neurologist, was brought to the hospital in an ambulance. When admitted his pulse was ninety-four, weak, and dicrotic. His pupils, which were widely dilated, did not respond to light. His tongue was dry and furred, his lips were parched, and his teeth were covered with sordes. His speech was thick and incoherent. He could not stand, and he was put to bed immediately. He had rapidly lost flesh. Two months previous to his admission he had fallen on the ice and struck the back of his head, but there appeared to be no connection between this accident and his insanity, which had lasted about a week. He had had leeches applied behind the ears, followed by a succession of blisters; and internally bromide of potassium, iodide of potassium, calomel, cannabis indica, hyoscyamus, chloral, bichloride, atropine, and morphia had been given.

The insomnia had not only not been relieved, but the patient had slept little or none under increasing doses of powerful narcotics. How much food he had taken was hard to ascertain, but there was evidence that the amount was insignificant. All medicine of a sedative nature was withheld; three grains of calomel were given, and he got a free evacuation from it. He was sponged frequently, and egg-nog, chicken broth, and beef tea were given. Water was also liberally allowed. The first night he slept two hours, and when awake he was kept in bed by a nurse. Within twenty-four hours his tongue became moist and the delirium less active; but he slept none the second night. The following day, however, he got several short naps, and that night he slept six hours. He was given fully four quarts of milk, or its equivalent, every twenty-four hours, and on the third day he ate solid food. At this time his pupils were getting responsive, and he had only an occasional hallucination of sight, which he was able to correct. Four days after admission his mind was perfectly clear, and he was dressed and weighed, tipping the scales at 145 pounds. His mouth was now in good condition, his bowels continued regular, and indeed all his functions well performed. He was put upon a ferruginous tonic, and in six days he gained eight pounds, which was increased eight pounds the next week, reaching 162 pounds, where it remained a fortnight longer, when he was discharged.

No. 5.

<table>
<thead>
<tr>
<th>Date</th>
<th>Weight</th>
</tr>
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<tbody>
<tr>
<td>Feb. 21</td>
<td>145 lbs</td>
</tr>
<tr>
<td>Feb. 27</td>
<td>158 &quot;</td>
</tr>
<tr>
<td>March 6</td>
<td>162 &quot;</td>
</tr>
<tr>
<td>March 13</td>
<td>162 lbs</td>
</tr>
<tr>
<td>March 19</td>
<td>162 &quot;</td>
</tr>
</tbody>
</table>
No. 6 is a prosperous farmer who was admitted on April 16, 1892. Two years previous he had la grippe, subsequent to which he was under par, having a constant sense of tire. Two months previous to admission he had been anxious and worried over church matters, had slept badly and lost flesh. When admitted he was maniacal, and was brought to the hospital with his hands strapped. He was placed upon a generous diet and his bodily functions attended to. Though he almost immediately showed improvement physically, he was not able to be taken to the scales for two weeks, when he weighed 172 pounds, evidently considerably more than when admitted. Tonic treatment was kept up, and in another fortnight he weighed 179 pounds, at which time he was rapidly regaining his equilibrium. He was discharged recovered May 26th; he weighed 180 pounds. His condition has remained satisfactory.

No. 6.

May 1, 1892 .................. 172 lbs. May 22, 1892 .................. 179 lbs.
May 8, 1892 .................. 174 " May 26, 1892 .................. 180 "
May 15, 1892 .................. 179 "

No 7, a mechanic, was admitted to the hospital on May 30, 1893, suffering from melancholia, which had been active for the space of eight months. He had delusions of contamination and refused to eat. He was fed mechanically until September 17th. His weight line was steadily downward until early in September, when he began to eat fruit, at which time there were observed signs of mental improvement. He would smile and occasionally speak. After he took food voluntarily, and the use of the tube was stopped, there was rapid improvement, not only mentally but also physically; for a time he gained a pound a day. In December he had influenza, when his weight fell off four pounds, but there were no unusual mental symptoms. He continued to get fatter and made a good recovery. In five months he gained thirty-six pounds.

No. 7.

June 19, 1893 ............... 125 " Nov. 13, 1893 ............... 132 "
July 3, 1893 ............... 123 " Nov. 20, 1893 ............... 136 "
July 31, 1893 ............... 112 " Dec. 11, 1893 ............... 137 "
Aug. 28, 1893 ............... 112 " Jan. 1, 1894 ............... 133 "
Sept. 4, 1893 ............... 109 " Jan. 22, 1894 ............... 137 "
Sept. 18, 1893 ............... 114 " Jan. 29, 1894 ............... 143 "
Oct. 9, 1893 ............... 125 " Feb. 12, 1894 ............... 145 "
No 8 represents a patient sixty-five years of age, admitted on June 23, 1893, with melancholia, weighing 130 pounds. There was a previous history of overwork, worry, and neurasthenia. Improvement was prompt and corresponded to the bettered nutrition. He was well in six months after admission, but was permitted to make his quarters at the hospital while looking for a situation as accountant. There was a gain of 33½ pounds in weight.

No. 8.

<table>
<thead>
<tr>
<th>Date</th>
<th>Weight (lbs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 23, 1893</td>
<td>130</td>
</tr>
<tr>
<td>July 10, 1893</td>
<td>135</td>
</tr>
<tr>
<td>Aug. 7, 1893</td>
<td>140</td>
</tr>
<tr>
<td>Aug. 14, 1893</td>
<td>145</td>
</tr>
<tr>
<td>Sept. 4, 1893</td>
<td>150</td>
</tr>
<tr>
<td>Sept. 25, 1893</td>
<td>153</td>
</tr>
<tr>
<td>Nov. 1, 1893</td>
<td>162</td>
</tr>
<tr>
<td>Dec. 25, 1893</td>
<td>163½</td>
</tr>
<tr>
<td>Jan. 29, 1894</td>
<td>162</td>
</tr>
<tr>
<td>Feb. 5, 1894</td>
<td>161</td>
</tr>
</tbody>
</table>

No. 9, a law student, was admitted on July 8, 1893, in a condition of acute maniacal excitement of one month's duration, which had followed a period of depression. He was very disorderly: his mouth was parched, breath hot and offensive, and voluntary attention was weakened.

Stimulants were given, with sulfonal at night. He took food readily, and symptoms of exhaustion soon subsided. On July 24th he weighed 109 pounds. He passed through a very noisy and active excitement. In August he bruised his left fore-finger by pounding his hand against the wall, and it was necessary to amputate the same, which Dr. T. G. Morton, one of the surgeons of the hospital, did on September 24th. Except during the most painful period incident to this accident he steadily put on flesh, and early in October he began to have, first hours, and then days when his mania was not so great. When he had gained about twenty pounds in weight, his pupils became less widely dilated, and from this time on he improved rapidly in mind. During most of his excitement he was unwilling to take medicine, although remedies to regulate cerebral circulation were administered. As soon as he was well enough to cooperate, iron and arsenic were prescribed.

He had no delusions during the last two months of his hospital residence, and he slept from ten to fourteen hours every night. For a month before his discharge he frequently visited his home, sometimes remaining a day or more. In every respect the termination of his disorder was satisfactory. He gained thirty-six pounds.
No. 9.

July 24, 1893 .......... 109 lbs.
July 31, 1893 .......... 115 "
Aug. 7, 1893 .......... 116 "
Aug. 14, 1893 .......... 120 "
Aug. 28, 1893 .......... 121 "
Sept. 11, 1893 .......... 117 "
Oct. 18, 1893 .......... 125 "
Oct. 30, 1893 .......... 131 "
Nov. 6, 1893 .......... 134 "
Nov. 13, 1893 .......... 137 "
Nov. 20, 1893 .......... 140 "
Dec. 18, 1893 .......... 145 "
Jan. 1, 1894 .......... 145 "

No. 10, a young business man, was admitted July 23, 1893. One uncle has been insane and one brother drinks periodically. A year previous to his admission he had rheumatism, which was followed by depression with hallucinations of hearing. He spent a few weeks in Canada, and made some slight improvement. In April, 1893, hallucinations of hearing returned and he was taken on a trip to the Far West, which did not improve his condition; indeed, all his symptoms grew worse, he had many delusions, suffered distressing hallucinations and steadily lost weight. Upon admission he was dominated by the "voice of God," was unwilling to go out of doors, and would eat no meat; he was very anaemic and his hands were tremulous. His tendon reflexes were normal. Iron and arsenic were given and he was induced to eat fat-producing food; it was not, however, until the middle of November, 1893, that his delusions permitted him to take animal food. He ate many bananas. His general condition promptly improved; yet one week in September when he was very restless and agitated under his hallucinations and the delusions growing out of them, he lost six pounds in weight. He worked in the gymnasium and spent much time in the open air. After gaining thirty-five pounds, his hallucinations disappeared and he became tranquil and co-operative. His melancholy is lifting, and as I write he is a ruddy, athletic man, weighing 172 pounds, a gain of forty-two pounds in seven months.

No. 10.

Sept. 4, 1893 .......... 145 "
Sept. 18, 1893 .......... 146 "
Sept. 25, 1893 .......... 140 "
Oct. 9, 1893 .......... 156 "
Oct. 23, 1893 .......... 160 "
Nov. 13, 1893 .......... 165 "
Nov. 17, 1893, ate meat...
Nov. 20, 1893 .......... 166 lbs.
Dec. 4, 1893 .......... 167 "
Dec. 18, 1893 .......... 168 "
Jan. 8, 1894 .......... 169 "
Jan. 22, 1894 .......... 171 "
Feb. 12, 1894 .......... 172 "
Dec. 20, 1893 .......... 131 "
No. 11, a milk dealer, fifty-three years of age, weighed when admitted 160 pounds. Six months previous he had acute Bright's disease and was confined to the bed four weeks, following which he was exhausted and easily tired. For the space of three months he had been depressed and more recently suicidal. He was cheerful in a grim sort of a way and seemed to regard his apprehensions as matters to joke about. He imagined for many months that his head was going to be cut off, that those about would be hung or shot, or would meet some other violent death in the near future.

He was placed upon tonics and attention given to his food and to his excretory functions. He worked in the gymnasium and spent many hours daily in the sunlight, the endeavor being, of course, to divert his attention from himself as well as to improve his general health.

He responded physically and in ten months had gained forty pounds. In the late autumn of 1893 there was a remission in his delusions, and he slept soundly; then his condition was variable for a time; some days he was full of delusive ideas, while others he was rational and calm. He paid short visits to his home, and convalescence seemed hastened thereby. He was finally discharged well on January 24, 1894. It is of interest to know that while this patient gained satisfactorily in weight, and was strong and ruddy for many months before real improvement in his mental condition took place, and that while the number of red corpuscles was in excess of what is considered normal, the percentage of hæmoglobin remained low until near his discharge. The same condition obtained in other protracted cases some of which are not included in the accompanying tabulation, and it is to be hoped that in the examination of the blood we may have pointed out to us the indicated treatment in cases which now give so much trouble or become chronic.

No. 11.

<table>
<thead>
<tr>
<th>Date</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct. 26, 1892</td>
<td>160 lbs.</td>
</tr>
<tr>
<td>Nov. 28, 1892</td>
<td>165 lbs.</td>
</tr>
<tr>
<td>Jan. 1, 1893</td>
<td>160 lbs.</td>
</tr>
<tr>
<td>Feb. 6, 1893</td>
<td>175 lbs.</td>
</tr>
<tr>
<td>March 13, 1893</td>
<td>181 lbs.</td>
</tr>
<tr>
<td>April 1, 1893</td>
<td>185 lbs.</td>
</tr>
<tr>
<td>May 22, 1893</td>
<td>187 lbs.</td>
</tr>
<tr>
<td>June 26, 1893</td>
<td>190 lbs.</td>
</tr>
<tr>
<td>July 15, 1893</td>
<td>194 lbs.</td>
</tr>
<tr>
<td>Aug. 4, 1893</td>
<td>200 lbs.</td>
</tr>
<tr>
<td>Sept. 10, 1893</td>
<td>200 lbs.</td>
</tr>
<tr>
<td>Nov. 15, 1893</td>
<td>200 lbs.</td>
</tr>
<tr>
<td>Dec. 15, 1893</td>
<td>196 lbs.</td>
</tr>
<tr>
<td>Jan. 24, 1894</td>
<td>200 lbs.</td>
</tr>
</tbody>
</table>
In the cases referred to above the average duration of hospital treatment in those recovered, nine in number, was eight months and ten days, the shortest period being one month and two days, while one remained twenty months and twenty-seven days. In every instance it would seem from the history of the case and knowledge of the progress of the disorder as though insanity would not have occurred had appropriate treatment been begun when the first departure was made from the normal state physically, and, that opportunity having passed, the duration of the illness would have been shorter had greater attention been paid to metabolism before hospital aid was resorted to.

The average gain of weight was twenty-eight and a half pounds; of the recovered cases twenty-six pounds, which is near the average of a larger series of cases in which these are included.

There is no doubt but that our maniacal patients pass through their attack with less violent demonstration than was the case not many years ago, and that mechanical restraint is now seldom resorted to except for surgical reasons. Can the form of disease have changed in a decade? Is it not more probable that the lessening in the intensity of excitement is due to the greater attention paid to food in institutions for the insane?

While there may be other reasons for the apparent contentment and calmness of the English and Scotch asylum patients, the full diet of the people and the good table furnished in the establishments for the insane there should, I believe, be given much of the credit.

Cross the channel, and in Irish asylums one will witness a Babel never equaled in our hospitals even in the olden days.

If further illustrations are necessary to show the tranquilizing effects of food, one need only study the lower animals (who also set us good examples in sanitation), for they lie down and sleep after filling their stomachs. It is the fat ox that chews the cud of contentment, while the lean one bellows and breaks down the fences.

The lesson which it seems these tabulations and histories teach, is that, as mental disorder is usually attended with malnutrition, the prophylactic is in maintaining the system in the best possible condition; and, in treating acute insanity, nutrition should be improved in the most prompt manner. It is of course not claimed that all will get well, for some patients are inevitably incurable, but it is
believed that class which furnishes the recoveries will supply a greater number if the bodily functions are regulated and maintained at their highest degree of excellence.

**Discussion.**

Dr. C. B. Burr: I am sure we are all agreed that these papers are of great practical value. There is no other one question of so much importance, in my judgment, as the administration of food in insanity. That it has its influence in modifying mental excitement, in reducing turbulence, in promoting the comfort and order of our halls, I fully agree with Dr. Moulton.

One point in Dr. Josselyn's paper impressed me very much and that was the necessity for tactful management in the giving of food. As our experience increases, recourse to mechanical feeding is less and less common. While I cannot give a report like that of Dr. Searcy, I can say that there is a growing disposition with us to let patients go for a little time and not resort to mechanical feeding. The attendant and the physician by tactful management can overcome objections which patients have to taking food. I was very much pleased with the mention which the Doctor made of boiled eggs. I have had a similar experience;—that patients who are suspicious will take eggs that are boiled in the shell if they see them cooked. I have known others that would take potatoes which were baked without peeling. There are any number of expedients that one who is patient and careful may use to induce patients to accept food and through which the suspiciousness which arises from delusional ideas may be overcome.

I would like to ask Dr. Moulton if he has charts similar to those which he has exhibited for all his patients or for a large number.

Dr. Moulton: We keep a weekly record in a book and charts can be made from them. We weigh all of our recent patients once a week and the older patients once in two weeks.

Dr. C. B. Burr: The importance of these charts has impressed me. I have never seen the relation of mental improvement to increase in body weight so cleverly and nicely pointed out as through these charts. I agree with the Doctor that printed charts of this character might be kept with great advantage in hospital halls and in halls for recent cases. I congratulate the authors on their excellent papers.
Dr. H. A. Tomlinson: The two gentlemen who have spoken probably voice the sentiment of every one connected with the treatment of the insane, but they do not quite represent all the difficulties connected with feeding patients in large State hospitals; where the matter of food, the importance of its cooking and preparation, is not taken fully into consideration, and where as a matter of expense it is kept down as much as possible. This I have found, in my State institution experience, one of the greatest difficulties. Although I have been able to obtain a considerable degree of success by following out the method sketched by these gentlemen, yet, it seems to me that there is a great deal to be done in our large institutions which can only be done by stimulating public opinion to appreciate the importance of food. Our Board of Trustees and the public can appreciate the housing, keeping warm, and the feeding of healthy individuals, but they do not appreciate the feeding of the sick. They do not appreciate that it is an economic factor, and that if more attention were paid to the quality, preparation and serving of food, we would cure a larger number of our patients and do it more quickly.

I have in use a system similar to the one given, with regard to keeping track of the body weight, and I have been often astonished at the results which have been obtained. In some of our acute cases we weigh daily or twice a week.

There is another point suggested to me with regard to this, of which Dr. Cowles spoke this morning, and that is the advantage to be gained by increased intelligence amongst nurses, in carrying out proper plans for feeding the sick. The average young man or woman that we get has practically no knowledge whatever concerning food, except the eating of it. When they serve the patients they usually serve enough for a lumberman or coal heaver, and are surprised that they do not eat it. Of course the medical officer cannot always see this and the nurse, not being trained to appreciate the difference, does not know.

I would like to refer to one case which illustrates what Dr. Moulton has called attention to—a case of mania in a girl where the patient seemed hardly able to live from hour to hour. She came to us drugged intolerably, and it took nearly a week to get rid of the effects of the drug. Her pulse remained rapid, she was constantly delirious, cyanosis was present for a time every day. She was restless and tossed about day in and day out for
six weeks before there was the slightest sign of improvement. With persistent care in feeding, food being given with the nasal tube every two hours (because if we gave her a certain quantity she vomited), she finally improved and during the last four weeks in the hospital gained fifteen pounds and got well. I attribute her recovery to the care in feeding.

Dr. Russell: I would like to ask Doctors Josselyn and Moulton what is their opinion in regard to the relative nutritive value of different classes of food. For instance, in patients who refuse solid food, what is their opinion as to the relative nutritive value of say, milk and eggs and of animal broths that they have spoken of. Also to what extent have they used alcoholic stimulants in the treatment of these cases and with what results.

Dr. Josselyn: A preference is to be given for milk and eggs with cream, to animal broths and beef tea. In practice it is found that patients will take milk and continue to do so longer than they will take other forms of liquid food. There are, however, cases that will take and assimilate broths more readily. So long as the patient is doing well with milk, or milk and eggs, there need be no change.

The same rule applies to the administration of alcohol as in general medical practice. A tablespoonful of whiskey in a tumbler of egg and milk given three or four times a day to weak patients with a rapid, feeble pulse is of benefit. A great many of those cases are so suspicious that the odor and taste of liquor will cause them to refuse to take it for fear of poison. In a few exceptional cases the excitement is increased by stimulants.

Dr. Moulton: In regard to the administration of milk, there is less difficulty in giving it to patients than many suppose. A great many patients will say they cannot take milk, when upon trial they can take it freely, three or four quarts a day. There is some liability, though, of disturbing the digestion by giving milk continuously, and when the secretions are locked up, or a more stimulating food is desired, the animal broths seem to do better. I am using a milk tumbler devised by Dr. Morton of this city. It is graduated, having on it a scale showing when the milk is to be given, and opposite the number of spoonfuls at each time, so that you can regulate precisely what your patient should get.

Dr. Tomlinson: There ought not to be any difficulty in selecting food if one remembers that the carbohydrates produce force
and proteids produce tissue. One must be guided by the condition the patient is in, whether emaciated and weak, or more weak and less emaciated.

Dr. Fuller: It has been my duty the past three or four years to deal with an increased number of patients who refuse food, and we have gotten into the habit, and we see no reason to get out of it, of using liquid peptonoids, good milk and a little brandy. Patients come to us emaciated and prostrated. We wait upon them about two days and if they do not begin to eat we use the tube. I have been really surprised at the recovery of so many patients.
Memorial Notices.

JOSEPH WORKMAN, M. D.

By C. K. Clarke, M. D., Kingston, Ontario.

On April 15, 1894, Dr. Joseph Workman, one of the oldest and most eminent members of the American Medico-Psychological Society, died in Toronto, Canada.

Doctor Workman reached the age of eighty-nine, and had withdrawn from active work for so many years that he was not personally known to the younger members of our Association, but those who were fortunate enough to have met him must have been attracted and inspired by the intellectual force of the eminent alienist.

The Workman family has been an illustrious one in Canada, and the generation that has just lost its last representative made a reputation for ability and success quite remarkable.

Tradition says that the first of the Workmans went to Ireland with Cromwell, and shared in the confiscation of land that then took place, but little is known of the family until William III appeared. When William landed in Ireland he saw a comely woman carrying a handsome child. The child received marked attention from him, and was the first descendant of Cromwell’s trooper, that is well known.

About the time of the American Revolution, two brothers, Benjamin and Joseph Workman, emigrated to America and settled in Philadelphia. Both were schoolmasters, and Benjamin remained in Philadelphia, but Joseph returned to Ireland after the war was over. Joseph was now about thirty years of age, and opened a school near Lisburn. Soon he fell in love with one of his pupils, Catherine Gowdey, married her, and in the hamlet of Ballymacash raised their family of eight sons and one daughter. This Catherine Gowdey was endowed with wonderful vitality, both physically and mentally, and was active until her death at the wonderful age of one hundred and three. All of her family seem to have inherited her good health and lived far past the allotted threescore and ten years. The mother seeing little hope of her sons bettering themselves in Ireland was bent on pushing them on to Canada, to which country two of them emigrated, the parents and the others eventually following. At New Glasgow, in the county of Terrebonne, the “skirmishers”
were established. (Terrebonne—good land; they made a mistake that time), but a home was created and success came at last. Joseph Workman, the subject of this notice, was born at Ballymacash, 26th May, 1805, and began to practice medicine in Montreal.

In 1836 he removed to Toronto, where he soon made a name for himself. In the early days when Canada was passing through the throes of rebellion against the tyranny of the Family Compact, such a fiery spirit could not remain at rest, and Doctor Workman's reputation as a pungent and trenchant writer was soon established. However, his bent was in the direction of scientific work, and we soon find him lecturing in the Rolph School of Medicine.

In 1847, the fever year, he did heroic work in caring for thousands of unfortunates who suffered in the fever sheds.

In 1852 he took charge of Toronto Asylum. The condition of affairs existing in that institution at the time was deplorable, and the crude ideas affecting asylum management were repulsive indeed to a man of the culture and refinement of Doctor Workman. He bent himself to his task with determination, and for twenty-two years he gave himself to the work of helping the most unfortunate class in the community. Such success as this man achieved can come to very few, and yet no true man could be jealous of the high place that must be accorded him, so clearly was he entitled to his honors. His reputation was founded on good deeds performed in the interests of humanity. For months at a time he shut himself from the outside world, so great was his devotion to the cause in which his sympathies were enlisted. His personal influence on patients was wonderful, and truly it could be said that his asylum was built for the insane rather than the officers. As an alienist, Doctor Workman was well known the world over, and, as a result of his scientific work, was made an honorary member of medico-psychological societies in Britain and Italy. Gifted with a command of beautiful language, a wit keen as a Damascus blade, having a perfect grasp of a man's mental attitude, and a profound knowledge of science, it can be easily understood why he was "facile princeps" among witnesses in medico-legal cases.

In home life he was a model. No man could have been more loved in his family circle than he was.

His interest in young men was an admirable trait: he understood them and always inspired them to develop what was best. Those who were fortunate enough to have his intimate friendship were
blessed indeed. By the medical profession of Canada he was greatly beloved, and regarded as one of the leading intellectual forces in the scientific ranks. Even at his great age he was ever at work, and when physical infirmity left him unable to write, he still clung to his books with all the old love, and up to the day of his death the most recent medical literature was to be found on his table.

Such in brief is the history of one of the most eminent alienists America has had. His memory will long be cherished by those who knew and loved him, and his works will stand as a fitting monument for one who was so great and noble.

JOHN C. HALL, M. D.

By R. H. CHASE, M. D., Frankford, Philadelphia.

John C. Hall, M. D., late Superintendent of Friends’ Asylum for the Insane, at Frankford, Philadelphia, died at the asylum July 4, 1893, after a brief illness, leaving a wife, son and daughter. The immediate cause of his death was neuralgia of the heart. His general health had been for some time impaired, but it was benefited by a recent voyage to the Bermudas, from which he had returned apparently much improved by rest and change of scene.

John C. Hall was born near Harrisville, Ohio, March 12, 1843, of Quaker parentage. Carefully reared and instructed by religious parents, his early years were passed amid rural scenes, so conducive to the healthy development of sturdy manhood. At the age of twenty he left home to attend Westtown Boarding School, Pennsylvania. He gave evidence in his school-days, by his studies and general deportment, of the sterling traits which marked his character in after years. After completing his course at school in 1866, he engaged as clerk at the Friends’ Asylum for the Insane, Frankford, Philadelphia. Here his life-work was marked out in his mind and he determined to become a physician. Being of a studious turn of mind, he not only discharged in these years the duties of his office with satisfaction, but he found time out of hours to prosecute his medical studies. He attended lectures at the University of Pennsylvania, where, by diligence, he was graduated as Doctor of Medicine in 1868. Upon receiving his diploma he was appointed to the position of assistant physician in the Philadelphia Dispensary. In this ancient institution of medical charity, so rich in material for study to the young practitioner, he spent profitably
his first year as a physician. At the expiration of his dispensary service he was elected, in a competitive examination, one of the resident physicians of the Philadelphia Hospital. This service was not only of great benefit to him in after years from a medical standpoint, but the associations he then formed were of incalculable advantage to him; for among them were young men who subsequently ranked high in the profession, and a few like himself who attained eminence; some of these proved life-long friends and associates. The combined length of his dispensary and hospital experience comprised nearly two and a half years. This course of study and practice is exceedingly fruitful to a young man, and is generally regarded as equivalent in experience to ten years of private practice. In 1870, thus trained and equipped, Doctor Hall settled in Frankford, engaging in the general practice of medicine. Shortly after becoming established in private practice, he received the much coveted appointments of visiting surgeon to both the Jewish and Episcopal hospitals, the most prominent institutions of the kind in the northern section of the city.

He married, on October 7, 1875, Mary H., daughter of William R. and Sarah H. Dutton. His married life was a most congenial one. The loving sympathy and efficient aid of his wife, who was truly a helpmeet to him, contributed in no small measure to his success in life.

During these years of private practice, Doctor Hall had not lost interest in Friends' Asylum, but frequently came to visit the superintendent, Dr. Joseph H. Worthington, with whom he was on terms of intimate friendship. The asylum having grown in the course of years to require additional medical aid by the increase of its staff, Doctor Hall was appointed, in April, 1876, as assistant physician, being the first to occupy such a position in the history of the institution. In the latter part of the following year, upon the resignation of Doctor Worthington, he succeeded him as superintendent and physician-in-chief, which position he held, for a period of sixteen years, until his death.

He was a member of the Society of Friends, and, also, a member of prominent medical and scientific societies, among which may be mentioned: The American Medico-Psychological Association, the Philadelphia College of Physicians, the American Medical Association, the Philadelphia County Medical Society, the Philadelphia Neurological Society, the Pennsylvania Historical Society, and the Art Club of Philadelphia.
Doctor Hall's professional reputation rests largely on his long and able management of Friends' Asylum for the Insane. His career, therefore, while unattended with remarkable incidents, was exceptionally successful. In connection with the care and treatment of the insane, to which his life had been devoted, and as the honored head of an institution of high rank, he became widely known in the medical profession throughout the country. His work in connection with Friends' Asylum was of a progressive nature. In no period of its history has the institution shown such material progress, and to his energies and judgment are due much of its present prosperity. During his administration the asylum has been greatly improved and expanded in many ways. He was fully alive to the best interests of his patients. Every plan that has been devised to promote either the comfort or the cure of the insane, he earnestly sought for his patients, and expense was not spared to surround them with everything needful that the age has suggested for their alleviation. For a number of years he successfully conducted a branch home in connection with the asylum at the seashore, which met with much commendation, and it was among the first departures of the kind instituted for convalescents.

Recognizing the importance of physical exercise and occupation in the treatment of the insane, he turned his thoughts to devise means to furnish the patients under his care with proper appliances. As a result the fine gymnasium building, the generous gift of a benevolent friend, was erected, containing on the second floor a large and well appointed gymnasium for the use of both sexes, and on the first floor special rooms for art and manual training. These ample provisions were supplemented by other features to occupy and amuse the patients. The more important work, just previous to his death, was the erection of a detached cottage for the excitable women patients, and this was just completed at his death. This building is connected with the main one by a tunnel, and is planned and fitted up in accordance with the latest views, and represents the best methods in the treatment of this class of the insane.

For a long time the demands upon his strength were excessive, and it is probable that his failing health was mainly due to his great industry and unremitting application, fired with a zeal that granted no time for rest or recreation.

Doctor Hall's character was well rounded, giving evidence of the highest and noblest traits. In place of great brilliancy, his
mind was characterized more for good common sense, judgment, and rare discernment of human nature. In his dealings with men he was always actuated by the purest motives, and his sense of honor was keen. He was a true friend to those who gained his respect and esteem, and his frank, open nature and cordial manner easily drew men to him. His position gave him many opportunities for doing good, which he prized, and there are many who can bear witness to his generous bounty. The affectionate regard in which he was alike held by his patients and subordinates at once attest the excellent qualities of his heart which bound them to him. Trained in a life school, where it is said, "the insane might see that they were regarded as men and brethren," his sympathies for the afflicted became ever more full and deep, as they were always the objects of his most earnest and solicitous care. It could be truly said of him that he was wise, generous, and just.

EDWARD CARRINGTON FISHER, M. D.

By F. T. Fuller, M. D., Raleigh, N. C.

Edward Carrington Fisher was born in Richmond, Va., in 1809, and died in 1890, having lived eighty-one years, threescore of which had been devoted to the relief and amelioration of stricken and suffering humanity. His career as a physician was begun in Richmond, from which place he went to Staunton, becoming assistant physician in the Western Lunatic Asylum there, under Doctor Stribling.

When the State of North Carolina began to make provision for the care of the insane, he was appointed superintendent of construction of the asylum buildings, and accepted the appointment September 15, 1853, to take effect on the first day of October following. When he assumed supervision of construction the massive stone foundations of the main building had been laid, and the walls of the central portion and north wing had been completed and covered. The main structure was completed under his direction, and while the original plans did not permit all that might have been desired in the finished edifice architecturally, it embodied the main features most to be desired in a hospital building, viz., sunlight and ventilation, and on the whole proved to be one of the best equipped institutions of the kind in this country. Throughout the progress of construction the work of Doctor
Fisher was characterized by prudent economy, conscientious care, and eminent faithfulness to the duties of his position.

On October 1, 1855, he was elected physician and superintendent of the North Carolina Insane Asylum, and accepted the position. The first patient was admitted, by him, to the Asylum on February 22, 1856, and was soon after discharged as cured. He held the position till July 7, 1868—the period of "Reconstruction," when he was displaced, from political motives, by the Republican party. He returned to Virginia, and about 1871 again became connected with the lunatic asylum there. The "Reconstruction" turmoil, which agitated Virginia in 1881, again removed him from his active life work, but he was restored to his place in 1884, and remained there until his death.

Through all the changes which occurred during the time from which he began his work as an alienist till his work was done, his peculiar fitness and ability for treating the mind diseased were acknowledged, and it was only through political myopia that his public work for unfortunate humanity was interrupted. The interruptions, however, were not of long duration, and the value and effectiveness of his ministrations as an alienist are emphasized by the fact that each interruption was soon followed by his recall to that particular work. And to that work—indeed to all work which came before him—he gave his best physical and mental energies. Being turned out from the North Carolina asylum in 1868, he went to a farm to make provision for his household and spent two and a half years thereon, faithfully and earnestly endeavoring to meet and bear the responsibilities which came with that period of turmoil and irregularity; and in the earnest efforts to support his family he worked till he swooned in the field and was helped up and revived by a passing physician who saw him fall.

He was the pioneer of the work for the insane in North Carolina, and there is no sadder chapter in the history of that work than his displacement, which lost to the State the work of a fine mind, a thoroughly earnest and competent alienist and Christian philosopher. He identified himself with all the interests of the asylums, with which he had connection, with skill and sagacity and a conscientious fidelity in the discharge of every duty involved, which secured for him and for those committed to his care the happiest results. Tempering all his actions with the gentle graces of a Christian, his courteous and dignified bearing and kindly manner gave him a delightful charm as a companion.
MEMORIAL NOTICES.

It would be an injustice to the memory of Doctor Fisher to say that he was "celebrated;" nor was he "eminent," as those terms are understood by the world. It is not risking anything to say that whatever ambition he may have had inspired him only in the direction of accomplishing happy results. This achieved, there was no announcement from him as to what had been done save in the communication of methods of treatment to the profession. He was too modest, too loving and sympathetic, too devoted to his work for the unfortunate to be celebrated, except among those who saw and knew how he worked with his heart and soul in the effort to restore reason and rekindle the noble light of intelligence to the darkened mind and soul. His whole nature was compounded of sympathy and kindness, and he quickly became established in the affections of those to whom he was related as physician, and he made strong and lasting friendships by the sympathetic tone of his letters in reply to the anxious inquiries of friends. There was no more humane and skilful alienist in the whole country. No one ever accepted his duties with more earnest and faithful effort to perform them. His life was one of long usefulness—bright, noble and blameless.

ALEXANDER NELLIS, JR., M. D.

By J. M. Mosher, M. D., Ogdensburg.

Alexander Nellis, Jr., first assistant physician of the Willard State Hospital, Willard, N. Y., died at the hospital December 27, 1893. He suffered an attack of epidemic influenza, complicated by pneumonia, and resulting in early and extreme prostration. Within a few hours he became delirious and unconscious, and so continued at intervals for five days preceding the fatal termination. Dr. Nellis was born at Schenectady, N. Y., February 11, 1846. He received his preliminary education in the common schools of Amsterdam and at Eastman's Business College, Poughkeepsie. In 1870 he registered in the office of Doctors Snell and Robb of Amsterdam, and in December, 1872, graduated from the Albany Medical College. For nine months after graduation he served as assistant city physician in the Albany City and County Almhouse and Asylum, and in October, 1873, was appointed assistant physician at the Willard State Hospital, then known as the Willard Asylum. He remained at Willard until May, 1880, when he resigned and took an extended journey through the West and
Southwest, finally locating in Denver, Colo. Having received the appointment of surgeon to the Mexican National Railway, then in process of construction, he left Denver and removed to Corpus Christi, the headquarters of the railroad, and afterward went to Laredo, on the Rio Grande. He spent a year on the frontier and saw much of Mexican life. He was called home by the serious illness of his brother, and in March, 1883, was reappointed assistant physician at Willard. In April, 1889, he was promoted to be first assistant physician. In October of the same year he married Miss Mary E. Meddick of Ovid, who survives him.

He was a member of the Montgomery and Seneca County Medical societies, and president of the latter in 1885. In 1891 he was made a delegate to the Medical Society of the State of New York, and at the time of his death was eligible to permanent membership. He was an active member of the American Medico-Psychological Association, and, in 1889, he was Vice-President of the Alumni Association of the Albany Medical College. His published contributions are:


Presidential address, Seneca County Medical Society, "Insanity and its Treatment," published by request of the society, June, 1887.


He also assisted in the compilation of the general index of the the first forty-five volumes of the *American Journal of Insanity*, published at Willard in 1889.

Doctor Nellis entered the service of the Willard State Hospital four years after the institution entered upon its active work. He was a witness of its growth and an active agent in its development. He entered fully into the sentiment of charity and humanity underlying the practical administration of its affairs, and was always aggressive and loyal in its behalf. He was conscientious and studious in his profession, and tolerant to a high degree of the vagaries of his patients.

The annual reports make repeated complimentary reference to his work, and to his especial efforts to procure amusement and diversion for the patients, involving labor beyond the actual requirements of his position. He served long and faithfully, and lived and died in the spirit of the motto above his desk:

"They serve God well who serve his creatures."
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