A FEW REMARKS ABOUT OBSERVATION WARDS AND HOSPITALS.¹

By E. STANLEY ABBOT, M. D.,

Assistant Physician, McLean Hospital, Waverley, Mass.

In the last few years so much has been said and written about psychopathic and observation hospitals that I feel that an apology is due for presenting on this subject a paper which contains so little that is new or original. The attempt some three or four years ago to induce the Boston City Hospital, of which I was at that time a subordinate officer, to receive into its wards cases of doubtful insanity and of delirium tremens brought the matter rather forcibly to my attention. Dr. Baldwin's paper before this Society in 1901 on the subject of the proper provision for such cases was inspired by the same movement, of which he was an active promoter. Most communities of any considerable size have to face this problem. In this country a few cities, such as New York, Brooklyn, Philadelphia, Pittsburg, Albany, and perhaps some others have made special arrangements to solve it. Three of these, New York, Philadelphia and Albany, I visited. It occurred to me that a few observations on the principal features in the actual working-out of the problem might be of interest to others as well as myself.

The class to be provided for is much larger than the title of Dr. Baldwin's paper indicates. The increasing differentiation or specialization of organized relief for various kinds of dependents leaves still a miscellaneous residuum of cases not yet adequately provided for in most communities. These residuals, as I shall call them for the sake of brevity, include not only the cases of doubtful insanity and of delirium tremens referred to by Dr. Baldwin, but also such conditions as sudden outbreaks of violence or

¹Read before the American Medico-Psychological Association at St. Louis, May 30 to June 3, 1904.

excitement, suddenly developing puerperal insanity, epileptic or alcoholic or other convulsions or seizures, attempted suicides, persons found dazed or irresponsible in the streets, and persons so deeply intoxicated as to need medical observation. In this class should also be included those cases of undoubted insanity which are waiting for the necessary forms of commitment to be made out, a process requiring from a few hours to a few days in some communities. Most of these cases, except the last class, require more or less prolonged observation before they can be sent to the appropriate place of relief or care. They represent emergencies of greater or less urgency. In New York nearly 76 per cent of the residuals are found to be insane, a little over 14 per cent are not insane, and 10 per cent are cases of delirium tremens. In Albany over 61 per cent are acutely delirious or insane, 12 per cent are not insane, and over 26 per cent are cases of intoxication or delirium tremens. The data for Philadelphia were not available at the time of my visit. In Boston, of the cases falling into this category over 64 per cent are insane or epileptic, nearly 15 per cent are not insane, and over 20 per cent are cases of delirium tremens.

It is obvious that all these cases need medical observation. Most of them need general or insane hospital care, and many need it at once, without the delay necessitated by formal commitment. The protection of the community or of the friends of the patient occasionally requires the instant restraint of a patient. In the interest of the 12 to 15 per cent of the not insane (and perhaps of the 10 to 20 per cent of the delirium tremens cases) this restraint should be possible without certification of insanity or the disgrace of arrest by the police. These conditions cannot be well secured in the police stations or jails, nor yet in workhouses or almshouses, where such cases are sometimes sent. Whether they can be found better in general hospitals or hospitals for the insane will appear from a consideration of what is now being done for the residuals in this country and abroad.

Under the reform administration in New York the new management of Bellevue Hospital reorganized the working of the Insane Pavilion. The building, a separate pavilion, is unchanged at present. It contains two wards, one for men and one for women. Each consists of a long, straight, wide hall which is also

a day room, with single rooms for patients on either side, and bath, toilet, dining and serving-rooms. There is a dormitory room containing 5 beds for the sickest bed-patients. There is no way of separating quiet and well-oriented patients from the noisy and disturbing ones except by secluding the latter in their rooms. Each room has a sliding door with a peep-hole, the windows are guarded, the walls smooth and with hard finish. The wards are kept locked. There is no airing court for out-of-door exercise. Patients were formerly under the care of the visiting and house staff, whose invariable order was "sedatives and restraint s. o. s." Under the new régime there are three resident salaried physicians, all of whom have been assistant physicians in hospitals for the insane, and four consulting alienists and neurologists; the medical and surgical visiting staff may also be called in consultation. Since this change was made about 85 per cent of the "sedative and restraint s. o. s." orders have been found unnecessary. The men's ward is in the care of a woman supervisor who has had long insane hospital experience, and the orderlies are assigned to duty from the state insane hospitals for specified terms. The women's ward is in care of a head nurse and pupil nurses from the Bellevue Hospital Training School for Nurses—a concession to the training school. Patients are brought as emergencies by the police or by friends who claim that they are insane; or they are committed for 5 days on a charge of insanity by a magistrate upon application of friends; or committed by the superintendent of Out-Door Poor for 5 days for observation; or they may be transferred from the general wards of the hospitals. All intoxicated persons and cases of incipient delirium tremens applying are sent to the alcoholic ward of the hospital and not admitted at all to the Insane Pavilion—only well marked cases of delirium tremens are admitted, which accounts for the low relative percentage of such cases in New York as compared with the other cities. Patients stay very rarely as long as ten days, and only occasionally as long as a week; five days is the usual outside limit. If found on sufficient observation to be insane, they are committed to hospitals for the insane on certificate of two of the resident physicians; or they are discharged, or given in charge of their friends, or transferred on account of medical or surgical ailments to the appropriate wards

in the general hospital. Instruction to students is contemplated, but not yet begun.

The cases passing through this pavilion are numbered by thousands. Their stay is brief—three or four days. The pavilion is a mere distributing station from which the patients are sent to the appropriate place of relief as soon as that can be determined. During the time necessary for this determination they have good care under the direction of specialists in the kind of disease that afflicts the great majority of them. Among the plans for the new Bellevue it is contemplated to so change the construction of the pavilion as to allow the grouping of patients, in order that the quiet and inoffensive may not see the turbulent cases. If authority to hold the patient for observation against his will for five days without legal process were conferred on the department, thus making unnecessary the magistrate's commitment on a charge of insanity—a prejudgment that is not always confirmed—some injustice to patients might be avoided. For purposes of study and of clinical instruction it would be advisable that patients remain a longer time under observation—say not to exceed two months. This however would necessitate a considerable enlargement of the accommodations, and for economic and administrative reasons might not be feasible.

At Blockley Hospital in Philadelphia the municipal almshouse and the general and insane hospitals are grouped together under one general management. There is no separate pavilion for the residuals, but four wards, two for men and two for women, in the building of the general hospital department are used for reception or detention wards. One of each is for alcoholic and delirium tremens cases, the other for the residual class and all cases committed to the insane department. The building is old, not originally intended for this use, and in many respects not now well adapted to the needs of this class. They are dormitory wards, without separate rooms for individual patients. They are kept locked, and have guarded windows. These wards are under the medical supervision of the salaried resident physician in charge of the insane hospital department. There are two regularly appointed visiting alienists, whose function is indicated below, and the medical and surgical staff can be called in consultation. The nurses are those of the general hospital. The patients are brought

by friends or by the police as emergencies, or on certificate of insanity signed by two physicians not connected with the hospital. After admission those not already committed as insane are seen by the two visiting alienists and if insane are by them certified as such. Those patients who are likely to require hospital residence for a month or more are transferred to the insane hospital department. Others are kept in the Detention Ward for one, two or three weeks and discharged from there or sent to appropriate wards of the general hospital. At the time of my visit data were not available concerning the number or kind of cases passing through the Detention Ward. Except in regard to the structural deficiencies, which prevent a segregation of the quiet from the disturbed observation cases, the general plan of care works satisfactorily.

The semi-public Albany Hospital has a pavilion a little removed from those containing the wards for the general medical and surgical cases, but connected by corridors with the main group of buildings. This Pavilion F has now been in operation for two years. It contains two locked wards of 17 beds each, all but four of which are in single rooms, the four being in a small dormitory room. There are three sitting rooms, and the whole ward is capable of being subdivided into smaller sections which allow segregation into small groups of three or four patients. Some rooms have guarded windows, plain smooth interior finish and sound-proof walls. Quiet and well oriented patients need not see noisy and turbulent ones. There is no closed court-yard for out-of-door exercise. The medical care of patients is under the close supervision of a visiting physician who has had several years' experience as assistant in hospitals for the insane. He visits the pavilion twice daily. A medical interne of the general hospital visits during his absence in case of need, and often with him. The medical and surgical staff of the hospital can be called in consultation. The nursing service is in charge of a supervisor who was trained in both insane hospital and general hospital training schools; the nurses are assigned from the hospital training school to service for a specified time in Pavilion F. There is but one orderly or male nurse in the pavilion. Almost no restraint or sedatives are used. Formerly the delirious patients in the general wards were given large doses of hyoscine and other

sedatives. Delirious patients from the general wards and any suitable patients, except such as may be brought by force or fraud, are admitted without commitment or other formality. This exception occasionally makes the pavilion fail to meet some of the most urgent needs of patients or their friends. No patient is kept who demands discharge except such as have been committed to a hospital for the insane and are waiting transfer. Patients are kept from a day or two to six months. Clinical instruction is given to students of the Albany Medical College.

This method of taking care of the residuals works admirably except in the case of such turbulent cases as require immediate hospital care but who are sufficiently oriented as to know their surroundings and refuse to go to or remain in the pavilion. The governors of the hospitals have refused to accept the authority to admit or hold a patient, even for a brief limited period of time, against his will, lest the hospital become liable at some time to suit for damages by some disgruntled patient, and to avoid the similarity to a hospital for the insane which such authority would imply. An appreciable number of patients have been declined for this reason. Only 331 patients have been admitted to Pavilion F, though Troy, Schenectady and other neighboring cities and towns have contributed as well as Albany itself. If the numbers should increase largely the system of having a visiting physician would probably prove inadequate and a salaried resident physician with insane hospital experience would become necessary. Since patients are kept for treatment it would be advantageous to have an out-door yard for the use of patients who might otherwise escape.

In Germany many municipalities have established what they call psychopathic wards, pavilions or hospitals, easily accessible from the more densely populated parts, admission to which is obtained with a minimum of formality. They are all constructed and organized as far as possible on the lines of a small hospital for all classes of the insane. Dr. Clark's concise and instructive paper before this society last year mentioned most of those in Germany and described especially the newest one at Kiel. We in America cannot afford to overlook this German movement when our municipalities are contemplating the proper care of their residuals.

It is clear from the foregoing descriptions that the nearer the

conditions approach those of the insane hospitals the more satisfactorily are the residuals cared for, and the better are their needs and those of their friends and the community supplied. If this be so, why are not the already established hospitals for the insane adequate and satisfactory?

The reasons are several. In the first place, many cases are emergencies occurring in the centres of population, while hospitals for the insane are remote, often requiring a journey of an hour or more by rail and a mile or more by carriage, with facilities ill adapted to the needs of an exhausted or excited patient. Then, admission is possible only on certificate of insanity or, in some states, also on the voluntary written request of the patient. Again, the time required to secure the legal form of commitment varies in different states from a few hours to a few days. Further, a considerable percentage of residuals (12 to 14 per cent.) prove to be not insane, yet many of them need observation to determine this fact who would not voluntarily commit themselves. It would therefore be necessary to put upon them the "stigma of insanity" as many regard it; it will be many years before public sentiment becomes so enlightened that it will not be so looked upon. And lastly, the average person shrinks from the words *asylum*, *insane*, *lunatic*, which enter into the names of almost all the hospitals for the insane. The sentiment may be unreasonable, but the fact remains that it is at present a potent factor in delaying the admission of patients to such hospitals, sometimes to the great detriment of the patient.

It may be asked why, especially in a large community, the wards of a general hospital are not adequate to meet the needs of this class. The reasons are many. The chief ones are briefly as follows:

1. General hospitals have not the authority to hold persons against their wills.
2. The wards of general hospitals are open, not locked, and a patient may easily escape. Also the nurses' attention and time are taken up by manual ministrations to the sick, and they cannot watch suicidal patients or those liable to escape.
3. The nursing force is not mobile enough to meet such emergencies as sometimes arise, requiring the presence of several

nurses to properly handle a violently disturbed patient, without neglecting other patients.

4. Noisy patients disturb the other sick patients, who need quiet. Sedatives are therefore necessary, and often these are bad treatment.

5. Violent or excitable patients would have to be kept in bed by means of restraint; this is often bad treatment.

6. Unless the residuums in the general hospital were under the care of a psychiatrist, their treatment would be directed by the general staff, to whom epilepsy, hysteria, delirium and insanity almost invariably mean large doses of sedatives and mechanical restraint—this is the experience at Bellevue and at Albany and accords with my own observations in the Boston City Hospital. It is often very bad treatment.

7. The general visiting staff has not the time, nor usually the interest, to make sufficiently detailed and accurate observations for the diagnosis and treatment of mental cases. The house officers or internes are too inexperienced.

8. It is always possible to meet any emergency somehow, and the fact that emergencies of the kind under consideration have been met successfully in the wards of a general hospital is not a sufficient reason for thinking that they are the best or even are in general adequate to the needs of these cases.

The essential conditions to be met therefore by any community that is to look after its residuums in the best way our experience has thus far pointed out are as follows:

1. Locked wards having some guarded windows and separate rooms for patients, and capable of having portions shut off so as to segregate different classes of patients.

2. These wards should be in, or very easily accessible from, the centre of population.

3. The medical care should be under the direction of a physician, preferably resident, especially in large communities, who has had experience in the care of the insane.

4. The nursing service should consist of persons of whom at least those holding the more responsible positions should have had experience in the care of the insane.

5. The requirements for admission should be as few and as little formal as possible—the patient's obvious or stated need

should be the only absolute requirement. No certificate should be required.

6. Authority to hold a patient against his will without certificate for a specified time, as five days, should rest with the governing person or body.

In addition to these essentials it would be for the benefit of patients to have quick and easy facilities for consultation with physicians, surgeons and specialists in the different branches of medicine and surgery. This can be very easily arranged if a ward or pavilion in connection with a general hospital is used. Fractures and other surgical injuries are not uncommon as the result of suicidal or violent outbreaks; and more or less obscure or severe somatic conditions, some of them lying within the fields of the various specialties, are also frequent. It is also almost a necessity to have good facilities for at least such microscopical, bacteriological and chemical examinations as are commonly made in the ordinary examination of general hospital patients; and this need becomes absolute if patients are to be kept any length of time for treatment, as at Albany, instead of being sent elsewhere after a short period of observation, as in New York. Larger laboratory facilities are advisable if the institution is large enough to be independent, as at Giessen, Kiel and elsewhere in Germany, and more especially if first-class clinical instruction is to be given to students. If such clinics are to be held, or if patients are to be kept under treatment, they should be able to remain for different periods of time, but not to exceed four to six months. If patients are to be kept for treatment, therapeutic means of various kinds must be supplied.

Each community that intends to make suitable provision for its residuals should decide in what form it shall supply the essentials. The first thing to determine is whether the institution is to be a mere distributing centre which only gives proper care until the patient can be sent to the appropriate place of relief, or a place for prolonged observation and treatment as well. Much larger accommodations are required for the latter. In New York, considerably more than two thousand patients pass through 60 beds annually, whereas 174 patients passed through 33 beds in a year at Albany. It should be said, however, that more patients could have been accommodated at Albany. The German idea is to have

places for treatment rather than mere distributing points. Certainly if they are to be used for study or instruction, and also if they are to help prevent the congestion of the hospitals for the insane, they should have facilities for prolonged observation and treatment.

The next point to decide will be as to whether a ward or a pavilion connected with a general hospital, or a separate institution such as those at Giessen and Kiel is most desirable. This will depend largely on the size of the community. Many American cities of 15,000 to 20,000 inhabitants, and even some that are smaller, have already general hospitals. The addition of a small ward or pavilion to such a hospital might not be beyond the means of the community. Last year Dr. Clark advocated such addition in cities of that size. The difficulty would be to find an alienist to assume the charge of it. Psychiatry is so poorly taught in the medical schools of this country that there are few alienists outside of hospitals for the insane. I know a city of over 65,000 inhabitants among whose physicians there is none who has any special knowledge of insanity. This is a condition however that is being remedied and in the not far distant future it will be less difficult to supply this need. Dr. Sommer, director of the clinic at Giessen, advises that every city of 50,000 inhabitants should have an independent hospital. This is possible in Germany where psychiatry is so much better taught. Here the independent institution might well be founded only in those larger cities that have good medical schools, the pavilion plan serving even large communities well. That at Albany, for example, which draws its patients from a widely scattered population of probably 200,000, is entirely adequate for its purpose. It must be borne in mind, however, that supplying the need will cultivate a demand, and in a few years after the establishment of the ward, pavilion or hospital there will probably be a larger number of patients in proportion to the population than at first.

Finally, before closing, I wish to speak of one possible abuse of the psychiatric pavilion or hospital, which raises a sociological question. A pretty large percentage of the beneficiaries of these clinics are persons who have become for the time being social parasites through self-indulgence. I refer to the cases of alcoholism and delirium tremens. Over 26½ per cent of the patients taken

care of in Pavilion F are of that class. During their incapacity they need skilled care and nursing, and they get it. Their pathway through the mazes of delirium is rendered as easy and pleasant as their condition will allow. Sometimes it is so pleasant that delirium tremens has comparatively little terror for them. They lose one of the strong incentives of self-restraint. If drunkenness is a punishable offence, why should not delirium tremens, which makes the person more dangerous to, and more dependent on, his friends or the community, be punishable in a greater degree? Why should not the patient, after recovering from his delirium, be fined or imprisoned for having had it? Unless in some way it is made disagreeable or disgraceful to acquire delirium tremens, such excellent care as these wards or hospitals can and will supply will only serve as a premium on self-indulgence to the point of personal incapacity and dependence on the public.