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MEDICAL WORK IN WARDS OF HOSPITALS FOR THE INSANE.

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When I was invited to prepare a paper upon the subject of medical work in hospital and asylum wards it occurred to me that this included all the medical work of hospitals for the insane. I can not expect you to listen patiently to a review of the usual requirements of a medical department of an asylum, and I will, therefore, present to you some suggestion of methods that tend to give more distinctly the hospital character to our wards, and thus remove them farther from their character as detention places. This alone is a great subject, and I do not expect to exhaust it, but I hope it will form a basis for a free discussion to follow.

There are three important elements that enter into the treatment of an insane person in a hospital for the insane: (1) The medical officer, whose relations are closer to his patient than that of the family physician; (2) the nurse, and (3) the ward, with its appliances; and this should include the whole environment of the patient. These are not given in the order of their importance, for the nurse rationally stands at the head, although her efficiency depends largely upon her training and direction, and this depends upon the physician. This classification of remedial agencies might be infinitely subdivided, but for our present purposes it is unnecessary, and would be superfluous.

There are also three important periods in the hospital history of every new case: (1) The admission and examination; (2) the treatment during the acute stages, and (3) the termination, either by recovery, death, or chronicity. This applies not only to cases of generalized insanity, but to all new admissions, whether they are in acute stage or not, until their condition — mental and bodily — becomes thoroughly determined and recorded.

This One

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The examination and treatment of the patient in nearly all public hospitals for the insane devolves upon an assistant physician, the medical superintendent acting in the capacity of a counselor, either in all the cases received, or in those of unusual interest or severity of disease, or with complications. Hence it is necessary that the assistant physician should be capable, and should be qualified by education and training for this special work; that he should be governed by well-defined methods of procedure, for which the medical chief is responsible, and that he should not be burdened with non-medical duties. Allowing that insane hospital physicians, as a class, are superior men, and those who gain advancement are selected men, it must be admitted, with regret, that sometimes the temptation of a humdrum daily routine is not resisted, and they become medical automatons in the matter of their inspection and treatment of patients and in their ward duties. Occasionally a brilliant, active, and sanguine assistant, bent on original research, will flame across the medical firmament of a hospital, but too frequently like a comet without an orbit. But in other instances, with a definite goal, and with loyalty to well-matured and precise methods, the assistant develops into the scientist, and his department becomes not only a hospital in name but in fact.

The medical chief is largely responsible for the development and progress of his assistants. Upon his discernment and sagacity rests very largely the character of his staff, not only in original selection, but in their development. As a rule, the assistant physician enters upon his special work before he reaches the "climax of initial fecundity," in other words, during the period of psychological evolution, and the impressions and tendencies he absorbs at that time are likely to become elements of his organization as it relates to his chosen work.

I believe that medical superintendents do not confer with their assistants regarding their medical work as frequently as they should. At the St. Lawrence State Hospital the medical superintendent meets his physicians daily in conference after their morning work, between the hours of 12 and 1, noon, and I am inclined to believe this daily experience meeting of an hour is of infinite value. At any rate it might be made so. It is not uncommon for a superintendent to find that an assistant has outstripped him in scientific attainments, and that Gamaliel can properly sit at the feet of Paul. This should not be a matter for regret.

The training of young medical men by an interne service before

charging them with independent responsibility is of great value, and should be generally adopted. In New York each State hospital is allowed two internes, but this number is not sufficient to supply the requirements. There should be as many internes as there are assistant physicians. Between the nurse and the medical officer the interne can perfect the link of clinical evidence that requires time in greater proportion than special skill.

There is always a paucity of physicians in our public hospitals. In wards for recent cases, there should not exceed one hundred patients for each physician, and if the ward classification is quite strictly confined to recent cases, the number should not exceed fifty. Fortunately, in the larger hospitals, the medical force is large enough to provide for an exigence in the service for acute cases.

The assistant physician should be relieved as far as possible from clerical work, and duties that are not of a medical nature. Ward government and hygiene is properly a medical duty, and can not safely be separated from the medical service, but case writing and recording should be delegated to clerks, the physicians dictating to a stenographer. The conventional case-book has no place in the true medical work of the hospital, and is maintained, chiefly, because it is a requirement of law. It becomes a repository of facts for statistical purposes and an epitome of incidents in the history of the patient. It is useful as a reference book, and can be maintained as such, but as a medical record it is insufficient. The clinical record should contain the medical history of the patient, and this should chiefly be the work of nurses, as I will shortly explain.

I believe it is unwise to separate the pathological and clinical work in our hospitals; and consequently the practice of maintaining a special pathologist as an independent functionary is to be deprecated. The physician whose relations, clinically, to the case were the closer, should be the interpreter of the morbid appearances. He can not be so unless he holds the position of master in the manipulation of the morbid tissue. There can be no objection to giving him the assistance of expert manipulators thoroughly acquainted with technique, but their relation to the case should be mechanical. They should hold the position of assistant to the physician, instead of the physician being occasionally favored by the pathologist with a glimpse into his sacred precincts. When I find my colleagues resorting to the laboratory in their recreational hours, I feel that their spirit of research requires no assistance.

The nurse is the more important element in the treatment of the patient, not only because she is the immediate agent to carry into effect the prescribed treatment, but as the direct and constant witness upon whom the physician depends for the bulk of his information. Consequently, she should be efficiently trained, as much for the observation, detection, and the proper recording of all symptoms, as for the management of the patient. I use the feminine pronoun purposely, for I believe that the time is not far distant when women will displace men in the care of the large proportion of insane men who are not violent or erotic. We have had nearly a year's experience with women as the sole attendants in two of our more particular wards, and their success is not only marked, but they are eminently pleased with their work. A previous experience with a mixed service—part men and part women—was not a success and was abandoned. We are contemplating the organization of a new building for male patients with women nurses alone.

The training school is such a universal adjunct of an insane hospital that a reference to it is sufficient. From such evidence as I have, I believe our training schools in insane hospitals lose in comparison with the general hospital training schools, in failing to give a thorough bedside clinical instruction; hence, there should be hospital wards quite similar in their appliances and conditions to a general hospital ward, in which there should be required a term of service of all students of the training course, under constant and effective instruction. Lectures and recitations are very well, but practical bedside instruction is of greater importance. Nurses that have come to us from other schools, we have found quite incapable in clinical observation and recording, without further instruction.

Like physicians, there is usually too small a proportion of nurses in public hospitals, for economic reasons, but with increased enlightenment of legislators this fault may be remedied.

The ward and its appliances is the least important element in the treatment of an insane person. Given an enlightened physician, and intelligent and well-trained nurses, the structural arrangements of any of our hospitals are efficient to obtain desirable results in the treatment of acute cases. The ward environment in any design can be adapted to requirements, if crowding can be prohibited, and this is absolutely essential. A large proportion of cases of generalized insanity in the acute stage should have isolation, and this may be expedient or not, in accordance with the structural provis-

ion made for it. In the modern hospital adequate hygienic conditions prevail, and provision is made for convenient hydro-therapeutic treatment. The wards for the recent cases should be the nearest to the medical officers, and should be easy of access. It is now generally admitted that nurses should not live upon the wards, but should have periodic repose in some other building than the one in which they are engaged.

The reception and examination of a patient is a most important period in their hospital history, both as regards the impression upon the patient and in establishing proper treatment at the outset. It is undoubtedly advantageous to have receiving wards where the patient should meet the physician and nurse, and from whence a transfer will not be required — the patient remaining upon the ward where received. The initial impression of the hospital often remains and influences their future, either for good or otherwise, and it is requisite that this impression should be as favorable as it can be made. Hence the nurse engaged in the reception of a patient should possess tact and a large fund of common sense in addition to her training. The physician will endeavor to make an early impression of honest dealing, which often requires the exposure of duplicity on the part of relatives. The exhaustion of travel may render the patient unfit for a detailed examination, and it is good practice to delay the critical examination until the patient has had repose. Urgent conditions may require an immediate examination and treatment, but as a rule the nurse can take the patient in charge and report to the physician the temperature, pulse, weight, and condition of the skin. The assignment of the patient, upon reception, to a nurse whose specific duty it will be to aid the physician in a careful observation of symptoms, I believe to be of the greatest importance. The clinical record of every case should be started at once, and trifles should be recorded. Every new arrival should be placed in bed to await the examination by the physician. The examination should be exhaustive, as regards the bodily and mental condition, and no attempt at classification or diagnosis should be made until this is completed and digested. The condition of every organ and all the excretions should be ascertained. An important examination is that of the blood, with reference to the hæmoglobin, proportion of red discs and leucocytes, and in many cases its proper staining and mounting to ascertain intracellular conditions. The circulation and condition of the arteries should be carefully noted, and I hope the time is not distant when every medical officer will

consider his examination incomplete until he ascertains the state of the retinal vessels and circulation and the field of vision. The routine examination should also include the reflexes, electrical reactions, and the discovery of all complicating neuroses, if they exist. The antecedent history of the patient in full is desirable, when it can be obtained, which is seldom. It is remarkable how little the family physician appreciates signs that to the psychiatrist are of the utmost importance. Until psychiatry is taught with greater assiduity in our medical schools, we can hardly look to the general practitioner as a scientific ally in our special branch of medicine.

Whatever the antecedent history of the case or the preliminary examination may indicate, every new admission should pass a period of critical examination and observation, and a positive diagnosis should be arrived at, and all complications determined, before the classification is settled. One of the most unscientific procedures is to classify a case as chronic, and probably incurable, upon the evidence of the history furnished with the case—in most instances imperfect—and upon a superficial examination at the time of admission. Equally unscientific is the continued expenditure of valuable time upon the mass of terminal cases that crowd most of our institutions, where the bodily functions have regained a normal state, and the mental condition is uniformly characterized by its organic cachexia. I am not one to underrate the importance of having all classes of insane under skilled observation and care; but I maintain that the medical staff of a hospital should devote its chief energies to the class of cases in which curability is a possible result, and that this should be a general function devolving upon all members of the staff, irregardless of their domestic location or their fixed governmental duties. I urge constantly upon my staff of physicians the importance of keeping watch of the new cases; if not engaged in their immediate care, to study and criticise the conclusions and treatment of the medical attendant. The healthiest indication of a medical service is the exercise of the critical faculty. The asylum rut must be avoided. It is not a bugaboo; it is sometimes a reality destructive of every scientific impulse, but it is not the universal condition that Doctor Mitchell would have us believe.

The period of treatment during the acute stage, and in doubtful cases the period of watchful and recorded observation, brings into exercise the active and highest function of the hospital, represented by its three important elements—the physician, the nurse, the ward and its appliances. This is equally true of a general and of

an insane hospital, and the distinction between the two, in a medical sense, should be slight. The mental complication of the case should not disturb the hospital methods, and in fact the only element requiring modification by reason of this complication is the ward and its appliances. So far as safety and that feature of treatment that engages object-consciousness is concerned, certain modifications of and in the ward will be required. These are familiar to you. In all other respects the general hospital standard should apply.

The physician's directions for treatment should be intelligently and absolutely executed, and the physical and mental symptoms of the patient should be accurately observed and fully reported. There can scarcely be any question for controversy in this proposition, and I think I may safely aver that therein lies the pith of all the improvement in insane hospital methods of recent times. The improvement in personal attendance, and in nursing of the insane by intelligent and trained nurses, has made it possible to put the treatment of an insane person upon practically the same basis as the treatment of disease without mental complication.

Perhaps the greater source of complaint of our hospital methods, from the medical outsider and the medical insider, is in regard to case records. The hospital physician finds that to keep complete records of his clinical work consistent with its importance, even with the aid of a secretary, is a permanent drain upon his hours. The outsider complains that the hospital records, in a medical sense, are of no value, as they do not present detailed symptoms of a minor character that have an important meaning. Where clinical recording depends wholly upon the physician, I believe this criticism is valid.

The method of clinical recording I shall now particularize. I believe it to be ideal, and in order to be as explicit as possible in a few words, I will describe its application. As before stated I hold that the usual case record should be confined to the requirements of law, contain useful statistical information and an epitome of changes and incidents in the life of the patient. Under the direction of the physician these records can be relegated to clerks. The important medical record should be made upon the wards and it should begin with admission. The form of these records is a matter of convenience, and is not a vital question. The object to be attained is detail in symptomatology, and in avoiding the duplication of work, hence the original notes should become the permanent

medical record of the case. At the St. Lawrence State Hospital, for expedient purposes a series of forms have been adopted, a copy of each of which I herewith submit. The nurse records every incident of the case, every symptom as it is manifested. As the physician is engaged in his examination the nurse becomes his secretary. The physician's memory of clinical data does not become thereafter a factor in the case. The physician writes his prescription—the nurse copies it upon the record. The physician's directions are recorded. Charts show fully and quickly, at a glance, series symptoms. It is remarkable to what extent charting can be utilized in clinical work. My assistants chart the temperature, food consumption represented in units, amount of sleep in hours, conditions of the blood and urine, and mental symptoms. Diagrams represent topographical invasions. The clinical record at once presents to the attending physician and his colleagues a mirror of the case since admission, in an intelligent form, easy of comprehension and at the bedside. It eliminates errors the result of a lack of information. With the termination of the case the sheets, making a complete clinical history, are filed for easy reference, and from time to time they are bound in volumes. If the indexing is done by the improved card catalogue, nothing remains to complete convenience of reference, and the work can be accomplished in this perfect manner with relief to the physician and with immeasurable benefit to the nurse and patient. The medical interne's duties lying between the nurse and the physician, he performs the case work that goes to the laboratory, and a laboratory sheet becomes a part of the case record.

The application of mechanical and physical treatment is sometimes a vexatious question, owing to the usually small proportion of nurses who are qualified in all respects to administer it, and to the distribution of patients for other purposes of classification. Under a competent teacher, the training school should furnish a sufficient number upon whom should devolve the massage, Swedish treatment, administration of electricity and balneotherapy, as a feature of their course. It is a good and safe practice to designate nurses to these several duties for a specified period, with a requirement to execute them for a department, instead of confining them to a ward duty. The instructor would necessarily have to be satisfied of their efficiency, but nurses in course of training could give an apprentice service as assistants, and thus be prepared when their turn came as direct agents. An absolute requirement is the prescription of phys-

ical treatment in as precise terms and measurement as the direction for medicinal treatment. This is not at all difficult. The galvanometer in electrical treatment; varieties, time, and location in massage; temperature and time in baths, all permit direction with precision. Gymnasium work should be in the hands of a master competent to recognize symptoms of fatigue. The physician must constantly satisfy himself of the competency of his agents who carry into effect these important remedies.

The stimulation of object-consciousness, or the so-called moral treatment, is a function of the insane hospital not required of the general hospital. It does not require any words of mine to impress you with the importance of this class of medical work. The means employed are innumerable, both to modify morbid sensorial impressions and to produce new sense impressions. The psychiatrist must not only be a physician in the ordinary meaning of the term, but he must have a reliable apprehension of essential domestic felicities and of avocational impulses, that he may opportunely place his patient under conditions where mind impressions will aid recovery.