other students tend on other grounds. He himself would be the last to speak slightly of Darwin and his school, but the general tendency of modern thought was to make us feel that the Darwinian doctrines have not that value with which they are credited by Darwin and his followers. We had come to see that the theories of development following the old lines do not explain anything. The old theories of a Providence arranging everything to an immediate end which was patently visible, theories which were rejected by careful thinkers as long ago as Voltaire (who ridiculed them by saying that on these theories the nose was an organ made to support spectacles), had been cleared away by Darwin's deeper consideration of these matters; yet the trend of modern thought is towards feeling that the doctrine of development does not at all account for everything. If the human race is the last thing in development in this world, if the human intelligence or ethical feelings are the crown of human life, we are brought by the very reception of this belief to the conviction that the highest intellect and highest ethical feelings of man must have a meaning; and if the human ethical feeling says there is a meaning in the universe that must be true, otherwise development has developed to nothing, intellect means nothing, moral feelings mean nothing, there is no purpose in anything, and our views of development are a dream. Again, that there is a purpose beyond the powers of natural or sexual selection to bring about, that there is a something beyond the mere organised selfishness which the struggle for existence really means, is evident to us when we look even to the lower forms of life. It is obvious that in many of the activities of the lower animals there is a purpose quite beyond the mere struggle for existence; the economy of the hive shows us a number of animals working for a common end which is utterly inconceivable on the ground of a struggle for existence, natural selection, or sexual selection. The worker bee, who is a non-fertile female, struggles, not for herself, nor for her offspring, which she cannot have, but for an ethical end, for the good of the race. Again, in the human race we are brought into collision with two great forces which are contradictory to each other, namely, intellect and the moral feelings. The keenest intellect does not tend to benefit the whole race, therefore the moral feelings have sprung up. The basis of all moral feelings is self-sacrifice, which is not brought about by the struggle for existence, not fostered by sexual selection. The ethics which form the basis of human society are not dependent on natural selection, sexual selection, or environment, therefore there is something beyond. There is a tendency in things, there is a tendency in our own mind, in our own acts, which is the real guide and real basis of our acts. Dr. Graham quoted Hume as saying that the mere fact that a person believes a thing is no proof that it is true, but the bearing of this was not clear to his (the speaker's) mind. If the whole human race has certain feelings, instincts, and aspirations, they have come there with a purpose, with a history and with a future, as certainly as has the nose on our face.

Dr. GRAHAM replied shortly.

Mental Unsoundness and Mental Disease in a Local Prison. By WILLIAM COTTON, M.A., M.D., D.P.H.,
Medical Officer, H.M. Prison, Bristol.

EXCLUDING debtors (who are non-criminal prisoners), a *local* prison is one containing persons charged with an offence awaiting trial, or convicted and serving a sentence of imprisonment of less than two years. A *convict* prison contains convicted prisoners sentenced to three or more years' penal servitude. All prisoners sentenced to penal servitude have

been while awaiting trial, or are for a short time after sentence, detained in a local prison, and thus come within the cognisance of the medical officer there.

In the recognition of unsoundness of mind among the criminal inmates of a local prison like Bristol, there are some difficulties at the outset :

1. Apart from an individual's criminal record (if any), there is, as a rule, no available information from third parties (such as relatives, or neighbours, or medical attendants) as to their mental antecedents or previous family and social history. Even when the behaviour of a person charged with an offence is such as to attract attention in a court of first instance, so that he or she is remanded for a report from the prison medical officer, or when insanely written documents are found about him, or when one would expect that a previous term in an asylum or certified inebriate reformatory must be known to the committing authority, in all cases the prison medical officer has to shift for himself, without reliable information, as best he may.

2. Another serious difficulty arises from the habitual untruthfulness of most prisoners, who, as a rule, will answer "yes" or "no" to questions, unless they fancy "no" or "yes" would be more advantageous.

3. Then, again, the majority of prisoners are, on reception at a local prison, presumably bemused with recent or habitual drinking, or both, so that initially the clinical picture may be quite disguised and liable to misinterpretation.

On the other hand, we have in prison practically continuous observation by day and night (and if necessary in hospital) of all doubtful cases under physiological conditions of regularity, rest, exercise, warmth, food, and freedom from alcohol, and though it takes at least seven days to get the drink well out of a man, at the end of that time, in the case of an individual whose immediate and remote mental antecedents are unknown, and perhaps unknowable, one may give a fairly confident opinion upon the substantial or residual insanity then present. And conversely in the case of any person charged with an offence, it is a safe practical rule never to report on such an unknown prisoner's mental condition until he or she has been at least one week under observation—that is, under at least one week's complete freedom from alcoholic dosage.

As regards their mental condition, the prisoners at Bristol

(and probably at other similar prisons) may be roughly distributed into four fairly natural groups :

I. The first group consists of sane and (at least on duty) temperate prisoners whose mental condition (and general physique and health) is much above the average of the outside world. Most of these are the real professional criminals, enemies avowed (in prison) of society, who have calculated the chances and taken the risks of the game. For example, there are master burglars, master swindlers, organisers of swindles, forgers, the whole tribe of sharpers, confidence tricksters, and false pretence men, and fraudulent bankrupts and the like, acute, subtle, plausible, shameless, audacious, and often of dignified presence and ingratiating and even fascinating manners. All these gentry are pretty numerous in a local prison while waiting their trial at Quarter Sessions and Assizes, and then they are sent elsewhere to penal servitude, most of them for a good long spell. Some of the most admirable psychological studies of the greater Victorian novelists are descriptive of individuals of this group, not to speak of later and more sensational writers, and the daily newspapers.

It is among the false-pretence men—who like to keep their hands in, I suppose—that the prison medical officer meets the most painstaking, industrious, and (it may be added) successful malingering. Some of them simulate insanity itself most skillfully, and others more coarsely and crudely, while both serve a useful purpose as excellent foils and control experiments for the real thing. Then, again, it is here that the feigned attempts at suicide—the “dinner-hour suicide”—are made. The *modus operandi* is generally the same, and is no doubt traditional. At the hour of tin collecting, when the discipline staff are sure to be most numerous about, or after ringing his bell, a prisoner is presently found blue in the face, suspended by his handkerchief to the ventilator or a hook in the wall, or else lying on the floor with a strand of oakum twisted tightly round his neck. A successful suicide in a locked cell is a terrible thing to think of, and implies either a sane man purposely ending his misery, or a case of insanity overlooked. Yet from what I have seen of seven or eight feigned attempts it seems to me that most of them were very narrow escapes from death by voluntary misadventure. Subsequent confession in these cases leaves little doubt of their feigned nature.

In this group of sane prisoners, and other sane prisoners, who are undergoing a long term in prison—say any time between one and two years, the extreme limit—there is certainly a tendency towards the end of their sentence to become what is known among the older warders as “gaol-dotty.” A “good” prisoner (warders classify prisoners “good” or “bad” irrespective of the cause of their detention) is observed to return his food and mismanage his work. On examination he is found to be shaky and nervous, to have lost weight, to have palpitation, and to sleep badly and to have morbid fears about losing his remission marks. This condition is possibly due to the monotony of prolonged prison life, but more probably to the anticipation of facing the world again, with, it may be, the inevitable social penalties of a first crime. The tendency being known, rarely develops far, and if it does, ordinary medical treatment and a few daily visits soon put things right. It is said that the discipline in a local is more severe than in a convict prison, so that prisoners who have reason to know prefer three years’ penal servitude to two years in a local prison. That a man, however, should become certifiably insane in prison without showing signs of insanity within a short time of reception, or without a marked previous insane or intemperate history, must be very exceptional, and is outside my own experience in a local prison.

II. The second group, that of inebriate prisoners, forms of course the largest in the local prison, constituting probably 90 *per cent.* of the males and perhaps even a larger percentage of the females received into Bristol prison. It consists of men and women of all the mental grades of the reputedly sane general community who through drunkenness and its associated follies have become the subjects of a criminal charge, or in whose offence drink has been in the wider sense a contributing cause; when the drink is out of them they are like other people, and when the drink is in them they are for a time (and perhaps all the time) practically more or less insane. In the surroundings of a prison they are sober and normal, or soon become so, and probably would continue so in any non-alcoholic environment. Very many of them are alcoholic recidivists, and (if they survive the accidents of drunkenness outside long enough) in time no doubt become progressively degraded, and finally may be the subjects of terminal alcoholic

dementia (clinically, a slow progressive general paralysis of the inebriate). Though more their own enemies than society's, there is no crime, however serious, that members of this group may not commit, except such crimes perhaps as imply high technical execution and systematic planning ; as is notorious, to their account most of our crimes of violence belong. To this group might very naturally be referred (because of associated intemperance) those who on account of their deficient intelligence are hardly able to earn their own living outside independently, though able to perform good unskilled taskwork under ordinary supervision.

It is among this group while in prison that the severest typical cases of acute post-alcoholic insanity, or delirium tremens, are found. As seen in our prison, delirium tremens occurs more suddenly, is more severe, is sooner over, and ends in a more definite crisis, than in private general practice. From unknown causes we get a number of cases in one month in epidemic fashion, and then for several months none. Most of the inebriate prisoners received are pretty well sobered before arrival, and little notice is taken of what would be called delirium tremens in the outside world, or of ordinary forms of drunkenness on first reception. Cases with symptoms of delirium tremens on arrival must, of course, have been for a day or two previous in an irresponsible condition ; and so far their condition requires to be carefully noted for the information of the judge. The terrible cases we have in prison have as far as we can discern a latent period (with no obvious symptom and only an acknowledgment of recent excessive drinking, presumably suddenly cut off) of twenty-four to sixty hours ; and the patient is clothed and in his right mind by the eighth day, unless he dies. We have had two deaths nominally from delirium tremens within the last three years on the eighth day of reception ; but as both patients died in epileptiform convulsions, it is possible that a *post-mortem* examination might have given a different explanation.

III. At the other end of the scale from the first group we have a group of (generally habitual) petty offenders, who are just as obviously under the general average of physique and mental ability as the others are above it. They are rather a-social than anti-social ; from bad heredity and bad environment they have little or no chance in the struggle for social survival ; no

doubt they are sometimes the tools and scapegoats of more designing knaves. They are poorly born, poorly bred, poorly nourished, poorly clothed, mere social flotsam and jetsam, and hardly likely to do much in life except propagate their kind. Many are crippled or maimed, some are partially deaf, and some are almost blind, while some have evidences on them of old head injury. Many have impaired or exaggerated reflexes and inequality of the pupils without discernible mental disease⁽¹⁾, or are even ataxic. Outside most of them are of course occasional or chronic drunkards ; charitably we may suppose a very small dose of alcohol likely to upset them. In prison, where the competitive struggle for existence is suspended, and no man may exploit his neighbour, where alcohol is for a term inhibited, and where subsistence is guaranteed to the feeble and stricken in body and mind for minimum tasks, many brush up wonderfully and might alternatively (so far as they have been intemperate) be referred to the group of inebriate criminals, the second, and in prison, as I have said, a mentally normal, group.

But within the larger group of prisoners who cannot independently make or keep their living outside from mental defectiveness, yet who do pretty well under ordinary prison supervision, there is an inner circle or sub-group of partially demented prisoners who though not certifiably insane (at least in prison), yet are fit only for a much modified prison discipline—they have to be treated as sub-normals, the “weak-minded prisoners.” They are probably, if we could trace their record, a very composite sub-group, being either cases of a chronic alcoholic dementia, or congenital imbeciles who have survived to adult life, or the subjects of confirmed and mild dementia secondary to some attack of acute insanity ; a few have long been subject to epilepsy, a most dangerous class when out of control ; some are simply dotards ; and a few are obviously the subjects of post-hemiplegic mental impairment. Many of them are known to us from former incarceration and become “prison pets.” If these cases are not carefully noted and provided for, what happens is that some fine morning the prisoner is found in an emaciated, half moribund, dazed condition, in a disordered dirty cell, having probably lain out all night uncovered in the cold. It is these prisoners who come to look upon prison as their home, and who, if they survive the perils of freedom, help to swell unduly our prison mortality. Of nine

deaths in the last three years and a half, three have been of this class of "weak-minded prisoners."

IV. This, the smallest and, to the alienist, psychologically the most interesting, group, consists of prisoners indubitably insane and certifiable as such, who are essentially and primarily lunatics and only secondarily criminals. While the test of "weak-mindedness" is largely an industrial one, the present group is distinctly pathological, abnormal, and unpunishable.

The only part of the prison they are really fit for is the hospital; they are an anxiety to everyone and a danger to themselves, and the whole staff is glad to get rid of them without some disaster. On reception some appear to be quite sane, some are flustered as with drink, some are actually drunk, some are taken to be "weak-minded" in the special sense, and others are such as few medical men would fail to detect in five minutes' conversation as cases of madness of a definite clinical and symptomatic type. It has been my lot thus to diagnose in our prison cells one case of hypochondriacal melancholia and another of myxœdematous insanity, two or three insane querulants or litigants, several cases of classical general paralysis of the insane, different forms of senile and climacteric insanity, one case of puerperal (probably), and several cases (alas!) of lactational insanity, organic dementia not seldom, all kinds of non-alcoholic delusional insanity, the different forms of stupor, one terrible case of excited suicidal melancholia, and very rarely the more ordinary forms of morbid depression.

These unfortunate and unlucky people are charged with the whole gamut of crimes, from "wandering abroad without any visible means of support and unable (!) to give a good account of themselves" up to "murder." They are a great responsibility, for one never knows that the "wandering" delusional criminal of one year may not become the "murderer" of the next; by timely diagnosis two lives at least may be saved. Some have been repeatedly in prison before, regarded as of the inebriate or even weak-minded group, and, gradually deteriorating from the stress of life at large, untended in the streets and roads, at length become certifiably insane; *e.g.* when the industrious and well-behaved, but crazed, deaf prisoner talks of translating his delusional rights and wrongs into the definite action of going to "Buckingham Palace" with a "revolver" on his discharge, it is time to suggest certification, for the reason

that, although he may not get as far as London, he might get the length of the "revolver." It is not safe to trust to a misfire. No doubt such prisoners' previous sentences have been due to an over-looking or a confusion with others of the essential condition; just as, *per contra*, weak-minded habitual criminals, or delirious and even sane inebriate criminals, when drunk, occasionally land in an asylum.

Apart from cases accused of serious crime and committed to Quarter Sessions or Assizes (most interesting cases medico-legally, which may require special procedure on account of the formal raising forensically of the questions of criminal responsibility and ability to plead), there are three principal methods of dealing with cases of unsound mind in prison:

1. A prisoner on remand (it may be for inquiry) who shows serious mental symptoms has the fact of his insanity reported to the committing authority; he may then by the authority be discharged to the care of his friends, etc., or certified under the Lunacy Act, generally as a pauper, and sent to an asylum or the workhouse. It is no part of my duty as a prison official to certify under that Act; but occasionally I am requested as a practitioner, and sometimes feel it advisable to come forward and offer to do so. Otherwise the Report is drawn up in terms which can be utilised to form part of the usual medical certificate under the second head of "facts indicating insanity communicated by others." In some cases one simply certifies the existence of "mental deficiency," or can merely give a negative report as to the period under observation.

2. Under the Criminal Lunatics Acts a prisoner may at any time during his incarceration be brought before two of the visiting justices of a prison and two medical practitioners and certified as insane and sent to an asylum. By prison regulations the initiative rests with the prison medical officer. An inquiry of this kind inside a prison is not always very satisfactory, as in questions of insanity generally the medical witness has to pit his legal ignorance against the lawyers' medical knowledge. At any rate, in the case of a criminal in prison the rules of legal evidence tend to prevail over those of scientific testimony. Whereas under the latter everything bearing on the case has to be considered, under the former anything decisive of the matter may be ruled out, such as relatives' or prisoner's letters, previous history, a warder's night reports, and

medical opinion generally. Thus, if the prisoner is at the moment of inquiry quiet, then he is "sane"; but if noisy and excited in speech and behaviour, then he is "shamming" unless he is "drunk." The presumption of malingering, in the ordinary sense, is over them all, whereas as a matter of fact in some cases the only simulation is the artful dissimulation of delusion, to avoid certification and a further indefinite detention. An abortive inquiry of this kind is a very serious matter, as it may in the case of a prisoner awaiting trial gravely prejudice the defence (?) of insanity. Unless, therefore, there is a risk of a death in prison of such an insane prisoner by suicide or misadventure, or in the course of his malady, such a course of procedure is not always advisable. Further, the period of incarceration is frequently too brief for the necessary steps to be taken.

3. The prison regulations provide that in the case of any "weak-minded prisoner" the medical officer shall on the prisoner's discharge report to the police of the district to which the prisoner is to be discharged that he is of deficient intelligence and not fit for ordinary prison discipline (with such details as may fully describe his condition), so that if he is again brought before any court the facts may be known. The expression "not fit for ordinary prison discipline" is sometimes taken to mean unfit for "any" prison discipline, but this is a misunderstanding. This form is an exceedingly useful because an elastic one, and it may be filled up in terms utilisable for the usual medical certificate, under the Lunacy Act, where further developments towards certifiable insanity appear likely, and control of the individual is advisable. When time does not permit any other course in the case of a very insane and dangerous prisoner, a special and more urgent report is made to the police, and the prisoner is on his discharge from prison arrested as a wandering lunatic—within a couple of yards of the gate it may be—and subsequently certified as such, I suppose.

In order to give proper proportion to this simplified sketch of a somewhat complicated subject, I now give a few figures in tabular form, for last year and the year before, of Bristol criminal prisoners whose mental condition required special treatment, report, or certification. All the prisoners were adults.

Column A is for cases of acute post-alcoholic insanity; that is, delirium tremens and allied conditions (such as attempted

suicide under post-alcoholic melancholia) apart from mere drunkenness itself. Column B is for cases of low-grade insanity, partial dementia, or "weak-mindedness," as defined in this paper; and column C is for cases of high-grade insanity of definitive and recognisable type, which if not actually certified as insane and sent to an asylum while in prison, ought to be so dealt with on their discharge. The total numbers to be distributed under columns A, B, and C in the six months now ended are fifty males and six females.

H.M. Prison, Bristol.

Period.	Estimate of number of individual criminal prisoners received.	Individual cases of unsound mind requiring special treatment, report or certification.			
		A.	B.	C.	Total.
I. One year ending March 31st, 1903	Males, 1613	13	22	13	48
	Females, 688	2	7	8	17
II. One year ending March 31st, 1904	Males, 1688	14	47	14	75
	Females, 611	3	3	9	15
III. Six months ending September 30th, 1904	Males, 913	7	34	9	50
	Females, 372	0	1	5	6

(¹) *E.g.*, of 1135 male prisoners (including debtors) received consecutively, at least 4 *per cent.* had unequal pupils not obviously due to an eye disease or other peripheral lesion. It would be interesting to know the prevalence of this stigma in the general male adult population.

DISCUSSION

At the meeting of the South-Western Division at Bailbrook House, on October 28th, 1904.

Dr. WEATHERLY said that Dr. Cotton's paper pointed out clearly what he had been maintaining for many years—that many who went to prison ought never to go there, but ought rather to go straight from the court to an asylum and remain there for the rest of their lives. Dr. Cotton had shown that he got a large number of prisoners who came up over and over again for crimes they never ought to have been allowed to commit. His paper had thrown a light, a big light, upon the neglect of the duties of the magistrates or the police surgeons in many cases. One thing in the paper which interested him especially was Dr. Cotton's reference to the class of moral insanity—a very difficult class, as he admitted, whose condition it was very difficult to find out when they got them in prison.

Dr. STEWART (Bridgend) said it was very interesting to have heard as they had the attitude of the prison surgeon. Their own attitude as asylum physicians was that many prisoners, as Dr. Weatherly had said, were irresponsible. When present at assizes it had seemed to him deplorable that judges, barristers, and juries should be engaged in dealing with half-imbecile creatures who came up

time after time. He did not see any prospect of improvement except in the education of the magistrates and of the prison officials up to a certain psychological standard.

Dr. BRAYN said he did not personally consider that crime and insanity were at all synonymous, but there were a certain number of people in prisons—he spoke as having experience only of convict prisoners—who were not certifiably insane but who were weak-minded people. The term “weak-minded” was comprehensive. It included not only imbeciles or idiots, but those who would be termed “eccentric” and those who showed a deterioration of mind but who were not certifiably insane. He had always held that these persons ought to have indefinite sentences, but not in prison, and they ought not to be allowed out unless they had friends to look after them or unless they were able to earn their own living. As they knew, there was a committee sitting now as to this class of case. They had a good example at Broadmoor at present. It was that of a youth who had always been a trouble to his parents, always getting into difficulties. He talked rationally but he forged cheques and did all sorts of extraordinary things. They got him certified at last and he went to a private asylum, from which he escaped. The medical men saw him and found that he spoke rationally after his escape; however, they certified as well as they could upon his previous history. The Commissioners ordered his discharge, and the consequence was that he is now in Broadmoor. The difficulty with these cases was that medical men could not certify them. They had to certify as to facts, not as to impressions of what had happened before. Many of them were a class of case which no medical examination could make out. He quite agreed as to the difficulty of getting family history, and he supposed it was still more difficult at Broadmoor. He received cases there from the extreme north of England and it was impossible to get information. Another point as to the “criminal type” was that many such cases were not really of the criminal type; they were people who were perfectly good up to the time they had committed the crime. One thing was certain, that if they did not get their history when they came in they would never get it after they had mixed with the other prisoners. Dr. Cotton had mentioned the difficulty in the way of the prison doctor dealing with those cases which were certified before trial as criminal lunatics and the testimony of the prison medical officer as to unfitness to plead. He held very strongly that a prisoner should not be certified as insane before trial unless he was quite unmanageable in the infirmary, and that he should not be certified as unfit to plead unless it was absolutely necessary, for otherwise he always had the grievance (although they might know that he was really guilty) that he was a criminal lunatic without having been proved to have committed a crime.

Dr. MACDONALD said Dr. Brayn's case of the boy at Broadmoor was extremely interesting, and he would like very much to know what the Commissioners thought of the matter now. There was one interesting point about the table Dr. Cotton had prepared, and that was the enormous difference in the lower grade in 1904 as compared with 1903, and further he was not prepared to see the extraordinary difference there was between the sexes. He was afraid it did not reflect very creditably upon the male sex. It was a most interesting contribution to their proceedings, and he was sure they were all very much indebted to Dr. Cotton for his paper.

Dr. J. STEWART (Clifton) said he had been much interested in the valuable information Dr. Cotton had so diligently compiled, and they were under a corresponding debt of gratitude to him. It was very much the habit to speak contemptuously of all people who had the misfortune to be in prison. They as psychologists, who went deeper into the thing than the general public, could see what the general public could not see and what they would not believe if they were told, that there were a number of poorly born, poorly bred, poorly fed, and in every way unfavourably circumstanced people among the habitual offenders.

Dr. COTTON, in replying to the comments offered, said it was a curious thing that prisoners charged with any offence were not seen by any medical man. Another thing was that the magistrates in sending a prisoner to gaol might send with him some information. What information they had they generally got next morning from the morning papers, and in some cases of lunatics who had been sent up without any information at all that might have come too late. As to the habitually weak-minded offenders, he did not think it was possible to send them to

the asylum. The asylum was too good for them. They required a firm discipline all the time, and the pity was that they should be subject to the modified prison discipline for so short a time. A sort of prison asylum would be the best thing for these offenders, these weak-minded persons who lead lives of a low criminal character, stealing, drinking, and committing acts of folly against which the public had to be protected. The asylum was too good for them: the prison discipline must be modified for them and it was modified. It was impossible to certify them because they were not delusional. The existence of dangerous delusions was the test of insanity so far as concerned their prison inmates. The criminal responsibility of a prisoner referred to the state of mind of a prisoner at the time he committed the deed, and of that the prison officer had no direct knowledge, he could only testify to the time he had the prisoner under observation. The question was often referred to the prison medical officer, but it was really not his business. It was only his business to testify to the condition of the prisoner when in prison. He had to determine the fitness of the man to plead and the extent to which the man was punishable, not the state of mind at the time of the crime. As regarded the increase in numbers for the second period to which his figures referred, he believed himself it was due to the Licensing Act which came into force at the beginning of the second period and which enabled the officers of the law to cast their net a little further afield. Anybody could be taken up now for being drunk in a public place, whether they were disorderly or not. That gave a wider sweep of the net, and the larger the sweep the more weak-minded they got. With regard to the proportion of males and females too great importance should not be attached to the figures because in the case of the females the figures were smaller and not very conclusive. In the case of the males there were sufficient numbers to draw certain conclusions, but in the case of the females the numbers might be due to some accidental consideration. With regard to the use of the term "inebriate," there were probably as many forms of drunkenness clinically as there were forms of lung disease, but the word "inebriate" was used in the sense found in the Inebriates Acts.

A Plea for the Closer Study of the Body-Weight and its Relation to Mental Disease. By C. HUBERT BOND, D.Sc., M.D., Medical Superintendent, County of London Colony, Ewell.

MY paper will not be a lengthy one, and should perhaps be prefaced with an apology. For it contains no new facts, nor have I the results of any investigation to communicate.

I am also fully alive to the fact that, from the therapeutic standpoint, the subject can acquire no new force from anything I can say; for the simple reason that the "gospel of fat," as applied to the treatment of mental disease, has been so eloquently and convincingly preached by Dr. Clouston that none remain of whom converts can be made. We all fatten our patients as early and as rapidly as we can, though some of us perhaps pursue a more vigorous alimentation than do others; and probably most of us in saying good-bye to our recovered cases are in the habit of cautioning them to keep a close watch on their body-weight.