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Part I.—Original Articles.

*The Presidential Address, delivered at the Sixty-second
Annual Meeting of the Medico-Psychological Association,
held in London on July 16th, 1903. By ERNEST
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GENTLEMEN,—In commencing the work of the office to which you have elected me, I desire to convey to you my sense of the honour conferred and of the responsibility which this honour entails. In heartily thanking you, I assure you it will be my constant care to maintain impartially the rights of members and the freedom of debate. While checking exuberant verbosity, I shall endeavour to encourage useful discussion and to expedite business at all our meetings, and shall look to you for the support which is necessary to preserve intact the dignity and privileges of the Chair.

For fifteen years I have been closely connected, either as South-Eastern Divisional Secretary, Examiner, Auditor, or member of Council and of the Standing Committees, with the work of this Association, and am therefore fully conversant with its requirements and aspirations. I do not, however, attribute to this fact my election as your President, but am inclined to deem it a mark of regard for the work done in recent years in the public asylums of the metropolis to advance the care and

treatment of the insane. Our much esteemed editor of the JOURNAL, Dr. Henry Rayner, in 1884 was the last medical superintendent of a county or borough asylum in the metropolitan area who presided over us. We are fortunate in still retaining his valuable services.

Inasmuch as ours is an association with large vested interests, high aims, and great responsibilities, it has occurred to me that I can best serve those interests by addressing you to-day not upon any special subject, as has been done on several recent occasions—notably last year by Dr. Wigglesworth, with marked ability,—but upon the legal and general desiderata for the insane and those to whose care they are committed, and upon whose efficiency their chances of recovery so much depend.

I am the more induced to take this course for these reasons. We are near to legislative changes. There is much diversity of opinion upon the changes necessary. We recognise that certain sections of the law have not worked in the best interests of our patients—nay, further, have tended in many instances to delay their treatment and retard their recovery,—that early treatment must be encouraged by new enactment, that efficiency in both care and treatment must be ensured, and that abuses which have existed in the recent past must be checked and rendered impossible in the near future.

Before, however, we discuss our requirements, we must remember that the occasion demands a retrospect as well as a prospect. What were the incidents of the year just concluded? What was its scientific progress? What were our losses by death? The most striking incident was probably the disastrous fire at Colney Hatch Asylum, whereby fifty-one lives were lost. The facts of this calamity are indelibly imprinted on the memories of all of us; and a fire which occasioned the greatest loss of life of any in the metropolis since the great fire of 1666, and coming as it did so near home, cannot fail to engage our attention as to its cause and lessons. The probable cause was a spark or sparks from the smoke shaft distant about twenty-six feet from the window of the clothes room, which might have been open at the top an inch or more at night to prevent stuffiness, for it is the usual custom so to leave the windows of these rooms. The stoker would fire up at 5 a.m. to get his day rooms warm for the patients and staff at six, and the high wind blowing would carry the sparks in

the direction of the clothes room, in the upper part of which the fire was first discovered about 5.20 a.m. Now what are the lessons this fire conveys? They appear to be—

1. That all temporary buildings are unsuited to the insane.
2. That provisions for dealing with fires must be complete in all our institutions, and that our fire brigades must be as efficient and self-reliant as they can be made.
3. That all stoke-holes, furnaces, and smoke shafts at various points in the buildings must be abolished, and live steam from one general station used as the heating agency in place thereof.
4. That all alternative exits and escape staircases must be systematically used by patients for their egress; otherwise in the event of fire the insane refuse to leave except by the door they are accustomed to go out by.

It is a moot point whether outer doors should be master-locked at night. I think it unnecessary, since electric bells can be fitted which will ring when the door is opened at forbidden hours. Before leaving this subject I must allude with pride and satisfaction to the one bright feature in the catastrophe, the heroic conduct and self-sacrifice of Dr. Seward and his staff. They worked to exhaustion in their efforts to save life and relieve suffering. We are proud of such fellow-workers who so nobly did their duty!

The large percentage of deaths from pulmonary tuberculosis in public asylums and hospitals for the insane has engaged our attention during the past year. Thirty years ago, when I first took duty in this branch of medicine, the insane were deemed peculiarly liable to this disease; in fact, insanity was thought to predispose to death by pulmonary tuberculosis. To-day, however, we recognise that this predisposition arose in the main from defective hygienic conditions, too little cubic space by day and night, insufficient ventilation and ill-regulated heating, too little fresh air and exercise, uncleanly habits, and a total absence of isolation whereby alone infection can be guarded against. The general hygiene of our institutions has been vastly improved in recent years, and during the past twelve months the question of constructing or allotting suitable hospitals and sanatoria for the isolation and proper treatment of patients suffering from pulmonary tuberculosis has attracted the attention of the committees of many public asylums. In some cases temporary isolation hospitals or special wards and

grounds have been set apart for this purpose. Amongst others the authorities of Lancaster, Warwick, Claybury, and Leavesden Asylums in England; Woodilee, Gartloch, and the Crichton Royal Institution in Scotland, have taken steps in this direction. The subject is a difficult one, as the varied mental states have to be considered (in addition to the physical condition of our patients) in planning or allocating buildings for this purpose; but the action of these committees is undoubtedly in the right direction. While discussing this matter I would draw attention to the value of light and its health-giving properties in the general treatment of the insane. Our day rooms should have light on all sides. At Stone the wards are only separated by glass screens, and we have glass panels in the upper half of every door (single rooms included) except where contra-indicated. When we first introduced these in 1887 the Committee said, "What a dreadful glazier's bill we shall have!" My reply was, "The more glass you have the less you will have broken, because the less will be the feeling of restraint to the patients," and such has proved to be the case.

In the matter of artificial ventilation our inlet air-ducts in asylums are commonly fouled by patients pushing the *débris* of food, bits of clothing, cigarette ends, etc., through the gratings. To overcome this Messrs. Kite and Co. have made, from my suggestion, a grating for wards and dormitories removable by the ordinary gas or shutter key, whereby access is gained to a flap regulating the intake, and to a wire tray which catches the *débris* mentioned, which *débris* can then be systematically removed. The warm air can also be diverted by the nurses from the ward below to the dormitory above, and *vice versa*.

The introduction of electric plant into asylums has brought with it many advantages, and not the least of these has been the exhaust fan ventilator. Our dormitories, formerly never properly ventilated without draughts, are now kept delightfully sweet at all times and cool in summer by electric fans which extract the vitiated air from several points in each ceiling; and, moreover, the exhaust draught can be carefully regulated by the night staff.

The great increase in the mortality from dysentery in asylums in recent years continued to engage attention during 1902. It is a regrettable fact that this disease has become endemic in some of the most recently constructed institutions,

in which it has undoubtedly been introduced by cases transferred from other asylums where the disease existed. Thanks to the investigations of Dr. Mott and others, we have recognised that this endemic disease may at any time become epidemic and communicable under conditions of overcrowding and defective sanitation. Fortunately the attention drawn by the register for diarrhoea and dysentery instituted by the Commissioners in Lunacy will tend to check any such sanitary defects in our buildings. Active workers in the Association have also recently been occupied in investigating auto-intoxication, the toxæmic origin of certain forms of mental disease, and the value of antitoxic treatment—a subject which offers an excellent field for scientific research. Many of us in years past have been struck by the marked mental improvement in apparently chronic cases during an attack of enteric or other febrile disorder—an improvement, alas! of but a temporary nature, and attributable solely, I believe, to the antitoxic action of the fever germs.

The splendidly equipped pathological laboratories of London and Edinburgh, fed by the asylums of the metropolis and Scotland respectively, continue to pursue their excellent work, as evidenced by the *Archives* published last year. The appointment of pathologists to our large institutions for the insane, and the prominence thus given to pathological research, is being productive of excellent results. Combination in pathological investigation under capable directors, however, promises even better results than can be achieved by individual efforts, and such combination should therefore be encouraged in other parts of the kingdom and empire.

In contemplating the active field of our workers in psychiatry, we are irresistibly reminded of those whom the hand of death has removed from our ranks, some in the plenitude of years, others in the full maturity of manhood, and others, alas! in the age of early promise. In 1902 Mr. Holland, the Nestor of the Lancashire superintendents and father of Whittingham Asylum, went to his rest after a period of well-earned retirement extending over nearly a quarter of a century. About the same time Dr. Hills, the doyen of East Anglian alienists, who for twenty-six years controlled with ability and success the destinies of the Norfolk Asylum, paid the debt of nature after fourteen years' freedom from responsibility. It is a curious fact that his

former chief at the Kent Asylum at Barming Heath, Dr. James Huxley, an early member of this Association (elected June, 1847), a pensioner of forty years' standing, and a brother of the late Professor Huxley, survives him. Other losses in this category were Dr. Gasquet, formerly of the Burgess Hill Retreat, a quiet worker of a retiring disposition; and Dr. George Mickley, formerly of St. Luke's Hospital, who enjoyed for but a short period the pension allotted him. Under the second heading we lament such men as Drs. Arthur Strange, Bonville Fox, and Law Wade. The first-named lived a generation for his people at Bicton, universally beloved by all connected with the Salop and Montgomery Asylum. In Bonville Fox we lose a delightful personality and a cultured physician, who had the best interests of this Association at heart; and by the death of Law Wade the public asylums of the West of England were deprived of one of their best superintendents. In April of last year many of us listened to an interesting paper on asylum dysentery read at the South-Eastern Divisional Meeting at Brookwood by Dr. Macmillan, one of the assistant medical officers at Claybury, a young physician of promise. Little did we surmise that within a few months he would fall a victim to the disease he was investigating, to the great sorrow of all who knew him and appreciated his qualities of mind and energy in scientific research.

The concluding of this brief retrospect brings us to the prospect, and to the desiderata of our Association and of its various divisions. The Lunacy Commissioners' Blue Book issued in June, 1902, tells us the indisputable fact that insanity is on the increase, that the average annual increase of patients for the quinquennial period ending December 31st, 1901, for England and Wales was 2270 (2140 rate-paid and 130 private), an increase exceeding the average annual increase of the preceding ten years by 483, and that of the preceding five by 500. The average annual increase of the rate-paid insane in the county of London is about 500, but curiously enough this increase has been greater in those years in which large new asylums have been opened by the County Council. This Blue Book also tells us there is one insane person to every 298 sane, whereas in 1859 the proportion was one to 536; and that the advance in the ratio has been almost entirely in the rate-paid class; that there has been no sustained advance in the average

recovery rate in the past thirty years ; and that there has been an important diminution in the death-rate. The last-named facts point to the accumulation of the chronic insane. To learn that there has been no material advance in the recovery rate with the development of rational principles of treatment and the vastly improved environment of the insane is not pleasant reading, and it is our duty to discover, if possible, why this is so.

In the first place we must discuss the population we are dealing with. Are there any racial or environmental changes when compared with the population of 1859? Under racial changes we note—

1. That with the increase of our population there has been less encouragement for eligible aliens to settle in our country and intermarry with our people ; consequently less infusion of new blood into the race than formerly. The aliens we do receive are mostly needy town-dwellers of poor physique, with neurotic inheritance and frequently with constitutions undermined by disease. Moreover they are often undesirables of the criminal type. Such immigrants are likely to be detrimental rather than of benefit to the future nerve stability of our race.

2. The influence of heredity. This was fully discussed by Dr. Wigglesworth in last year's address. The intermarriage of neurotics and those with inherited taint of insanity, now all too common, should be discouraged by every one, and prevented if possible by State interference. Only last year a young fellow, a private patient at Stone, on recovering from an attack of acute mania, married almost immediately the daughter of a lady patient who was a bad case of chronic mania. The *fiancée* used to visit her sweetheart and mother the same day. I did my utmost to discourage the alliance, but in vain. Disaster awaits the progeny.

3. The altered type of occurring insanity. When I look back to the admissions in county and borough asylums thirty years ago, I am forcibly impressed by the fact that there is a vastly increased number of cases of melancholia relatively to mania in new admissions nowadays. Then in the Norfolk Asylum we had plenty of cases of true acute mania, most of which had a definite cause and made good recoveries in from two to six months. Now we seldom see that typical acute mania, but are inundated with cases of melancholia without

definite cause, of insidious onset, in which treatment is beset with many difficulties, convalescence protracted, relapses are common, and from which chronic insanity often results.

During the last few years one has also been struck by the large number of cases of evolutionary mental breakdown occurring in patients from eighteen to twenty-eight years of age of the upper and middle classes, the result of the strain of education and the worries of life upon brains unequal to the stress under which we live. Is it, then, that the race is less robust mentally as well as physically than formerly, and that mental breakdown tends to the asthenic type? There are, I fear, facts which might lead us to this conclusion.

4. Too early marriages among the poor and too late marriages in the upper and middle classes are more frequent than fifty years ago; these do not conduce to a healthier stock mentally or physically.

5. I am afraid we must conclude that there are more congenital imbeciles born relatively to the births generally than in 1859. We are undoubtedly perturbed by the ever-growing feeble-minded element in the community, for whom early legislation is demanded. It was stated publicly the other day that one person in every 150 of the population belongs to this section; and when we consider how unfitted imbeciles are to battle with every-day life, and how incapable they are of adaptation to their environment, we must not be surprised that the feeble-minded at large are constantly a source of trouble, and often bring disgrace upon themselves and their families.

6. Inherited syphilis and hereditary tendency to pulmonary tuberculosis must operate as factors in causation more than formerly. That interesting disease, infantile general paralysis of the insane, of which I have seen quite a large number of cases recently at the neighbouring asylum at Darenth, has probably for its sole cause inherited syphilis. I must add I am not one of those who believe in syphilis as the only etiological factor in general paralysis of the insane; but knowing what we now do concerning syphilis as a cause of insanity, surely we should take part in agitating for the replacement upon the statutes without delay of the Contagious Diseases Act (Man).

7. The abuse of alcohol is, as we all recognise, both a cause and symptom of insanity, often indistinguishable. We are now

a spirit-drinking race, which we were not in 1859. There is no standard of purity of these spirits. May not both the immaturity and the adulteration by noxious constituents be important factors in the causation of insanity, and should not the Legislature enforce both the maturity and purity of all alcoholic drinks?

8. Many weaklings who would formerly have died in infancy are now reared to marry and reproduce a faulty stock. Under environmental changes we note—

1. The population is urban rather than rural to-day. We are rapidly becoming town-dwellers. Overcrowding is common. The people breathe less pure air and have less outdoor exercise under the beneficent action of the sun's rays. Their food is badly selected, less easily digested, and less nutritious than formerly. It is, moreover, frequently badly cooked.

2. The stress of life is far greater than formerly. Over-education during development, late hours and unnatural excitement, must leave their marks upon the race as well as upon the individual. Having discussed briefly certain conditions affecting the vitality and predisposition to mental disease in the present population, we are led to consider the existing arrangements and desiderata for the care and treatment of the insane. This I propose to do under the two headings, (*a*) rate-paid, (*b*) private.

Much has been done in recent years to improve the means of care and treatment of the rate-paid insane in the counties and boroughs. Unfortunately on the score of economy the patients have been congregated in too large communities under one roof, and especially has this been the case in the county of London, with its huge asylums, each containing from 2000 or 2500 patients. Has not this been false economy? It may be urged that with the larger number you can show a somewhat lower weekly maintenance rate, but true economy would be in better results in recoveries even at a considerably higher maintenance charge for a short time. Think of the cost to the rate-payers of the patient who becomes insane at twenty and lives to the age of seventy or eighty years in a county or borough asylum! Huge institutions containing both acute and chronic cases stand condemned by the public and the expert alike! The medical superintendent knows relatively nothing of the patients individually. There is a certain amount of classification, it is true, and the cases are allotted for treatment to

the care of the various assistant medical officers. These gentlemen are not all enthusiasts in medical treatment, or equally skilled. Some may do their utmost for the recent cases committed to their charge; others go the rounds and perform their ward duties in a perfunctory manner, devoting their best energies to the amusements which form a feature in asylum life, and which may be more to their taste. The recent admissions under officers of the latter class, unaided by medical science, tend to drift, and this is where the daily supervision of the medical superintendent is needed, but only obtainable in asylums with less than 600 patients.

The many chronic cases apparently drifting to dementia one has seen in recent years subjected to school discipline and re-educated back to natural life and mental health, is a source of great encouragement in our work in this direction, and forcibly impresses upon us the necessity of safeguarding, if possible by legal as well as medical effort, all patients against being classified as incurable and neglected as regards treatment while chances of improvement and even of recovery still exist.

For a long time past the possible value of physical drill for the female insane, who cannot be employed outside at manual labour, has occurred to me. We must have systematic methods of rousing the listless and apathetic drifting to dementia from their lethargy, and I believe good will result from the establishment of these physical drill classes. When alluding to this the other day at Claybury, I was delighted to learn the idea had also occurred to Dr. Ewart, who had started such a class and was hopeful of beneficial results. Since writing the above I find Dr. Goodall has also initiated physical drill at the Carmarthen Asylum.

At last the separation of the acute insane in the hospital from the chronic in the asylum, on the one estate, advocated by many of us twenty years ago, is being generally recognised as imperatively necessary to prevent the curable cases being lost sight of in a crowd of chronic sufferers. These acute hospitals, to my way of thinking, should be of the linear gallery type, the buildings extending east and west, the galleries with southern frontage being used for day space and transit, and intersecting the ward day rooms at right angles. The wards then are only separated by glazed screens in the galleries, and the sick wards are of the true hospital type and terminal,

removed from the noise and excitement of the centre, and having large secluded gardens. Telephones nowadays bring medical aid sufficiently near these terminal hospitals. There must be a subway under the galleries and wards for air-ducts, pipes, etc., with a trolley-way for food and stores, and a lift for each ward. The buildings should be two-storied, with all the upper floor for dormitories and single rooms. The other single rooms would be on the north side of the galleries on the ground-floor. The advantages are cheapness of construction and up-keep, compactness, facilities for medical and general supervision and treatment, and ease of administration. We have it all at Stone except the subways, and I know of no asylum in which acute cases can be so readily treated and supervised medically and generally. You have small wards, so much to be desired, and yet in an emergency with a temporary reduction of staff the dividing glass doors can be thrown open and the wards become one for the time being. The through traffic of wards, so much decried in the past in the asylums of the linear gallery type, was probably their strongest recommendation. The insane are very inquisitive, they like to see people through their wards, and appreciate anything which relieves monotony; hence detached villas will never be popular with many convalescing patients who take interest in their environment, and to whom the daily life of the wards and main buildings offers an attraction. I shall not readily forget that when we opened our new female hospital, which is terminal, one lady in the ward through which there is most traffic begged not to be sent there, adding, "How would you like to live in a village through which no one ever passed?" Again, the large associated dining hall is most popular, although some medical superintendents in the South do not believe in it. With ease of access from the neighbouring wards of either division, the patients look forward to all their meals in the hall. It varies the monotony, associates them with members of the other sex, gives them an opportunity of enjoying music during dinner, they get their meals quickly and properly served from the kitchen, and it allows of the wards being thoroughly ventilated while they are away. With the pavilion type of asylum, and the blocks at some distance from the central hall, I grant there are difficulties, but surely the advantages outweigh the difficulties. A time limit must be

fixed for the residence of patients in the acute hospital, which should be highly equipped in staff and material and should possess all the armamentaria for scientific treatment. Chronic patients from the main building should assist by day in its menial work. Detached villa blocks for the chronic insane, classified according to employment, with a separate villa for imbeciles, should be productive of the best results in work done, and should add to the comfort of the patients. The acute hospital and detached villa blocks will soon be in full swing at the East Sussex Asylum at Hellingly; and the Ewell Epileptic Colony, opened on the first of the present month by the London County Council, is a further example of the housing of a gregarious class of the chronic insane and weak-minded with a view to their useful and beneficial employment. In London we have the advantage of possessing the chronic imbecile asylums of the Metropolitan Asylums Board, to which we can draft many of our quiet and harmless chronic dements under Section 25, Lunacy Act, 1890. Similar institutions in the provinces would, I believe, be of great benefit, and would open out accommodation in the county and borough asylums, now occupied by this class of patients.

A Bill, known as the Lunacy Acts Amendment (London) Bill, has been introduced this session in the House of Lords by Lord Carrington. It was read a second time on July 7th. It is entitled "An Act to authorise the London County Council to provide receiving houses for the reception of persons mentally affected or alleged to be of unsound mind, and to authorise the detention of such persons in such houses, and for other purposes connected therewith." It passed through committee without amendment last Thursday. Gentlemen, there is more in this Bill than meets the eye. The houses are to be not only receiving houses, but detaining houses for treatment. I think I shall be able to show you that the receiving houses (and there are to be at the outset two of these at a cost of £125,000 each, but the ultimate number is not limited) are in reality our old friend the hospital for the insane *in* London (London County Council, Special Report, 1890) in another garb and in duplicate. The memorandum states the object of the Bill is to enable the London County Council to establish houses at which persons alleged to be lunatics may be received for preliminary examination and treatment. It con-

tinues as follows :—" In the existing practice in London under the Lunacy Acts, persons supposed to be lunatics are for the most part taken to a workhouse in order to be examined before being sent to a lunatic asylum. Experience shows that this system is unsatisfactory, and leads occasionally, in the individual cases, to harm which might be avoided.

" It is believed that the proper treatment of mental disease in its earlier stages, or of symptoms of incipient mental disease, will often obviate the necessity for sending to a county lunatic asylum persons who, under the present arrangements, cannot be otherwise dealt with.

" It is claimed for the system proposed that it will thus be not only beneficent, but economical in its operation by tending to lessen the number of persons detained as lunatics in the county asylums at the public expense ; while it will be useful in assisting the classification of patients and the diagnosis and cure of mental disease in its earliest stages.

" It is proposed that the receiving houses shall be available for the treatment of out-patients.

" The receiving houses will be under the supervision of the Commissioners in Lunacy, and conducted in accordance with the law regulating county asylums."

Now Clause 2 provides for the treatment of out-patients at the receiving houses with proper accommodation, medicines appliances, and requisites for the care and treatment of such out-patients ; in fact, the complete equipment of an out-patient department.

Clause 4 provides for the appointment of a superintendent of each receiving house, who shall be resident medical officer. It also authorises a staff of such other officers as the visiting committee think fit, and it specifies they may appoint a visiting physician or surgeon to any such receiving house. By Clause 11 the duration of the detention order in the receiving house made by the Justice is fixed at six weeks, but the period of detention may from time to time be extended by a Justice on the recommendation of any two members of the visiting committee, for any further period not exceeding three weeks at any one time. Clause 13 ensures provisions as to care, treatment, and visitation practically identical with those of the Lunacy Acts 1890-91. By Clause 14 patients can be removed from one receiving house to another.

The above are the chief clauses. Now is there any guarantee that the superintendent, who will also be resident medical officer of the receiving house, shall have been properly trained in the treatment of mental diseases in a public institution for the insane? Will the visiting medical staff appointed have had proper experience in the treatment of mental diseases in public asylums? As by Clause 11 acute mental cases can be detained in these receiving houses for treatment practically as long as the visiting committee, acting upon the advice of the medical staff, think fit, would the heart of the metropolis be suitable for these institutions? The scheme in reality means that these receiving houses *in* London are to be the acute hospitals for the insane and teaching centres for the medical schools, the present large asylums being utilised only for chronic cases. Few of us will admit that the acute insane can have their proper environment in the heart of the most populous city in the world. How are cases of acute mania and melancholia to be treated there? We know the value of rest in bed in certain acute cases of insanity, but where are the majority of the patients to have the benign influence of the sun, fresh air, and exercise? Where beneficent employment, recreation, outdoor and indoor amusements, so essential to successful treatment? Six years since, when visiting Glasgow with my committee, we found the authorities there had receiving houses for classification of the insane prior to distribution within the week to their various asylums. It is true a certain number of cases dependent upon drink recovered within seven days, but those receiving houses were not what these will be—hospitals for the insane where the patients can be detained for treatment six weeks, or even three months or more. The principle of the receiving house in London for classification is certainly right, but there should be no power of detention beyond from seven to fourteen days, which period would amply suffice for certain transient cases. I believe, however, that psychopathic hospitals on the outskirts of London for acute cases would be a boon for treatment and of benefit to students. We want facilities for treatment of incipient and unconfirmed insanity in the poorer classes, both as indoor and outdoor patients in our general hospitals, and as voluntary boarders and outdoor patients at the county and borough asylums. The out-patient department is an accomplished fact in several hospitals and asylums; the in-

patient wards for certain border-line mental cases is a desideratum. For many rate-paid imbeciles and chronic demented we ought to develop, under proper supervision, the boarding-out system so much in vogue in Scotland. True economy lies in this direction, and the reduced population in our rural districts should facilitate this undertaking.

From patients we turn to staff, and under this heading there are one or two points which demand our attention. In the first place the pension question is ever with us. Some of you will remember the great meeting of this Association held upon this question at Bethlem Hospital on May 16th, 1888. On that occasion I had the honour to lead a small—a very small—minority, who were opposed to the compulsory modified Civil Service scale of pensions. Well, we offered such persistent obstruction that we really won the day, and I venture to think you have reason to thank us for the uphill fight we successfully carried through. I said then, and I say it now, no absolutely fixed scale of pension is fair! Fix a minimum if you like, make that compulsory, and have a sliding scale for merit to the present permissive maximum. By that means, bad, indifferent, and good officers and servants will not all be treated alike. Power must be left in the hands of the visiting committees to regulate pensions according to merit. They will seldom do wrong. Those asylum officers who were most afraid in 1888 that the coming county councils would treat them badly in the matter of pensions, have realised in many instances their mistake, and the precedents already established must guide the near if not the distant future. It is to the interests of visiting committees and county councils alike to keep a service popular, and this can only be attained by the granting of liberal superannuation allowances on retirement to all those who have served them faithfully and well. Whatever is done for England and Wales in regard to pensions must be granted also to Scotland, Ireland, and the Colonies. In South Africa, where the Civil Service scale applies at present, I am told an agitation is proceeding to have ten years added to the individual's life as well as the ten years for special service. This would allow of retirement at fifty years of age. It is undoubtedly a move in the right direction, for few of those who have devoted their best energies to the care of the insane are equal to the constant strain of the work in the sixth decade of life. We

desire also a gratuity clause for deserving officers or servants, or for the widow or children of any deserving officer or servant who loses his life in the service.

The next point upon which I must speak is the dearth of applicants for the vacant posts of assistant medical officers at county and borough asylums. Twenty years ago there would be thirty or forty applicants for each vacancy ; now we get some seven or eight, or even fewer. Why is this ? It must be the office is less attractive than formerly, or is it that the additional year to the medical curriculum, the better pay obtainable of late for *locum tenens* work, and the many colonial attractions, have reduced the supply of candidates ? How is this dearth to be overcome ? Since the higher posts are limited in number, and but a small proportion of assistant medical officers can ultimately become superintendents, it seems to me only right that an assistant medical officer should be able to retire, say at the end of five years if he so desires, with a gratuity of £500, or at the end of ten years with one of £1000. This suggestion is very similar to what obtains in the army medical service. It would attract more young men of promise to our ranks, it would ensure them the wherewithal to buy a practice at a comparatively early age, it would disseminate throughout the country a more general medical knowledge of mental diseases, and it would protect assistant medical officers against remaining as such until at an age when only a small superannuation would await them. Similar and proportionate gratuities should be given to members of the nursing staff, male and female. This, I believe, is the custom in the post-office service on the marriage of their female clerks. Before leaving the rate-paid insane and their custodians, I would congratulate the Association upon the continued success of its scheme of training for nurses, male and female, and upon the enhanced value of the Medico-Psychological Nursing Certificate obtained after due examination. I am not a little proud that the City of London Asylum was in the van in this movement, for we commenced a systematic course of lectures and examinations for the nursing staff in 1887, and issued our own certificates in 1890, but abandoned these on the institution of the nursing certificate of the Association.

We now come to (b) the private insane. The only desiderata for the registered hospitals are—(1) the size of these

hospitals should be limited, and (2) their charity should be extended. The registered hospitals are doing a great work, but the control of large funds requires careful supervision. I would add that those of the registered hospitals with out-of-date buildings situated in populous districts should, in the interest of the patients, be moved into the country at the earliest possible date.

Next as regards licensed houses or private asylums. The Act of 1890 provided, as we all know, for the gradual extinction of these by competition. Under it no new licence can be granted, and there can be no addition to any existing licence. Those conversant with the demand for high-class accommodation know full well that the upper classes will not, as a rule, send their relations to public institutions, and therefore the best licensed houses will always be in request. The question then arises whether the time has not arrived for some alteration of the law in regard to these—an alteration which will admit, under proper safeguards, of the reception of an increased number of patients. Moreover the voluntary boarder system of treatment is so important, and has proved so valuable both for incipient and convalescing cases, that this system should be further encouraged by the voluntary boarders in licensed houses not being counted in the number for which each house is licensed, provided, of course, they do not encroach on the recognised accommodation. The voluntary boarder system should also be extended to county and borough asylums, both for private and rate-paid patients. At the present time several licensed houses receive rate-paid patients in large numbers. This is contrary to the spirit of the Lunacy Acts; it opens up the road to abuses, and is a condition demanding rectification by the Legislature at the earliest possible date. By the Act of 1890 the authorities in the counties and boroughs were encouraged to provide accommodation either in their asylums, or in annexes close thereto, for paying patients. There are nearly 250 such patients at the present time in the City of London Asylum. The reception of these patients has proved a great boon to the middle-class public, whose relatives in the past were frequently classed as paupers in order to be made admissible for treatment in county and borough asylums. It has, moreover, been of benefit to the institutions receiving them. We charge a guinea a week, and, in a few cases

requiring special care, two guineas. A first-class diet is given, and the balance on the maintenance goes to structural improvements and additional ornamentation of wards and gardens, whereby both private and rate-paid patients benefit. The paying patients are kept separate from the rate-paid as far as possible, but the infusion of the higher civilisation has levelled up the general tone and improved the moral and intellectual spirit of the institution. Many superintendents have said to me, "Don't you find the private patients an awful nuisance?" My reply has been, "They do give extra trouble, and their friends also; but the work is much more interesting with the cultured classes, and fully compensates officers, nurses, and attendants for the extra labour entailed." All paying patients are employed as far as possible—the gentlemen in the gardens, on the farm, in the workshops and wards; the ladies in house duties, needlework, etc.,—and I have been surprised to find how much work you can by force of example encourage these patients to do.

We are told there has been no increase in recent years in the number of certified patients in single care. This is a regrettable fact, and I think results from the large number of single cases treated, often by unskilled persons, privately and uncertified. Quite recently I dealt with this subject in a paper "Upon the Care and Treatment of Persons of Unsound Mind in Private Houses and Nursing Homes," a paper which elicited a very gratifying discussion, demonstrating clearly that serious legislative defects existed. The private insane ought to have the earliest possible skilled care and treatment under efficient official supervision. To ensure proper custodians and suitable environment all persons and houses receiving uncertified single patients should be subject to registration, and all such patients should be notified to the Commissioners in Lunacy, by whom or their deputies they should be systematically visited. The voluntary boarder system should be extended to these registered houses both for incipient cases and for convalescing patients on their discharge from certificates. The chief custodian of every patient should be held legally responsible for proper care and treatment, and if culpably negligent or inefficient should be liable to prosecution. Lastly, a large addition to the Lunacy Commission by the appointment of deputy or district commissioners to carry out the necessary work of supervision is urgently needed.

Let us all agitate for the removal from the statutes and discontinuance from general use of the terms lunatic, lunacy, asylum (when applied to a mental hospital for curable cases), attendant, and airing courts ; person of unsound mind, insanity, mental hospital, male mental nurse, and gardens taking their places.

Finally, let us ever remember that we are the officials and custodians of a great trust, that our life-work is a noble one with vast possibilities for good or evil, that the State very rightly safeguards the insane community on account of its utter helplessness, and that the advance in treatment for which we are all striving will more certainly be gained by the application of sure and steady methods founded upon experience and directed upon scientific lines, rather than by the reckless experimentation of the inexperienced upon defenceless patients. As the navigators of bygone centuries in seeking their Eldorado were encouraged from day to day by the discovery of some new island, which led them ever onward on the boundless seas to fresh lands and fields of adventure, until at last the continent of their dreams lay before them, so may we, urged onward by a strict sense of duty, and with a full appreciation of our noble sphere of labour, by patiently pursuing proper methods of scientific research and clinical investigation, hope to solve the hidden mysteries of the origin, prevention, and cure of the greatest of all human ills—insanity.

Dr. BLANDFORD.—I have great pleasure in proposing, and I am sure you will have equal pleasure in awarding, the best thanks of the Association to our President for his very able and suggestive address. It is not our custom to discuss the address of the President, and I have no intention of doing so on this occasion. I would, however, with your permission, make one remark. I was extremely glad to hear him draw your attention to that Bill which is now before the House of Lords ; I do not think it has yet got before the Commons. I am pretty confident that what he said with regard to that Bill is strictly correct ; that it is a resuscitation of the old proposition that came up from the London County Council in the year 1890, but which fortunately failed altogether and never became law. You may remember that the chief provision was that the physicians who were to have supervision of the home or homes were to have had no experience whatever of the care and treatment of the insane.

Dr. OUTTERSON WOOD.—It affords me personally the very greatest pleasure to have been asked to second this vote of thanks to our President for his address. I think that his masterly and extremely practical paper, to which we have all listened with so much pleasure, is the best proof we could have that we have elected a man as our President who will fulfil the duties of his office with credit to himself and with satisfaction to the Association.

The motion was received and passed with applause.

The PRESIDENT.—I thank you very heartily for this expression of your approval. It will be my earnest endeavour during my year of office to faithfully discharge the duties of the position in which you have placed me.