SOME PRACTICAL NOTES
ON THE
Symptoms, Treatment, and Medico-Legal Aspects
OF
INSANITY.

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SOME PRACTICAL HINTS ON THE
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In the preparation of the following notes, on some of the principal causes, leading symptoms, and treatment of insanity, and some of its leading complications, as well as on certain medico-legal topics incident to the subject, I have endeavoured to keep one main object in view, viz., to deal generally with such practical matters as may be of service to medical men engaged in practice, whose opportunities for observing and treating this disease, are, as a rule, few and fitful. I have, therefore, not attempted to give a simple epitome of the malady, but have selected certain points that appeared to me the most worthy, from a practical point of view, to bring under your notice.

It is much to be regretted that examining boards pay so little attention to the subject of insanity. It is certainly a great anomaly, that while ordinary cerebral diseases and their sequelæ, frequently, and very properly, furnish themes for examination questions; as soon as their importance is increased by the addition of symptoms of mental disturbance, the subject is almost ignored in the general pass examinations. I know of nothing more fraught with anxiety to a medical man, than to be hastily summoned to attend a case of acute insanity, (no other practitioner probably being at hand, with whom to divide the responsibility), the family in their trouble, looking up to him for aid, professional and lay, unless he possesses some knowledge of the distressful malady he is called upon to treat.

* The following extracts are transcribed from minutes of evidence taken by a committee of the London Council, appointed to report on a special hospital for the insane (1869).

SIR JOHN BANKS.—"It frequently happens that a man may be called upon to determine what may be a matter of life and death, or which may involve a large amount of property, and yet he may have never seen an insane person before."

DR. FERRIER.—"Students . . . are turned out into the world to practice their profession, and to deal with insane people, without, perhaps, ever having seen a lunatic."

PROFESSOR MARSHALL.—At present it is of course quite possible for an inexperienced junior medical man to be called upon suddenly to see a case of insanity, and thereupon to give a certificate which carries most formidable consequences with it; and I have had under my own observation instances of such junior practitioners really being at a loss to know what to do."
Let me urge the employment of the term insanity instead of lunacy—the latter, as perpetuating the ideas of the influence of the moon on the disease, should be consigned to the limbo of the past.

What is insanity? what is its definition? are questions more easily asked than answered, and yet they are occasionally put to medical men in law courts. The wisest have failed to give a satisfactory definition; and the more prudent course is simply to describe the symptoms of the disease instead. All definitions that I have seen, either include other states than those recognised as insanity, or they exclude some of its forms. The latest treatise on the subject omits a definition, and for the simple reason that "no standard of insanity as fixed by nature can under any circumstances be considered definitely to exist." (Dr. Savage, Insanity. 1886. 1.) The same acts may be evidence of sanity in one individual, and of insanity in another. "Insanity is a relative term."

Practically, the medical man has to treat one of two distinct conditions: 1. Mental disturbance. 2. Mental deficiency. Of these, the first named is by far the more important, and its great characteristic is change. Change from a previous condition. Change in the character, conversation, affections, habits, &c., singly or combined; implying corresponding changes in the nervous centres, and evidencing the presence of cerebral disease, or disorder. Either the intellectual faculties, or the emotions, or both, display some marked alteration from their previous state, when the individual was looked upon as sane and in his right mind. This will be noticed to include hypochondriasis; a disease included under insanity by some foreign authors. Although not so classed in England, it is but a slight remove from ordinary insanity.

Active insanity is usually a disease of maturity, Passive that of decay. Although cases of the acute form of disease frequently occur, and are sudden in their onset, the large class that come under notice in ordinary medical practice, are chronic cases, often extremely slow in progress, and of long continuance before the real nature of the malady is recognised, or owned by the family. These are apt to prove the bête noire of medical men in medico-legal cases, on being examined as to the probable period when the patient first

The medical witnesses complained of the want of clinical instruction in insanity. But the fault lies at the door of examining boards, who ignore the subject. Students are not likely to submit voluntarily to a course of instruction upon a speciality which would entail extra work. If insanity was included in the medical examinations, and a course of lectures on the subject, and clinical instruction for a set period were required, with inspectors to report from time to time how this was carried out, there should be no difficulty.
showed symptoms of mental disturbance, and ceased to be a responsible agent.

I pass on to consider some of the causes of the malady. As in other diseases, they may be predisposing or exciting: the same cause frequently operating as both. It may be laid down as an axiom, that anything which affects the nervous centres, may prove a factor of insanity; whether such disturbing influences be cerebral or centric, or reside in some other part of the body (eccentric.)

The number of causes of both physical and psychical character is multifarious enough. I propose limiting my remarks to three of the number, and at the same time, to call attention to some of the special forms of insanity incident to them.

I.—Hereditary.—By far the most important of all the predisposing causes. Its influence is shown in several ways. 1st.—The progeny of parents who have had insanity—those who possess the insane temperament, as it has been termed—not only have a far greater tendency to that malady than other people possess, but the attack is brought on from slighter causes. 2nd.—The disease is more likely to recur. 3rd.—The symptoms are often anomalous, or modified in character, as compared with the disease in those who have no such hereditary bias.

It is of especial importance to the medical attendant to be aware of the presence of this family weakness, as, more especially among the higher classes, he may have to act as the fidus achates in giving an opinion on questions of marriage; insanity, or a tendency to it, frequently operating as a direct bar to such alliance. In such an enquiry upon which an opinion is to be founded, it is not necessary simply to ascertain whether actual insanity has displayed itself, but also whether there be a neurotic disposition—exaggerated hysteria or hypochondriasis, epilepsy, idiocy, imbecility, moral perversion, great eccentricity, criminal propensities, &c., as it is certain that such disorders may be but phases of the tendency to cerebral disturbance, any of which may alternate with insanity, or merge into it. Interested relatives will frequently deny the existence of any such family failing as the presence of, or, a tendency to, insanity among their number; and yet, with apparent inconsistency, will acknowledge, under a species of cross-examination, the existence of many of its symptoms, notably of delusions, which are excused by them as "fancies."

This disease often shows itself at the same period of life as in the parent. A medical man attending one of his married patients in her confinement, and aware that the mother had been the subject of puerperal mania, would fail in his duty if he ignored the great tendency of the daughter
to the disease, and neglected to take precautions accordingly. The suicidal propensity especially is remarkably hereditary—Haydon, the artist, destroyed himself at the age of 61, his son at 65.

In medico-legal investigations, especially in murder cases, the question of hereditary predisposition is of the gravest importance.

II.—Intemperance.—This is undoubtedly a powerful factor in the causation of this disease, but not to the extent that some ardent advocates of teetotalism would lead us to believe. My friend, the late Dr. Bacon, of the Cambridge County Asylum, made a rigid investigation into the causes of insanity in a large number of cases received there, and ascertained that 14 per cent. was due to intemperance. Intemperate habits, however, produce mischief enough without the special pleader adding to the burden. In addition to the various diseases of the abdominal organs and lithic affections, they are associated with the following different phases of mental disturbance:

1st.—Acute Mania; occurring not so much from regular habits of intemperance as from occasional debauches. Soldiers, Sailors, and Travellers are very liable to it, partly owing to the comparative condition of freedom on their return home, and consequent relief from present anxiety, as well as from the warm but mistaken kindness of relatives.

2nd.—Dipsomania.—This is one of the most intractable diseases with which I am acquainted, and I may take this opportunity of making a few remarks upon it. The public generally, lawyers, and many medical men are apt to regard it as another name for ordinary drunkenness. If a medical man does so, he commits a very grave error. Drunkenness may be regarded as a bad habit, in which the person cannot refrain from drinking immoderately of intoxicating liquors, when he has the chance of doing so (especially among the lower classes) the pleasure being derived from the pleasant taste of the liquor, its exhilarating effects, and the so-called “good companionship” accompanying it. In dipsomania it is a very different thing—there is an intense craving for drink, but it is for drink of any kind, whether pleasurable to the palate or not. If wine, beer, or other ordinary intoxicants are not obtainable, then ammonia, ether, medical tinctures of any kind are largely drunk, and even the spirit in which anatomical preparations have been immersed, has been known to be used—a powerful evidence of the terrible craving that must exist. It is this “irresistibility” that characterises this disease. It is generally paroxysmal, and differs from habitual drunkenness, in the patient being frequently able to carry on his business or profession (and I have known medical men to be the subjects of it) without this were-wolf of
diseased practice being suspected. It is frequently hereditary. I have known a mother and several of her sons so affected. It is a form of mental disorder, kept up apparently by the peculiar condition of the stomach. I am not aware whether the pathological state of this organ in dipsomania has been satisfactorily investigated, but I should expect to find it injected, with much change in the character of the mucous membrane.

In one very aggravated case I noticed that between the paroxysmal attacks, the patient partook of large quantities of soda water and other diluents, apparently to allay the irritation of the stomach and the attendant craving. So long as the patient abstained from intoxicants he was all right, but one glass of beer or of wine, was quite sufficient to bring on the graver symptoms. In the interval the patient often deplores this unfortunate tendency and promises amendment, but strive as he will, the craving always gets the upper hand. The progress as to recovery is most unfavourable, although life in some cases does not appear to be materially shortened by it. During the attack the amount of moral perversity is exceedingly great, any lie or mean action being employed to obtain drink.

3rd.—Delirium Tremens.
4th.—Chronic Insanity.
5th.—Early decay of the Mental Powers. Not simply in their failure at an earlier age than usual, but in their becoming blunted and obtuse, so often seen in the habitual drunkard, and in those who are constantly in the habit of taking "nips" of intoxicating agents.

There are two other important aspects of intemperance which must not be overlooked:

1st.—The children of drunkards are often weakminded or idiotic. I have known several children of the same mothers to be idiots, where, excepting for the intemperate habits of one of them, both parents were healthy.

2nd.—The intemperance may be a consequence of the insanity, and not the cause—an instance of post hoc instead of propter hoc—and the medical attendant may have to decide which, especially when it is borne in mind that it is to some extent a comfort to the relatives to know, that the habit has been induced by the cerebral mischief.

III. Sexual Causes. Masturbation or self-abuse in the male sex is exceedingly common, as medical practitioners well know, although it is often denied by the head masters of large schools—who are usually very little acquainted with the social life of their scholars—but the fact remains, that it is in large schools where it is probably practised more than any where else. One headmaster whom I knew well, recognised its importance, and because he did so, was, I believe, the
means of inducing those of his scholars who practised it, to give it up. I entertain the opinion that it is not only extremely prejudicial to the brain development of the young scholar, and in many ways warps his energies; but that it is in many instances a powerful factor of insanity, acting both as a predisposing and an exciting cause, to a much greater extent than is usually admitted by specialists. True, the habit may be continued through the whole of an unusually long life without apparent harm, but this is no criterion to go by. When the patient commences this practice in early life, where there is a great loss of nervous power, and especially when there is an insane inheritance, insanity is likely to result from it.

Many times in my life I have been consulted by a parent about his son, aged from 13 to 18, owing to a convulsive attack of an epileptic character, in which there had been no previous indication of any such tendency. In such cases I have almost invariably found the attacks to be due to masturbation, the convulsive seizure being apparently due to an anaemic condition of the brain, and loss of nervous power. Although the habit will perhaps be strenuously denied before the father, it is generally admitted when the boy is examined by himself. In this stage a medical man can generally render much benefit to the patient. The shame of being found out, and the dread of his parents being made aware of it, with the good advice given, will, in many cases, be sufficient. An occasional aperient, plenty of manual exercise, alkalies if the urine be at all acid, cold hip baths and mineral tonics if the physical condition be below par, are all likely to be of benefit. In a few cases where I wished to make a stronger impression on the mind of the patient, I have taken him into one of the Asylum wards, and showed him one or two abject cases of chronic incurable insanity, brought on by this practice—a sight, that has on several occasions, made beneficial and lasting impressions.

If the habit increases and the sense of shame be in abeyance, the patient generally assumes a condition of fatuity, with occasional attacks of excitement and violence towards the members of his family—in some cases he has suicidal impulses,—the expression becomes imbecile, the face downcast, movements sluggish, and the eyes dull and averted—occasional attacks of epilepsy intervene. Under these circumstances the prognosis is a very unfavourable one as to recovery. Remedies in the majority of cases are of little avail. Blistering the prepuce is occasionally beneficial, but I have known the practice continued despite the blistering. Out-door exercise and work, and preventing solitary habits, are most likely to be of service.

I may remark that it is a common accompaniment or
consequence of insanity, especially in mania and epilepsy.

3rd.—Another sexual affection in the male may be here noticed—one termed by Dr. Savage, Sexual Hypochondriasis where a man without the slightest reason, believes himself to be impotent and that he has spermatorrhœa. He usually reads all the literature he can get upon the subject, and falls a prey to advertising quacks. It is likely to lapse into acute melancholia with strong suicidal tendency. These cases are very difficult to treat. The great object of the medical man in such a case should be to endeavour to prevent the patient from directing all his thoughts to himself,—plenty of good food, travelling, &c.

4th.—In the female, the influence of sex in operating to produce insanity, is more strongly marked than in the male. In the progress of her career there are several occasions when great physical and emotional disturbance take place, commencing with puberty; followed by the pregnant condition, delivery and lactation, and finally the climacteric period. In all these states the constitutional disturbance is very great, and renders the female especially liable to cerebral disturbance, especially if there be any hereditary predisposition. As if to act as a kind of counterbalance, the attacks, excepting those that occur at the climacteric period, are usually curable. Amenorrhœa is very common in insanity, especially in melancholia. The restoration of the menstrual function is attended in a large proportion of cases with improvement in, or recovery from, the mental alienation. In addition to the ordinary treatment by tonics and emmenagogues, warm hip baths containing a little mustard may be continued for several nights, about the time of the menstrual period, with much benefit. As an emmenagogue, much benefit may be derived in such cases from the administration of permanganate of potash, gr. i. increased to gr. ii. three times daily.

Insanity is more frequent during or subsequent to delivery than during the pregnant condition. The form of the malady does not differ from that in ordinary cases. Melancholia is more frequent in the period preceding childbirth. The labour is usually natural, and unmarked by anything calculated to give rise to the mental disturbance. Inheritance is a powerful predisposing cause. Except after injudicious drugging to procure sleep and quietude, the disease is generally curable, but is likely to recur, and with graver symptoms, at each birth. Dr. Savage has pointed out the great importance of precautions being taken in a transient form of this disease (and one very amenable to treatment), to prevent the mother killing her child. It is advisable for the medical attendant to inform some near relative of the family, of the probability of such an attack taking place, when from hereditary or other causes it is likely
to occur, thereby lessening his own responsibility, and showing that he is fully alive to the exigencies of the case.

The forms of insanity may be thus briefly tabulated:

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<tr>
<th>Perversion of intellectual faculties</th>
<th>With excitement</th>
<th>1. Mania.</th>
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<td>Loss of mental power (including acquired imbecility)</td>
<td>...</td>
<td>3. Moral Insanity</td>
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<td>Congenial deficiency (Amentia)</td>
<td>...</td>
<td>4. Dementia</td>
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<td>5. Idiocy.</td>
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<td>6. Imbecility.</td>
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This table is not a perfect one, but it is simple, convenient and practical.

All the forms, excepting the last two, may be acute or chronic, intermittent (recurrent), remittent, or continuous. There are many varieties of each, depending usually upon the causes. There are also certain complications, two of which require special notice, viz.:—epilepsy and general paralysis.

Altho' mania and melancholia are classed as different diseases, there is a growing tendency to regard them as one and the same. The symptoms of cerebral disturbance frequently commence with one form and pass into the other; and the two not infrequently alternate, a maniacal condition giving place to a melancholic one. Time will not permit of my giving details of the symptoms, suffice it to say that change in the conversation, and in the demeanour characterise both forms. In one, restlessness and excitement are the salient features, and general depression in the other. In both there is great sense perversion, as exhibited in the hallucinations and delusions, or in extreme incoherence. The temperature is not much influenced, except in the form known as acute delirious mania, a very dangerous variant. Habits often become dirty and destructive. Sleeplessness is characteristic, and will be almost invariably found to precede the acute symptoms—this in itself should be a hint to a medical practitioner, especially if he be aware that the patient has had a previous attack, or has an hereditary predisposition. The secretions are disordered, and hence constipated bowels, and arrest of the menstrual function, are very common. The old physicians thought that the odor of the insane was a pathognomonic sign. It is not now considered to be special to the disease, but rather to be deemed as an evidence of want of cleanliness, to be remedied by proper nursing arrangements. There can, however, be no doubt, that in the latter stages of general paralysis, a powerful animal odor is often apparent. There is great defect in nutrition. The appetite may be ravenous, or there may be indifference to, or a total refusal of food—the latter being very common in melancholia. Both may pass from the acute into the chronic stage, or the
symptoms may be ingravescent without having any acute period. The delusions gradually become more fixed, and in melancholia they more frequently relate to the patient's own condition. Some of the worst cases are those of despair, where from some fancied unpardonable sin, or from being the cause of ruin to others, they feel themselves irrevocably lost; a condition pictured by Goethe in Faust:—

"My peace is vanished, my heart is sore,
I shall find it never, and never more."

Hypochondriasis and disease of the abdominal organs are common in melancholia, and influence the character of the delusions.

The great principle to recognise in the treatment of the disease is that it is one of debility; and in every case the following objects have to be kept in view:—

1st.—To allay the excitement in mania; to relieve the depression in melancholia.
2nd.—To promote the secretions.
3rd.—To procure sleep.
4th.—To keep up the bodily powers.

When a case of acute disease is admitted into an asylum, the very first proceeding is usually to administer a warm bath at 96° to 98°, and if the skin be dense and dirty, as it generally is, to soap the body well. An immersion of five minutes for the first time is sufficient. If there be much heat of scalp, tepid water poured over the head (so done as not to frighten the patient), is often appreciated. If the patient is too weak for this to be effected, then the whole body should be cleansed while in bed, a macintosh sheet being first placed on the latter.

While in the bath, or in bed, the abdomen is carefully examined, and in the majority of cases, the bowels, especially the colon, are usually ascertained to be loaded with feces. If this be not the case to any great extent, an ordinary warm aperient is given. The majority need a good deal more than this: a much stronger aperient, as some Calomel followed by some Salts and Senna; or, what is better, 1 ounce of Castor Oil, with a drop of Croton Oil diffused through it, followed 2 hours afterwards by a copious warm Enema, containing plenty of Oil, and injected as far up the rectum as possible. It is surprising to witness, in many cases, the large amount of scybalous matter that comes away, especially if the patient be treated at home for a few days, and the cause is usually not far to seek. The condition of the bowels is apt to receive less attention, than the attempt to allay excitement by drugs, with the common result that constipation is increased, the secretions are more locked up, and the cerebral disturbance is aggravated.

The patient is put to bed, or on some mattresses covering
the floor of a small room if he be very restless, and food is administered to him, a short time—say an hour—after the aperient has been taken. This consists of beef tea or thickened soup, warm milk, containing a beaten-up egg, &c., repeated every two or three hours, and varied at each time. Quietness in all the surroundings is carried out as far as possible, the room is darkened, and only one person allowed in or at the door of it. All these means are very simple, and combined, they act as powerful alleviators both of excitement and of depression, and dispose the patient to sleep. Many Asylum cases (especially of mania) require no other treatment, nor does there appear to be any insuperable difficulty to carry out this practice in a private residence.

It may be laid down as an axiom, that until the bowels have been relieved, and the secreting organs are beginning to perform their functions properly, it is not safe to administer hypnotics of any kind.

The difficulties in the home treatment of an acute case are undoubtedly very great. Unless with a trained attendant, the directions of the medical man are apt to be carried out very imperfectly; the presence of sympathising relations (or even hearing their voices) are bad surroundings for the patient at such a time. Moreover, the patient's own sense impressions are likely to be fed by the sight of objects, that have been so long familiar to him.

Unless therefore, the treatment at home offers unusually favourable facilities, it is the plain duty of the medical man to urge immediate removal to an Asylum in all acute cases. He should point out to the relations that the disease is acute, and most probably curable, but that every day's delay diminishes the prospect of recovery. If they refuse to act upon his advice, then the whole responsibility of the case, whether it has a fatal termination, or lapses into the chronic form of the malady, will rest with them.

In the case of acute mania, consent is generally given for such removal without much urging; but it is otherwise when the patient has acute melancholia, the relatives cannot realise the case to be one of actual insanity, and too often withhold their sanction until it be too late for treatment, either in or out of an Asylum, to be of any service.

But even if removal to an Asylum be assented to, there is frequently a good deal of delay before it is effected. Communicating with the Asylum Authorities, getting the certificates properly made out (often a difficulty about the second certificate), and the consent of some important member of the family, all take time; and there is customarily the suggestion made by some relative at the last moment, of waiting "until to-morrow" to see how the patient is. During all this time the medical man is responsible for the case, and
he should endeavour to commence the treatment of the patient on the lines I have laid down. Occasional bathing and affusion to the head, keeping the bowels gently moved, and the administration of plenty of liquid food, being the principal points to bear in mind. Whether stimulants should be allowed is a matter that must rest with the medical man himself; personally I recommend them at the outset, and until the physical state of the patient has improved.

The question of the administration of hypnotics is a serious one. If the first principles of treatment to which I have adverted, have been attended to, and excitement is not calmed, or sleeplessness continues, then is the time for hypnotics. It must not be overlooked that a good warm basin of fluid nourishment, a tumbler of hot negus, mulled wine or egg flip, or of porter, frequently produces sleep when other measures may not be successful—the feeling of warmth and comfort engendered often acts like a charm.

If drugs are necessary, there is a certain fashion in selecting one. Opium has almost gone out of use, very undeservedly in my estimation, especially in certain classes of cases. Chloral gr. xx. or gr. xxx., combined with Tinct Hyoscyamus 3i-3ss, and repeated once 3 hours afterwards if required. By itself, Chloral acts as a simple hypnotic: an excited patient going to sleep under its effect, and waking to renew his excitement, apparently just at the point where he left off. Many pin their faith on Bromide of Potassium, but I am unable to speak well of it—I think it a most over-rated drug. Hyoscyamine, gr. 1/16, if administered twice daily, often has a most beneficial effect, and does not appear to affect the digestive organs.

Several of my medical friends have stated to me the results of their experiences in Asylum cases, of some of the new hypnotics. As they will doubtless be of interest, I will briefly allude to a few of that class of remedies, viz: Urethane, Chloralumide, Paraldehyde and Sulphonal. The first two are reputed to be very unreliable.

Paraldehyde is a valuable hypnotic. Dose 3i-3ss, with smaller dose to follow if required, is safe, having a stimulating effect on the cardiac respiratory centres, so that it may be given when Chloral is contra-indicated. Is is not followed by headache or by other unpleasant symptoms. The objection to it is its very unpleasant taste; it is best given in emulsion, with tragacanth and syrup of lemons. Sulphonal, dose gr. xv-xx, floated on water, warm milk or soup, or on bread and butter, or in the form of tabloids. It is slightly solvent in tea and coffee, very slow in action, and sleep prolonged, so must be given much earlier than ordinary hypnotics. Action is certain, it does not disturb the alimentary organs, and one dose is often sufficient for two nights. Is not cumulative.
Another preparation that has been mentioned to me with some commendation, is the Hydrobromide of Hyoscine, gr.160 —1.30, used hypodermically—in very noisy cases.

Formerly this class of remedies was very freely administered with a deleterious effect on the digestive organs, and frequently, I believe, producing irremediable brain mischief, from being used without the slightest discrimination. They should be given as sparingly as possible, and the effects duly noted.

One of the great dangers arriving from their employment, is the feeling the patient by and by suffers from, that he must have his night draught, otherwise he is sure he cannot sleep, and a craving for the hypnotic is set up, that is not easily allayed. The simplest plan in such a case is to continue the draught, with gradually diminishing doses of the drug employed.

In all cases of melancholia, I most urgently recommend the medical practitioner to regard the patient as of suicidal propensity, whether any such has been attempted or meditated, or not, and to direct the serious attention of the relatives to it, so that they may be on the watch to prevent it. If he does not do so, he accepts a most serious responsibility. It is a fact that a large proportion of those of who commit suicide in Asylums, are stated to be those who have exhibited no previous tendency in that direction. The very tendency of the disease, and of its depressing delusions is to develop this idea. A patient possessed with the notion that he has committed a sin that is not capable of being pardoned, feels at last that he has nothing whatever to live for, and he commits self-destruction to obtain rest; not that form of rest which is combined with the faith and hope of a bright hereafter, but rather the rest of oblivion.

"I would not if I could be, blest;
I seek no paradise, but rest;

is the poet's realization of this condition.

Refusal of food is present in several forms of insanity, and is a symptom that must not be neglected. The following are the principal causes:

1st.—From the delusion of being unable to swallow.
2nd.—From the delusion that all food of which he is required to partake is poisoned.
3rd.—From the delusion that he is depriving others of it, and therefore to eat it would be a sin.
4th.—For the purpose of committing self-destruction.
5th.—From simple obstinacy.
6th.—From indifference and waywardness.

I have known several instances of the first kind in ordinary chronic delusional insanity, the patient affirming either that he had no throat, or that it was contracted. Occasionally, an administration of food by means of the stomach pump will
convince him of his error, so far as giving no further trouble about taking his meals. This is generally sufficient also in causes 5 and 6. Occasionally patients who require to be fed in this manner, so far from resenting it, will even assist in passing the tube into the stomach.

The time for the forcible administration of food must be guided by the individual circumstances of each case. It must be borne in mind, that at the last moment preceding the operation, the patient may be induced to take it, particularly at the hands of an intelligent nurse. It is a wise plan to inform the patient that if not taken by a certain time, food will be administered forcibly, and not to delay the hour fixed upon. There are several modes of carrying this into effect.

1.—Laying the patient on his back, the limbs being restrained manually, an iron spoon is then introduced into the mouth, with the convexity upwards, and by it the tongue is depressed and kept in that position. An attendant pinches the nostrils, a small quantity of food (half-an-ounce) is then poured into the mouth—it is bound to be swallowed—a short time is allowed for respiration, the food is repeated, and so on. If the teeth cannot be readily separated, the liquid may be poured between the lips and the cheek, the latter being drawn away from the former, so as to produce a cavity, in this case, the food passes behind the posterior molar teeth. During the operation the patient will often take a large portion voluntarily.

2.—By means of a small tube, passed through the nasal cavity and so into the oesophagus, a plan I do not recommend. There is a special danger attending it, and the food is obliged to be of thin consistence.

3.—By means of a stomach pump. I have always preferred the patient to be in a sitting position:—the movements are more easily restrained, and the medical man has greater facilities afforded him.

Two points of importance require special attention:—

1.—Is to get and to keep the mouth open. Pinching the nose suddenly, or inducing the patient to talk, are generally followed by the teeth being separated slightly—an iron spoon or the bone handle of a knife is then introduced, and retained at one side of the mouth, to preserve a sufficiently wide opening, and to prevent closure of the teeth. The great point is patience—don’t be in a hurry; there is usually no inconvenience beyond a little delay in getting the mouth open. Mechanical levers and screws—the latter a taper instrument, generally supplied with the rest of the apparatus by instrument makers, had better be avoided. (In exceptional cases of difficulty, the teeth may often be separated, by the operator pressing his fingers between the last molars, and the ascending ramus of the lower jaw.)
2.—Is to introduce the oesophageal tube with the fingers alongside, by which means, when it arrives at the base of the tongue, the end of the tube may be depressed to facilitate its progress into the oesophagus, instead of impinging against the back of the pharynx. Avoid using the ordinary gag with a hole in the centre. Its employment gives you no command over the introduction of the tube, and the tongue may be injured by the latter.

When the required amount of food has been injected into the stomach, the tube should be withdrawn quickly, and the nose be firmly held, so as to prevent regurgitation.

Let me add two practical remarks:—

1st.—As to the stomach pump. The tube should be of large size, so as to allow of the administration of thick food; a small one is more likely to be attended with accident from kinking, and even from doubling upon itself, an instance of which occurred when I was present. Moreover its lower opening should be terminal, in direct line with the tube itself.

2. — As to food. Do not attempt to give too much at first:— a pint is sufficient, gradually increased to a quart, and given twice daily. Medicines, especially purgatives, may be added to it. It should be composed of several ingredients, and where possible varied at each administration. Half of it beef tea, meat juice, or soup, the other half of milk thickened with oatmeal, arrowroot &c. One or two eggs may be beaten up in it, and a little spirit added. Meat chopped very fine may also be one ingredient. Many get fat if the operation be continued I have known a patient to be kept alive for six months in this manner, during which period he never took a morsel of food voluntarily. This mode is far less repulsive than might be at first thought probable,—If a large tube be used there is less danger, and the results are more effectual than with other modes of forcible feeding. The time required for administering the food is also much less.

Moral Insanity from its medical as well as from its medico-legal point of view, is too serious a subject to be discussed in a few sentences, and may, therefore, be wholly omitted from the present paper.

A few remarks may be read on the three remaining forms of insanity, viz.; Dementia, Idiocy and Imbecility. Dementia, is a form that is very likely indeed to fall repeatedly under the notice of the general practitioner. I do not allude to that feebleness of mind and body incident to increasing age, but that which may be termed the exaggerated form, the sequela of chronic insanity, of epilepsy or of general paralysis. In the majority of cases, the patient requires, perhaps, the special attention of a good nurse; that of the doctor being principally directed to the support of the physical powers, the state of the bladder and bowels, the prevention of bedsores, and
general supervision. There is one symptom in Dementia, Amentia, and Chronic Insanity, in which the medical man can effect much good, if his directions be properly carried out. I allude to the habit of wetting the bed, so common in this class. To me it is a very repulsive sight to see a patient coiled up like an animal in bed, his coverings saturated with urine (often ammoniacal from want of frequent changing) and his person bathed in it, literally from top to toe. Where there is a tendency to bedsores, this state of things aggravates it.

In well conducted asylums it is recognised as a principle, that a large proportion of such cases can be gradually taught to leave off the habit, except in the occasional attacks of epilepsy. Not only is the condition of the patient made more comfortable, but a great nuisance to the nurse and the relations is alleviated. The plan is simply for the patient to be required at first to get out of bed, and empty his bladder into a proper utensil, say three times nightly; after a time twice only, and at a later period further reduced to once. The bladder slowly regains its power of retaining the urine collected in it during the entire night. Were it not for a plan of this kind, ordinary Asylums would need very large foul wards. If the nurse can be induced to take a large amount of trouble and perseverance with her patient, in carrying out a plan of this kind, the result would, in all probability, be one fraught with much comfort to herself, as well as to the patient.

There are two extremely important diseases frequently associated with insanity, which demand some consideration —I allude to Epilepsy and General Paralysis.

1.—Epilepsy is common in all forms of mental alienation (excepting melancholia), of which it is sometimes, but erroneously, asserted to be the cause. The cerebral affection that produces the one is also the factor of the other.

Epilepsy, as all present are well aware, is common enough, without being of necessity accompanied by other symptoms that can be affirmed to be those of insanity; at the same time, there are always indications of some cerebral disturbance about the period of the epileptic seizure, varying greatly in different individuals; and it is this very uncertainty as to the condition of the mind at a particular time, if some criminal act be committed (not unfrequently of a sexual character), that renders the task of giving replies, or information as to the responsibility or irresponsibility of the patient, so exceedingly difficult in medico-legal cases. It is frequent in the criminal class and those of low mental type generally; and its tendency is in all cases towards dementia.

Epileptic mania is characterised by outbursts of extreme violence; the more dangerous, because the more uncertain as to the time of their occurrence. During, what may be termed, the epileptic influence or furor, the patient may com-
mit the most brutal act, even murder itself, without being cognisant of having done so (on this subject, *viz.* *Insanity*, by Dr. Savage, {1806} 125.6).

The violent and homicidal excitement, more frequently precedes an epileptic attack, than follows it. Perhaps the violence is greatest when it replaces one. An old Head Attendant of the Asylum with which I was formerly connected, used to remark: "So-and-so is very bad and excited, I wish he'd have a fit." It was in his constant experience, that when excitement occurred without an epileptic seizure, it was of a more violent character. The nervous explosion at the time of the fit appears to relieve the brain.

Patients frequently bruise themselves during the fit, and the medical practitioner should be aware that they frequently accuse others of having assaulted them, in proof of which they exhibit any contusions they may have received. This has occasionally occurred in my own presence, the patient having had a convulsive seizure, complaining of the attendant having struck him. As a rule, wounds heal with remarkable rapidity in Epileptics. With reference to treatment, there are one or two points to bear in mind in all cases of Epilepsy, that is, whether associated with cerebral disturbance or not. It is the prevailing practice to treat such cases with Bromide of Potassium, often continued for some time. My own experience of it is not a favourable one. True, the fits, under its employment, frequently diminish in number and severity for a time, but I can not recall a case where any substantial benefit occurred to the patient. Of course I allude more especially to the malady combined with insanity, when there is almost certain to be some grave cerebral disease, and this alone would act as a powerful reason for not employing special remedies.

We know that this convulsive attack may be brought on by direct *centric* causes; but it also frequently arises from indirect eccentric irritation as well, *e.g.* worms in children and in the adult, from loaded bowels (often due to masses of undigested food), and is more especially marked in some of the imbecile insane, by the practice of rubbish eating, some remarkable cases of which it has been my lot to witness. A large proportion of epileptics are ravenous feeders.

There are two indications for the administration of purgatives: 1st, when the bowels are distended with solid matter, Castor Oil with one or two drops of Croton Oil is a very good form, in such cases an Enema is often needed in addition; 2nd, when there is marked cerebral disturbance, with venous congestion of the head, and tendency to greater coma than usual. When there is much sustained excitement *after* a fit, or when it replaces a fit, a Chloral may be administered.

In the case of idiots and imbeciles who are epileptic, a
soft cap, padded round the margin, will often diminish the risks of injury from fall. There is always danger from suffocation during the night. The bed should be made on the floor, or on a very low bedstead, and the pillow be a hard one. Some patients when in bed have a habit of turning over on their faces, and with a soft pillow, suffocation is likely to ensure.

The last to notice is General Paralysis, or General Paralysis of the Insane, as it is sometimes termed, owing to symptoms of insanity being almost unvariably concomitant with the paralysis. The medical man in ordinary practice may be called upon to treat such a case during its early period, or in the last stage, when all the powers of life are feeble and rapidly failing. It is one of the most difficult diseases to diagnose at its onset, and for some time afterwards; and in the greater number of cases, it is almost impossible to say when the disease really did commence. On the other hand, prognosis is usually easy, for a fatal result is almost invariable. I have known the Consulting Surgeon of a large Metropolitan Hospital to be affected with it, the disease being recognised by a specialist, while none of the patient’s colleagues recognised it, or had any suspicion that much was the matter with him. I have also known the principal officer of a large public institution to be the subject of the disease, without any of the medical staff being aware of its nature.

For a medical practitioner to be able to detect the nature of the early symptoms of the malady, to state its probable cause, and to give an approximation as to its probable duration, would, I need scarcely say, be of direct benefit to his professional status, and be also an enormous boon to the patient’s family and connections.

I know of a practical exemplification of this, in the instance of a medical friend of my own, in a large country practice, who obtained a considerable amount of kudos, and an increased number of patients, owing to his recognition of the symptoms of the disease in its early stage in a patient. His diagnosis and prognosis did not accord with those of some of his professional brethren who were consulted about the case, but the sequel proved his judgment to be correct.

This disease may be said to be one of progressive nervous degeneration, occurring generally between the ages of 25 and 40, in males much more frequently than in females, and affecting those with well developed brains. The symptoms are generally ingravescent. There are several varieties of it. Some cases have been reported where the mental symptoms were stated to be absent, but such cases must be exceedingly rare.

The causes of the disease are, at present, not clearly defined; but specialists are agreed it is frequently due to sexual excess; or on the other hand, it is certainly an effect
of the disease in some cases. General irregularities of living, and great anxiety, may be included among the ordinary causes. Dr. Savage has pointed out that over-strain, rather than over-work, produces the disease in many instances.

There are usually three stages of this disease, in any of which there may be an epileptic seizure, followed by marked loss of power, in fact the progress from one stage into another is frequently marked by a fit. The symptoms are physical and mental. In the first stage, when the disease is first recognised, there is evidence of a change having taken place in the individual. There is a gradually increasing loss of muscular co-ordination; the tongue trembles, so do the lips, the grasp is less firm than formerly; the gait is undecided, shuffling or dragging, the patient with difficulty walking along a straight line. Speech slightly hesitating, and attended with difficulty in the pronunciation of certain words. The pupils are sometimes pin-point, often unsymmetrical. The mental symptoms are usually of marked character. At first the patient is noticed to be somewhat exaggerated in his style of speech, and this gradually culminating into general exaltation of ideas, often with great restlessness and noisy excitement. Has hallucinations. The careful man becomes extravagant in his habits, and orders much larger quantities of ordinary goods than he requires or can afford, or of those he does not need. A very unpleasant symptom—Kleptomania—is apt to present itself; unpleasant to the family of the patient, as it sometimes leads to proceedings in the Police Court, and if a medical man who is competent to give an opinion, affirms it to be one of the evidences of the disease, General Paralysis, he is tolerably certain to be severely criticised in the public press. I believe it to be due to early impairment of the memory, rather than to any idea of acquisitiveness, the patient acting under the idea that the article taken really belongs to him. The character of the handwriting alters, and instead of being firm and clear, becomes tremulous, generally more manifest at the close of a letter than at the commencement.

In the second stage the patient usually becomes fatter, although the general bodily condition is more impaired; the physical symptoms increase, and the mental become more grandiose; the features are expressionless, from inaction of the facial muscles; the tongue is moved by jerks, with inability to keep it protruded; the hand-writing is more impaired, and letters usually contain evidences of delusions. Senses much blunted, appetite large. Haematoma auris is common during this period.

In the last stage, the mental condition passes from the early state—usually ordinary mania—into dementia. There is a general and gradual loss of power of all muscular life, and want
of control over the bladder and rectum. The patient has simply a vegetative existence. Taste and smell are almost in abeyance. He is almost insensible to pain; the slightest pressure or blow produces large ecchymoses which remain for a long period; sores and wounds heal with difficulty, and large bedsores are apt to form and cause the patient to sink rapidly. Grinding the teeth is a very common symptom.

One of the most important facts to be made aware of is, that the bones, in the later periods of this disease undergo a remarkable change, they not only lose part of their animal matter, but although outwardly they present no apparent alteration, they sometimes become mere shells of bone, filled with large cancelli containing fluid, and in this condition, are exceedingly fragile. These are the cases in which every now and then, several ribs have been found fractured after death, the existence of which was not suspected during life, and accordingly have been considered by the public as evidence of the ill-treatment to which the patient had been subjected. All the tissues in the body appear to undergo a remarkable change in this disease; the physical appearance of fatness is very deceiving. An old friend of mine used to liken such cases to over ripe pears—all fair without, and all rottenness within. The fragility of the bones is of great consequence to be remembered, as patients in the last stage are not unfrequently removed from the Asylum to die at home.

Of specific treatment there is none.

Attention to the state of the bowels is of the greatest need, as the accumulation in the large intestines is very apt to take place, especially in the later stages, requiring the aid of purgatives and enemata to remove it, otherwise extra cerebral congestion and epileptic seizures are almost certain to take place. If the patient is very restless and sleepless, opium must not be given. In my younger days I knew a Medical Superintendent who, in doubtful cases of this disease used to give a dose of opium to assist him in forming his diagnosis. If the case happened to be one of General Paralysis, it aggravated the symptoms. Chloral and Hyoscyamus combined, or Hyoscyamine by itself, are by far the best hypnotics, as they do not interfere with the digestive functions. The nates must be daily inspected as bedsores form so rapidly. All the parts should be kept as dry as possible. The one chief difficulty to treat, is the want of power over the bladder.

In the 2nd and 3rd stages owing to the remarkable ease with which food gets impacted in the pharynx, and even in the larynx, it is absolutely necessary that the whole of the food be passed through a mincing machine, and that the patient be prevented from stealing crusts and other articles of diet and bolting them, which he is apt to do, and so getting asphyxiated by choking.
The last stage is pre-eminently one that requires a skilful nurse, to be daily supervised by the Medical Practitioner. I do not here enter into the pathology of the disease, but there is one point relating to it that is of present interest. There is usually a large amount of serious effusion in the various cavities of the brain, causing undue pressure in the latter; and it has been felt by many specialists that if this could be relieved in any way, some remission of the symptoms might ensue. Very recently Dr. Claye Shaw, of Banstead Asylum, in an unfavourable case with respect to prognosis, but a favourable one for trying to relieve this pressure on the brain, had recourse to the trephine, and after the removal of the bone, opened the serous cavity below the dura mater. A quantity of fluid was discharged with immediate relief to the brain, and the mental condition of the patient underwent such a change for the better, that Dr. Shaw remarked he had become, to all intents and purposes, sane; and had he been called upon to testify to his insanity at that time he could not have done so, although, previous to the operation there would have been no difficulty. Subsequently to this, another case was operated on by Dr. Batty Tuke, in which the dura mater was left untouched. There was a good deal of bulging into the cavity caused by the removal of the bone, and the symptoms due to cerebral pressure were relieved. Both cases were reported in the British Medical Journal, and the first one called forth—very unwarrantably in my estimation—some condemnatory remarks by a Medical Correspondent (vide Nos. of Nov. 16 and 23, 1889).

The removal of the intracranial effusion afforded similar relief to that produced by tapping in ascites, pleuritic effusion, &c., but the operation effected more than this. Even when the effusion was not got rid of, the pressure was to a certain extent relieved by the trephining process—the cerebral symptoms are relieved, the mental symptoms were in abeyance for the time. It appears to me that in these cases the Medical men did their duty most completely to the patients, and had the satisfaction of causing a remission of the symptoms for the time being, as the result.

The trephine is likely to play an important part in the future treatment of Epilepsy and of General Paralysis.

I pass on to make a few remarks upon some of the medico-legal aspects of insanity.

A medical man may be fortunate enough to pass a whole lifetime, without any case of mental malady in which he may be professionally interested, causing him either anxiety or trouble, but it is otherwise the experience of a large section of medical practitioners.

Cases of insanity, sometimes very awkward and unpleasant
ones, occur from time to time in general practice, and much annoyance is apt to result from the neglect of a very simple precaution on the part of the medical attendant. I do not here refer to such instances of mental disturbance he may be called upon to treat at home, or certify for admission into an Asylum; but to those that may become the subjects of inquiry before a civil or criminal court, where the entire investigation hinges upon the question of sanity or insanity of an individual, and therefore depends upon the evidence of the medical man, who may be called upon to testify as to the acts and conversation of his patient at some particular time, perhaps long antecedent to the date of the inquiry. If he has not had the forethought to be prepared with the absolute facts on which his opinion has been founded, his cross-examination will probably be a severe one.

The precaution to which I have alluded, consists in his taking full notes of such cases on the day of examination, together with the dates. The importance of doing so in all patients exhibiting symptoms of mental disturbances can scarcely be over-rated. As time goes on, many important facts are apt to be forgotten, more especially the existence of some prominent symptoms in a particular day, and which may, in a disputed will case for instance, be of the greatest service. Such notes are good evidence of the condition of the patient on a given date, and the circumstance of their preservation may save the medical man much annoyance and trouble.

Criminal trials turning upon the question of responsibility or of irresponsibility of the prisoner at the time of the committal of the criminal act, especially of murder; and an inquiry before a master in lunacy as to the condition of mind of the subject of it, with the view of his property being taken proper care of in the event of his insanity being proved, may be cited as instances where the evidence of the medical practitioner is all important.

I now desire to draw attention to the Lunacy Acts Amendment Act of 1889, as one of the most important statutes that has of recent years been enacted, with respect to the medical profession. Although the majority of its clauses do not come into operation until May 1st, of the present year, some of them commenced from the date of the passing of the Act, August 26th, 1889. For the first time in the history of Lunacy Legislation, medical men who have signed certificates of insanity, are protected from those vexatious law proceedings, which have entailed so much anxiety, trouble, and expense to so many of them, during the last few years; the only proviso (a very proper one) required, being that the medical man "has acted in good faith, and with reasonable
care” Should any legal proceedings be attempted, a summary application may be made to a Judge, who, if satisfied that the medical certifier has so acted “ in good faith and with reasonable care,” may not only stay the proceedings, but order costs. Already, two such attempts have been quashed by the Judges, although one of the cases (Freeman v. Staples) presented some unusual features not contemplated by the Act. The Section of the Act (12), relating to this subject is clear and comprehensive; and medical men should be thankful to know that it is retrospective in its operation.

I will briefly allude to some of the other more important clauses:

1st.—Those relating to Pauper Lunatics. A—The power of signing the order of admission into an Asylum, is withdrawn from an officiating clergyman and relieving officer, and confined to a justice of the peace. B—Patients in workhouses, must not be detained unless under a certificate of the medical officer, and which lasts for 14 days only. During this period, the patient may be kept there “ against his will.” Beyond that time he can be detained only under an order of a Justice (Form i1), for which a Relieving Officer must make application, and be supported by two medical certificates, one from a medical man unconnected with the Workhouse; the second by the Workhouse Medical Officer. The remuneration of the former is left to the discretion of the Guardians (a weak spot). Where, however, a Justice calls in a Medical Man to examine a lunatic “ whether pauper or not”; he has the power of making an order upon the Guardians of the Union, for payment of remuneration and expenses. (Sec. 25).

2nd.—Single Patients.—Any person having the care of a single patient for remuneration, comes within the meaning of the Lunacy Act 8 and 9, Vict. c 100, s 92. Sect. 42 of the new Act, empowers the Commissioners in Lunacy, in the case of any patient, single or not, in any institution (charitable, religious, &c.) for whom no payment is made, to have periodic reports of their condition sent to them, or to visit them, and to report to the Lord Chancellor (if necessary) the result of their enquiries, who may, if he thinks proper, direct the patient’s removal to an Asylum.

3rd.—Private Patients.—No private patient can be received into an Asylum, or as a single patient, (except under an urgency order) unless under “ a reception order,” signed by a judge of county courts or a magistrate, or by a justice of the peace, to whom it is necessary to present a private application by petition, accompanied by a statement of particulars, and two medical certificates (Sect. 2, 3. Forms 1, 2, 3). The petition must be presented by the husband or wife, or by a relative of the patient (special particulars required in case of any one else presenting it). The judge
may see the patient if he deems it necessary, may examine witnesses, &c., all the proceedings being in private. He may adjourn the enquiry so as to obtain further evidence, &c., for a period not exceeding 14 days. If he dismisses the petition, he has to give the petitioner a statement of his reasons in writing, and forward a copy of the same to the Commissioners in Lunacy [Sec. 5].

A: An important deviation from the former Lunacy Act has regard to Urgency Orders [Sec. 8]. Should the patient’s case require immediate treatment, he may be received into an Asylum under an urgency order, signed by a relative (Form 4) and accompanied with one medical certificate; the medical man having examined the patient “not more than two clear days” previous to his reception. This may be made at any time, even while the petition is being considered, under which circumstance, a copy of the urgency order must be sent to the Judge. It remains in force for seven days, or if a petition be pending, it continues in force until this is finally disposed of.

Medical Restraint.—It behoves all medical men to be aware of Section 45. It requires that whenever mechanical restraint in any form, is applied to an insane patient for any reason whatever, a certain form (16) is to be filled up, and a copy forwarded to the Commissioners every quarter. This applies to every insane person, whether in an Asylum or Workhouse, or a single patient. Failure to comply with this clause will be regarded as a misdemeanour.

A few remarks on medical certificates of insanity may fitly bring the present paper to a close. In framing one there are many points to be considered, all of which should receive the eminent attention of the medical certifier.

1. To be scrupulously accurate in filling up all the particulars of place of examination, &c. The omission of the number of the street has been held to render a certificate invalid. In the event of an action at law, no judge would decide that “reasonable care” had been used, unless all the strictly legal entries had been made, as required by the Statute.

2. The facts upon which the medical certifier grounds his opinion of the patient’s insanity are of two distinct kinds.

A. Facts observed by himself.
B. Facts communicated by others.

Of the first, A—the facts must have been observed by the medical man himself, on the day he examined the patient, and at the place specified in his certificate; and these facts alone must be sufficient to testify that the patient is insane, and that he is a proper person to be detained in an Asylum, for care and treatment. Facts observed by him at other times, may be of value in corroborating those ascertained by him on the day of examination, further than this, they are of no legal value whatever.
Of the second heading, B—no matter how decided the insanity of the acts and conversation of the patient may be, the certificate is invalid unless the medical certifier himself from personal examination can testify to the existence of insanity. These hearsay facts may be of great importance in corroborating his opinion, but are of no service as substitutes for it.

The patient may have made a deliberate attempt to perpetrate suicide, or have committed some act of brutal violence under the influence of epileptic mania, and yet no symptom of the malady may be observable on the day of examination. However certain the medical man may be of the patient’s insanity, and that a return of the violence to himself or others is almost sure to recur, yet the practitioner’s duty is very plain; he cannot testify to the presence of the malady on the day of his examination, and all he can do, is to warn the friends, and to enable them to take proper precautions in case of a further outbreak.

3. It must not for a moment be forgotten, that the medical certificate is not only to testify to the patient’s insanity, but also that he is a proper person to be taken charge of, and detained under care and treatment. There can be little trouble in arriving at a decision that he falls under this denomination, if he be dangerous to himself or others, if he be destructive to property, or if he be in the habit of persecuting and annoying individuals on account of imaginary grievances. On the other hand, if the patient, though undoubtedly insane, be quiet and harmless, it is equally certain that the law never contemplated locking him up in an Asylum. I may quote Dr. Bucknill’s words on this point:—“No person of unsound mind may by common law be rightfully confined in an Asylum, if it can be proved that he is perfectly manageable, safe, and harmless in the enjoyment of his liberty.”—(Care of the insane, 26-7.)

The difficult cases to decide as to the question of Asylum detention, are those that occupy the borderline between these two classes, and it is these which more especially necessitate “reasonable care” being taken by the medical man. Another difficult class of cases to deal with is that of moral insanity, where the patient exhibits his mental impairment in deeds and not in words.—And another is that due to intemperance, where the case is not one of acute mania, but rather of exaggerated delirium tremens.

4. It is as well to bear in mind, that the certificate may be subsequently produced in a court of law, and the medical man be cross-examined upon it. The facts should be carefully considered and stated as pointedly as possible, and all vague terms such as excitement, eccentricity, &c., be avoided.

5. In arranging the statement of facts on which he forms
his opinion, the practitioner will find it convenient to arrange
it under three heads—I. Appearance. II, Conversation.
III, Demeanour; and not to forget the axiom, that insanity
implies "change from a previous condition." From this it
can be readily understood that if he has been in the habit of
attending the patient for other illnesses, his task will be an
easier one than if he be a stranger to him.

1. Appearance. The following points deserve attention
during the examination of a patient:—Varied aspect, attitude,
condition of dress, cleanliness.

2. Conversation. Condition of memory. Existence of
delusions. Noisy or the reverse. Incoherency. Altered
pronunciation. Great caution is necessary in the investigations
of statements, asserted to be delusions, especially if they
relate to persons, or to family matters.

3 Demeanour. Except in acute cases, the personal
testimony of the certifier has far more to do with the
conversation he may hold with the patient, than with his
demeanour; and it is on this heading that secondary testimony
is of value to corroborate what others have witnessed as to his
acts.

I have purposely limited the remarks in my paper, to such
as I deemed might perhaps be of service to those engaged in
general practice, if in this I have been successful, my object
has been achieved.