

DISCUSSION.

DR. FRANK W. HILSCHER, Spokane, Wash.—The method of treatment is on the principle which Dr. Mulhall of St. Louis described ten years or more ago. I remember seeing in his clinic a case of hysterical aphonia, treated by inserting a wet sponge electrode into the pharynx which frightened the patient so that he made an exclamation. The patient was then commanded to speak on penalty of a repetition of the operation. This same patient would lose his voice occasionally, relapsing into the former condition, but the physician had no trouble renewing the suggestion, going so far that he actually produced the suggestion by telephone. That was done in at least one case of which I know, and he told me that he had accomplished a similar result in a number of other cases.

DR. J. F. BARNHILL, Indianapolis, Ind.—I consider this paper as one of distinctive value. Cases of hysterical aphonia exist, and when we are consulted concerning them, knowledge of a certain method such as Dr. Loeb suggests becomes as valuable to us, trivial though the method may seem, as is the technic of the most complicated surgical procedure. I have treated some cases of this kind, one lately, in which there were lingual tonsils. I assured the patient that the removal of these would result in the cure of her ailment, and verified the prediction to the satisfaction of all concerned. I desire to ask Dr. Loeb two questions: 1. Has it been his observation in the class of cases he has described, that the pharynx and larynx are in an anesthetic condition? 2. He stated that the epiglottis is pressed down with the finger until there is considerable discomfort. Is it the intention to cause the patient pain by this pressure, or are we to understand by the term discomfort that some degree of asphyxia is produced?

DR. H. DUPUY, New Orleans—The success Dr. Loeb obtained from positive hypnotic suggestion promises excellent results in these cases. A girl of 19, a religious enthusiast, came to my office with an acute case of hysterical aphonia. I examined the parts thoroughly, and by way of suggestion I told her that there was something up behind the nose that caused the disturbance. I introduced my finger and made the manipulations we usually do for the recognition of adenoids. Her voice was immediately restored. Several months afterward the aphonia recurred and she was unwilling to again undergo what she considered a heroic maneuver. I would like to ask Dr. Loeb whether he has had any recurrences, and what is the longest time in any case in which there has been no return of the aphonia.

DR. C. M. COBB, Boston—I was told in the Hospital for Epileptics that there is often some serious constitutional idiosyncrasy or dyscrasia back of hysteria and that these patients often become insane or have tuberculosis later. The same suggestion was made by Dr. Edes of Boston. He said that he used to consider them almost immortal, but that they are not; the death rate among them is much higher than among normal individuals. I am very glad Dr. Loeb has given us the details of his treatment by suggestion. Probably every one who has practiced medicine any length of time has invented a method of suggestion of his own. One physician's method was to talk with the nurse outside of the door within the hearing of the patient, in the case of a married woman, for example, as to whom the husband was likely to marry if the patient did not recover. The nurse would suggest someone and the physician would say that it met his approval, since the woman was good and strong. The result would be that the patient recovered her voice speedily.

DR. H. W. LOEB, St. Louis—Personally I knew nothing about hypnotism or suggestion previous to this work, and I know now practically nothing about it. I have been forced to report this method, which differs from the other methods in its systematic performance. These patients, however, are prone to accept suggestion, not only for their relief, but also to their detriment. In one case, for instance, the patient came to have a new dislocation restored. In Dr. Barnhill's case an operation was found necessary; it is possible that that woman will have some operation performed on every part of her anatomy before she is through. Those are the cases the neurologists complain that we treat with the ablation or supposed

ablation of some organ, and the disease returns again and again. Such conditions as anesthesia and hemianesthesia may be relieved in the same way as aphonia. If we use heterogeneous suggestion we may often make mistakes. In the last few cases I have said nothing about the condition found; I simply look at the larynx and say that I will be able to cure the trouble. One case is of at least two years' standing. The pharynx is not always anesthetic, but it is often so in hysterical cases. As to the discomfort resulting from the treatment there is, of course, no pain, but only an impediment to respiration. I occlude the larynx until there is a distinct impression from the suffocation, then withdraw the finger and command them to speak and they simply can not help talking. I hope the members will use this method with caution, not to use a suggestion that may be duplicated and do the patient harm.

THE TREND OF MODERN PSYCHIATRY AND ITS RELATION TO GENERAL MEDICINE.*

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Amid the kaleidoscopic changes incident to modern medical progress, none are more conspicuous and striking than those which pertain to the study of psychiatry. To the average practitioner medical psychology was until within a very recent period, a sealed book, and even to-day its study is greatly neglected by many of our medical schools and colleges.

This indifference is well understood, however, when we remember the hypothetical character of former available knowledge concerning morbid psychical phenomena, as well as the difficulties which beset its practical clinical application in general medical practice. Moreover the numerous exigencies that belong to the care, management and treatment of the insane soon led the general practitioner to lose interest in its study, and all such cases were willingly referred by him to those members of our profession whose tastes or opportunities led them to select this form of practice, hence, the alienist became through sheer force of circumstances the first in chronologic order of medical specialists.

As insanity at times requires rigid isolation, hospitals devoted to the exclusive use of the insane were imperatively demanded, but cheerfully supplied from the generous funds of the state treasury. Owing to the extreme magnitude of such hospitals their control became a very tempting prize for rival political parties to possess, hence their management was soon added to the political spoils system.

The universal adoption, however, of this diabolical political practice imposed a great injustice on the unfortunates who were compelled to submit to its evil consequences, beside proving a serious hindrance to the progress of scientific psychiatry. Moreover the exclusive character of the work soon led the medical officers to separate themselves from the rest of the medical profession, which had the baneful effect of not only dwarfing their own medical growth, but also retarded the study and development of psychologic medicine. Not all of the medical officers were tainted with this special vice, but the general correctness of the assertion can not successfully be denied.

Without any desire to be pessimistic, and duly recognizing that in the development of the modern insane or psychopathic hospital with all its scientific parapher-

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nalía, our forefathers necessarily were compelled to pass through the period of what may be termed the mechanical stage of construction, at which time, perhaps, the size of the hospital, together with its more purely mechanical devices, such as the washing machines, steam cooking utensils and the electric lighting apparatus, was even of greater importance than its purely medical equipment or the more strictly scientific methods belonging to the study of psychiatry, yet we believe the time has now come when these purely mechanical matters can safely be left, in a large part, to others, reserving at the same time the right of the medical superintendent to be the chief ranking officer, to whom all such matters can be referred for final judgment, while his first and chief duty, as well as those of his assistants, should be the scientific study of insanity, as well as the best means for its appropriate care, prevention and treatment.

That this ideal is far from being realized in several of our state institutions, at the present time, is clear to all thoughtful physicians, and that many of them are still practically owned and controlled by the politicians is common knowledge. In this dilemma it was evident that something needed to be done in order to extricate the insane hospitals from their unfortunate predicament by rescuing them from the hands of the politicians, and at the same time infuse new medical life and spirit into the officers comprising the medical staff, by reminding them of their great weakness in thus isolating themselves from the rest of the profession, as well as emphasizing their unusual opportunity for scientific clinical and pathologic psychiatric research which they were wholly neglecting.

Fortunately for us the man and the occasion presented themselves about 8 years ago, and, while this great work of deliverance is still in its early infancy, yet the results so far attained are flattering, while to their honor let it be said the brilliant achievements already accomplished by the rescued medical officers have largely redeemed the former careless indifference into which they had unwittingly fallen. Prior to the able address¹ referred to, which was delivered before the American Psychological Association, May 16, 1894, by Dr. Weir Mitchell of Philadelphia, in which he severely criticised prevailing methods of the officers, as well as the care, management and treatment of the insane, little was actually being done of a truly scientific nature (except in a few notable instances), by those who had charge of the various state insane hospitals, to enlighten the general medical profession concerning the true nature and character of insanity. This bold and fearless address, however, has had the desired effect of arousing the alienist from his lethargic slumber to one of extreme zeal and scientific activity, which has resulted in a continual series of practical demonstrations and discoveries that greatly enlarge our former available useful clinical knowledge concerning the insane, as well as the intricate problems associated with psychopathology and clinical psychiatry.

While it is true that the alienist was first of medical specialists, yet he soon become too exclusive in his methods to be practical, and his willing isolation stunted the growth and development of scientific psychiatry to such an extent that there was complete stagnation in this department of medicine for very many years. Dr. Mitchell's address, however, marks the beginning of a new era in the scientific study of psychiatry in America by defining the line of demarcation between the inactive, unpractical, unscientific methods of the past and those

of the more modern, enthusiastic, energetic, scientific, practical ones of the present period. It also demonstrates conclusively the practical trend of modern psychiatry in thus repudiating political intrigue as the dominating controlling power which dictates the medical policy and appointments of our state hospitals, beside refusing politics the right to govern the standard of medical educational worth and fitness for such positions. To live out of range of critical shot and not be preceded and followed through the various wards of the insane hospitals by clever rivals in other departments of medicine, or to refuse advice and even admission to able clinicians working in other medical branches, was not only an ancient vice, but a method of doubtful practical utility which needed condemnation, as it certainly hindered the best growth and development of scientific psychiatry. Under the old régime of keeping aloof from the rest of the medical profession was it any wonder that a few years ago when the alienist was asked for his contributions to medical science that we were handed the latest biennial report of the hospital, which contained but a few fragmentary remarks concerning insanity, and sandwiched among incomprehensible tables of statistics and farm balance sheets, beside many pages devoted to the crying need of a new washing machine, additional buildings or more medical assistants?

That such was the case is a well-known fact (and unfortunately exists even to-day in a few of the more non-progressive state hospitals), but the trend of modern psychiatry contemplates the revolution of such worthless matters by substituting in their stead the inauguration of a practical scheme whereby those called on to fill such positions of trust and honor can demonstrate their fitness by their individual scientific attainments and more willing devotion to the scientific study of psychiatry, thereby placing a premium on their meritorious service. That insanity and its allied disorders can not be separated or divorced from general medicine, but that the intricate problems associated with each are more or less dove-tailed, is self-evident, hence, it is impossible to ignore the close relation that exists between mind and body on the one hand, and general and special medicine on the other. It was not, however, until this intimate relation or bond of union between the two was better understood that the science of psychiatry made any practical tangible advance.

With every step in the forward, progressive march, however, connected with the study of neuropathology, it was evident that those diseases termed mental were dependent on some lesion of the nervous system, hence nervous and mental diseases are closely allied, indeed they are to be regarded as being almost synonymous, so that the study of one depends on the study of the other, and as all parts of the human organism are subject to nervous control or innervation it follows as a logical sequence that the entire human organism is concerned at times in their clinical manifestations. In order, therefore, to be a competent alienist one must of necessity be not only a skilled neurologist, but also an able general medical practitioner. That American alienists have been slow to learn this great lesson is certain, but it is a very hopeful sign of the times and one that also beautifully illustrates the trend of modern psychiatry, when we realize the truth that the American Psychological Association has ultimately decided to affiliate with the Congress of American Physicians and Surgeons by holding their meeting together next week at Washington, D. C. Such an amal-

1. Jour. of Nervous and Mental Diseases, July, 1894.

gamation as this can not fail to accomplish much good to all concerned, as well as prove a valuable scientific impetus to the future study of psychiatry. In thus extricating the insane hospitals from their perilous political position, as well as win back to the common professional ranks this large and useful body of scientific alienists, Dr. Mitchell unconsciously exercised a masterly stroke of medical polity, as well as displayed shrewd strategetic diplomacy which argues well for the future study of psychiatry, beside forcibly illustrating the modern tendency of scientific exactness in practical psychologic medicine. That we are simply standing at the threshold of a practical working knowledge of insanity heretofore unattained by any previous period, whereby the general medical practitioner can recognize clinically from the varied symptom complex grouping, not only the evidence of diagnosis, but also the more important factor of prognosis, is very certain. This is clearly evident when we contemplate the progress recently made in psychopathology whereby our former conceptions of the acute psychoses have been greatly modified and revised, thus changing completely all former classifications of insanity, and rendering them more or less antiquated and obsolete.

In this advanced step of progressive medical development we see again the trend of modern psychiatry and recognize at once its practical clinical utility in general medical practice.

For centuries it has been the prevailing custom to classify insanity from either its etiologic, symptomologic, pathologic or psychologic standpoint, hence, those of us who learned our psychiatry within the past 15 or 25 years know full well how these earlier views were handed down and taught us, and how they still cling to our memory, thereby molding our forms of thought in classifying the more common types of insanity. It is only within the past ten years, however, that we in America have fully realized their faulty construction and that instead of considering such conditions as melancholia, mania and dementia, as distinct morbid clinical entities as was formerly taught and believed, we are now fully assured by the more advanced and correct views of Kraepelin that these are simply different stages of one and the same underlying pathologic process.

Hence, all former generalized schemes of classification which does not conform to this more correct teaching as demonstrated by modern clinical research and pathologic findings are not only proven to be wholly inaccurate, but utterly futile and misleading.

While these newer conceptions of insanity have been partially understood for some time, more especially in Germany, yet no systematic attempt to enforce their practical teaching in America took place until within the past few years, and at the present time there are but three text-books² to my knowledge published by American authors in which these newer and more correct views are set forth, thus embodying their establishment in American scientific medical literature. Without any desire to burden you with evidence of the fallacy of the older teaching by which these three common psychoses were considered distinct and separate clinical entities, it will suffice to remind you that it was very obvious to those who had large opportunity of practical clinical experience that changes in the emotional nature or variations in the states of feeling common to the sufferers

of the acute forms of insanity were absolutely of too evanescent a character to be made the basis of any scientific system of classification.

These at best are unreliable guides, and, consequently, misleading, for under such a method any new symptom or group of symptoms in which there was a decided manifest change in the condition of the emotional element would suffice to establish a separate species of insanity. For instance it is clear to those who have had any experience that cases of melancholia often present symptoms of mania and later those of dementia. The conception of these very different mental states represented in the same individual as being distinct morbid entities, has long dominated psychiatric teaching. That this view was based on the changes in the emotional nature of the patient is evident, but such fluctuating states of feeling are now recognized to be altogether too misleading to form the basis of accurate scientific classification, hence Kraepelin's proposition to make the tendency of the underlying disease process, whether toward recovery or dementia, a criterion of the character of the psychoses is certainly helpful. In this form of classification all the elements are included which belong to its cause, symptoms, course, duration and final outcome, and each is given the proper recognition it richly deserves. From this standpoint melancholia and mania are considered due to the same pathologic process, and while we are as yet unable to satisfactorily explain its special pathologic character, the clinical correctness and validity of this position can not successfully be gainsaid. Moreover, clinical observation and experience demonstrates the truth of the assertion that, when this principle is applied to the acute psychoses, one group of cases naturally tends toward recovery, while still another class has a characteristic tendency toward dementia. On this clinical fact depends the future welfare of our patient, hence, in every case of acute psychosis we look from the outset for the prognosis, as in the former case a favorable opinion can safely be ventured, while in the latter case the prognosis is beset with serious misgivings. Thus it will be seen that the trend of modern psychiatry is toward simplification in classification whereby a single species of insanity takes the place of several under the older methods, as well as establishing a new criterion by which the essential tendency of the disease as a whole is recognized and its natural clinical character revealed in the form of either recovery or dementia, which again determines its favorable or unfavorable final outcome, thus establishing a correct rule for prognosis.

Again the trend of modern psychiatry can be seen in the movement whereby the more accurate or recent insane can receive appropriate accommodations and treatment at the various general hospitals of our cities rather than be referred, as they are now, to the state insane hospitals.

In making this statement I trust it will not be understood that I undervalue the service rendered these poor unfortunates by the medical staff of our state institutions—far from it, for I have the very highest regard for them and their work, as well as for the magnificent structures in which they dwell; but as it now stands, scarcely any general hospital will receive for treatment persons suffering from mental derangement. The reason for this is well understood, even though a great injustice is sometimes done by such a rule. In the majority of instances at the present time such general hospitals are not prepared to receive such persons because the very nature of the case requires special quarters and privileges which

2. Brower and Bannister: *Practical Manual of Insanity*. Reference Handbook, Medical Sciences, 1903. Berkeley on Mental Disease.

are not now supplied or available. Moreover, the environment of the medical and surgical wards of the average city hospital are not calculated to benefit the recent or more acute forms of the various psychoses, and this is often urged against their admission.

But there are several good scientific reasons why provision for this class of patients should be made in our general city hospitals. Indeed, it is highly desirable that such cases should be admitted, and it is one of the hopeful signs of medical psychiatric progress that such a movement has already been inaugurated. Perhaps the most important reason, and that to which all others would appear subservient, is the fact that in its incipient stage insanity is most curable. Indeed, it is infinitely more curable than typhoid fever, pneumonia or even rheumatism and kidney lesions. The curability of insanity in its incipient stage is so very striking that it appeals to our more serious consideration, and while this truism has been emphasized for centuries we are so very slow in taking advantage of its true significance that I make that my excuse for again urging its recognition and practical importance. How very desirable to receive such persons in the early formative period of the malady, before the more serious complications occur, such as delusions, imperative concepts or phobias, hallucinations, suicide, homicide, or even incoherence. That we are then enabled to study more especially the causes, whether they be toxic or otherwise, and thus gain control or stay the progress of cell disorganization or even remove the conditions which favor their development, is clear to all.

The dilly-dallying process, however, of waiting for further developments, as now commonly practiced on the part of both physician and the friends of the patient, would largely be removed if our city hospitals would receive such persons for treatment. Moreover, this unfortunate disposition to wait often decides the question of prognosis whereby a presumably curable case is rapidly transformed into one of absolute incurability. On inquiry we often find this failure to act promptly depends on one or more of four conditions, viz.: 1. Ignorance of the necessity of providing prompt and appropriate treatment. 2. Fear of the stigma which follows commitment or exposure of family secrets. 3. Failure to recognize that insanity implies irresponsibility and that suicidal complications develop early. 4. Lack of funds to defray the necessary expense involved in the treatment. All these elements cause the parties interested to hesitate before taking the necessary steps to provide suitable and appropriate treatment. If the general city hospitals would make special provision by adopting a psychopathic department for such patients and receive them at a moderate financial rate or even on the same basis as other patients are now admitted, the prevailing objections would speedily disappear and it would become as common to refer the insane to such hospitals for treatment as it is now those suffering from typhoid or pneumonia.

The special advantage of such an arrangement would certainly tend to increase the percentage of recoveries, which is always so highly desirable and which constitutes the true aim and object of practical scientific psychiatry. The more accurate systems of classification that are now enforced render finer discriminations in diagnosis possible, which again improve our methods of treatment. Hence the trend of modern psychiatry is toward greater individualized care of the insane. This is greatly aided by the more correct and improved methods of examination, which again depend on the more strictly scientific

laboratory processes and modern mechanical appliances, all of which tend to enlarge our practical, clinical and therapeutical resources. In conclusion, it is my conviction that psychiatry has yet a great work before it, as well as a rich field for conquest in separating the various fads and frauds of the day and substituting in their stead scientific medical truth as revealed in the practical observation and experience concerning the demonstrated facts which pertain to mental influence and placing them on a practical scientific basis. That nervous and mental diseases are not always amenable to either pharmacology or surgery is very certain, but that they are powerfully influenced for good or ill by mental and moral means, as well as by the nature of their environments, is a statement in accord not only with our best knowledge, but also with our experience and judgment. That these psychologic means and measures powerfully affect the results obtained in their treatment is also very clear to every thoughtful physician, but that their specific nature as well as methods of application are not as well understood by the profession as they should be is also true. It would, therefore, seem within the legitimate province of the science of psychiatry to rid mental therapeutics of their empiric value by practical demonstrations and by the teaching of the genuine, thus differentiating the true from the false by appropriate, practical methods, and recognizing their special virtue by placing them on a scientific, ethical basis. To sum up, it would appear that the general trend of modern psychiatry is toward more strict accuracy in classification and diagnosis of mental disorders by the practical utility of all the recognized modern means and methods known to medical science. These again establish a more correct rule for prognosis, besides suggesting a plan of treatment to be adopted for their relief, all of which, when duly applied by the general medical practitioner, will not only aid him in the differentiation of the various psychoses and allied disorders, but will also furnish him the secret to their more successful care, management and treatment, which, after all, is the true aim and object of all practical medical science.

DISCUSSION.

DR. F. SAVARY PEARCE, Philadelphia—I think we all agree that to send certain cases of acute insanity to the general hospital instead of to the insane asylum is not only practicable, but highly desirable. We know that certain cases of acute insanity will recover, and if such patients could be sent to a general hospital their recovery could be hastened, and they would be spared the stigma of having been inmates of an insane asylum. A special ward should be set aside for these patients in the general hospital; otherwise the general medical men connected with the institution will surely find legitimate reasons for objecting to the presence of this class of cases in the hospital. In the institution with which I am connected I hope in the near future to see a special ward set aside, as far distant from the ordinary wards as possible, where cases of acute insanity can be treated. Another point is that the members of the patient's family are often the very ones who insist that he be sent to an asylum. The physician must educate the public to the fact that insanity is not infrequently a curable disease. We know that a great many of the incipient cases of insanity, and even some of the chronic cases, recover. According to Dr. Richardson, of the Norristown Asylum, 50 per cent. of the cases admitted to the asylum recover. I am convinced that the treatment of the insane must be revised very thoroughly. If the public could be made to appreciate the fact that patients suffering from insanity recover as frequently as do those suffering from many other diseases, I am sure that they would give us their co-operation in the establishment of special wards for the insane

in the general hospitals. This would also rid insanity of much of the mystery that now surrounds it.

DR. DANIEL R. BROWER, Chicago—It is not very long since I suggested the establishment of psychopathic wards in general hospitals. Since then, great progress has been made toward the realization of this project, and one of the most hopeful signs, as Dr. Punton has told you, is the amalgamation of the American Psychological Association with the Congress of Physicians and Surgeons. But this object is not always attainable. The maintenance of such a special ward is a very expensive affair. Since I gave up the medical superintendency of a hospital for the insane, I have been engaged continuously in the treatment of acute cases of insanity in a general hospital, and I think I have had a fair measure of success, sufficient, at least, to induce me to continue. Of course, cases that are treated in these general hospitals must be selected with care, and if that is done, a considerable number of them can be safely admitted. I wish to emphasize the point that it is possible, in well-selected cases of acute insanity, to get satisfactory results in the general hospitals.

DR. R. HARVEY COOK, Oxford, Ohio—In arguing for the admission of the acute insane into a ward of a general hospital, instead of a hospital for the insane, you imply either that the acute case can be better cared for in the general hospital, or you are endeavoring to prevent the stigma of insanity. If the acute case can receive better care, so can the more prolonged case. It then makes it imperative to convert our hospitals for the insane into general hospitals for humanity's sake. If, on the other hand, it be to avoid the stigma, how grossly unjust to the less acute case. Would it not be far better to place all insane cases in a hospital for the insane where proper classification can be had? Educate the people, let them know and feel that insanity is of no more disgrace than typhoid, thus removing in a short time the so-called stigma.

DR. J. H. MCBRIDE, Los Angeles, Cal.—I think we are all gratified to note that a change has taken place in recent years in the treatment of the insane, and that more attention is paid to-day to general medicine in the insane asylums than ever before. In regard to the curability of insanity, I can hardly agree with Dr. Punton. I think his proportion of recoveries is too large. My own experience is essentially summarized in the statement of a French alienist, whose name I forget. He said that of ten insane persons, five would recover from the first attack, and five would not recover. Of the five who recovered, two, certainly, and probably three, would relapse; the other two, or possibly three, would remain well. This leaves a probable recovery rate of 20 or 30 per cent.

DR. RICHARD DEWEY, Wauwatosa, Wis.—What impresses me most in regard to this whole subject is the difficulty of drawing definite lines, and the danger in making sweeping assertions. Insanity is so complex a condition that it is scarcely possible to generalize. There is a large number of persons who are insane in the ordinary sense of the term, and who, nevertheless, can be treated in the general hospital; then there are other cases for whom that plan is entirely inadmissible. We must ascertain whether the form of insanity is associated with dangerous or disagreeable elements before we can decide whether a certain patient can be treated in a general institution. Some insane patients are noisy; others have suicidal or other dangerous tendencies, and for all such special provision must be made. I do not doubt the desirability of treating certain cases of acute insanity in the general hospital, but the cases must be carefully selected and suitable provision must be made for them in the way of isolated rooms. I believe that this question will eventually work itself out if each of us not only will do the best he can with cases that come to him, but also especially make an effort to enlighten the general profession and the community. This class of patients also requires freedom in coming and going under suitable regulation. They should spend much of their time out of doors, especially in the pleasant season of the year, and the city streets are not good places for insane patients. Institutions where they are cared for should be surrounded by grounds where these pa-

tients can get plenty of outdoor exercise. I greatly appreciate the fact that the subject of insanity does not occupy the isolated position it formerly held, and that this disease is now being studied very much in the same manner as are other diseases.

DR. ALBERT E. STERNE, Indianapolis—For many years I held the view that so-called observation or reception hospitals would be very desirable in connection with the treatment of the acutely insane. In experiments that have been made in that direction, however, as wards in connection with general hospitals, it has been found that in the vast majority of those cases it became necessary to send them to an insane asylum after a comparatively short period of time. No alienist can foresee, in any given case, even of the mildest type, what the duration of the psychosis will be. He may in certain instances approximate its duration, but it is a rather common experience that the very worst cases of the acute variety of insanity, sometimes with the most unpromising outlook at the beginning, both as regards their personal aspect and the family history, may improve within a few weeks or even days, especially where the digestive element is a prominent one. Then, again, we have the experience that in the acute, seemingly mild cases, which we would prefer to send to the general hospital, the symptoms may steadily grow worse, and the patients may take weeks, months or even years to recover. No general hospital could possibly take care of these cases for any great length of time. It is unfortunate that a few insane must suffer with the general mass of the insane. It is unfortunate that a comparatively small percentage of persons who were insane for brief periods should have such a stigma placed on them. They could no doubt have been treated just as well, or even better, in a general hospital or at home. The Scotch plan of treating insane patients by the colonization method, which affords them plenty of freedom and out-of-door exercise, has proved to be excellent, but for the ordinary run of cases it would be found impracticable. The establishment of a detention hospital, separate from the main asylum, would be better. The fact has already been brought out that relapses are not uncommon among these acute cases. According to one of the German authorities, a vast majority of the cases of mania and melancholia suffer from relapses, and even in the interim it is a question whether they are entirely free from the disease. While I am an advocate of the detention hospital, I should not be in favor of separate wards for the acutely insane in the general hospital. I think such a measure would prove inimical to the majority of the patients in such an institution, and even, in the end, to the insane patients themselves.

DR. WILLIAM J. HERDMAN, Ann Arbor, Mich.—At the time Dr. Weir Mitchell made his strictures on the medical management of the insane asylums, I think he scarcely did justice to what was being done. In those years, the officials of many of the insane asylums were greatly handicapped by conditions under which they were doing some very good work. I know this was true in the Michigan asylums, and I was very familiar with them at that time. As we progress into a new field, we must go largely along the skirmish line, and do a great deal of individual work. In doing this, a man may not always be fully understood by his fellows. We have passed beyond that skirmish line now, and the main column is moving on. We are forming a line of battle, and each one is doing his part in clearing the field. I think the alienist has done his part, and done it well. I believe that the humane management of the insane has been developed to a degree that it could not have been developed by any other method. The time has now come for a change. That such a necessity is present, we all recognize, and with that portion of Dr. Punton's paper I am fully in accord. There is greater harmony between the alienist and neurologist, and this is as it should be. I believe that there is an opportunity for us to do most excellent work in dealing with acute cases of insanity in the general hospital. The percentage of such cases, however, is not very large; certainly not beyond 20, and I doubt if it would reach that. The number would be limited largely to cases of incipient insanity, associated with disorders of the

eye or ear, or of the genital organs or gastro-intestinal tract. Such factors not infrequently act as the last straw in overturning a weakened brain from a condition of sanity to insanity, and it is in that class of cases that treatment in the general hospital would be most desirable. Another factor to be contended with is the family of the insane patient. Many families refuse to allow their relative to be immediately sent to an insane asylum, whereas if such a patient could be sent to a general hospital, the consent of the family could be readily obtained. In these cases of acute insanity, prompt treatment is the most important element. In connection with this subject I recently made a suggestion which I think would cover the ground very well. In every state we have a number of well-equipped insane asylums, each one covering a certain district. For example, in Michigan we have four such asylums. Why would it not be feasible to establish in each of these districts subsidiary establishments, under the charge of a competent trained nurse? These dispensaries, if you would so term them, could be established in a private house, or in connection with private sanitariums, and the patient could be kept there until the superintendent of the asylum in that section of the state could be notified. Then the latter or his assistant could go and investigate the case, in consultation with the physician who had charge of the patient. Then, if the case seems to be a suitable one for the general hospital, let it be sent there; if not, it can be sent to one of the asylums. It seems to me that such a plan would prove both feasible and satisfactory. In many of these districts there are alienists who could arrange the details regarding a temporary residence for these patients.

DR. G. W. McCASKEY, Fort Wayne, Ind.—In Fort Wayne we have two fairly well-equipped rather small general hospitals, and our experience there with the treatment of cases of acute insanity has not been satisfactory. Some one in this discussion has said that 20 per cent. of the cases of acute insanity will be manageable in a general hospital. In my experience, it is even less than that. Furthermore, we can not foresee which of the cases belong to the 20 per cent. In one of our hospitals we have an entire floor, so far removed as possible from the other patients, reserved for the insane, and our experience has been such that I do not regard the plan as desirable.

DR. JOHN PUNTON—I think Dr. Weir Mitchell is entitled to much credit in being the originator of this modern method in reference to the better treatment of the insane. I agree with Dr. Dewey that every case of acute insanity is a law to itself, and it is almost impossible for any alienist to tell exactly what can be done for any case in the incipient stage. In reply to Dr. McCaskey, in my paper, I did not have in mind those cases that require bars to hold them, or those with suicidal tendencies. The ones I had in mind for general hospitals are the borderline cases.

ARTHRITIS DEFORMANS.

THE REPORT OF A SERIES OF ONE HUNDRED AND TEN CASES
FROM THE JOHNS HOPKINS HOSPITAL.

(FROM THE CLINIC OF PROFESSOR OSLER.)

THOMAS McCRAE, M.D., M.R.C.P. (Lond.)

THE JOHNS HOPKINS HOSPITAL,
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(Concluded from page 96.)

GROUP IV. SPONDYLITIS.

As already said, the cases with spinal involvement fall into two groups, one with general, the other with local involvement. The former is readily diagnosed, the latter is certainly much more easily overlooked. These cases are usually considered to belong to the "osteoarthritis" group. The bony changes predominate, and especially new formation of bone. Certain writers hold that the osteoarthritic cases are quite distinct from the type previously spoken of as "rheumatoid" or those in which other than bony parts are especially involved.

In certain of the cases of this series there seems no doubt of the occurrence of both types in the same patient. If this be true it goes far to prove that all the cases here grouped under the heading of arthritis deformans do belong to one disease which has various types. Not only were the two types of arthritis found in the one patient, but in some of those showing only osteoarthritic manifestations there was a history of attacks of acute polyarthritis exactly like those described under Group II, and from which the patient had recovered apparently completely. The histories are so characteristic that there seems little doubt of the nature of the old attacks.

There were 22 cases showing spinal involvement. In 13 of these there was spondylitis alone, while in 9 this was accompanied by symptoms in other joints; in other words, the lesions were of the polyarticular type, and these have been included in the analysis of Group II. In taking up the study of this group it is sometimes difficult to distinguish the symptoms from the spine and those from the other joints. In reference to the extent of spine involvement the cases were as follows:

	Gen. inv. of spine	Local inv. of sp.
Spine only involved ^s	6	7
Spine and other joints ^s	9	0

It is worthy of note that when the spinal involvement was associated with changes in other joints in no instance did we recognize involvement of a portion of the spine only. But, as said before, the confession is frankly made that only recently have we learned to diagnose the local form, and it is quite possible that instances of it have been overlooked. For the same reason the relative figures of these groups mean little as to their comparative frequency.

Incidence.—Of the 22 cases, 20 were males and 2 females. The striking preponderance of males is to be noted, especially as the other type is thought usually to occur much more frequently among females. All are white. The ages were as follows:

1 to 10.....	0	41 to 50.....	2
11 to 20.....	1	51 to 60.....	2
21 to 30.....	6	61 to 70.....	2
31 to 40.....	9		

Complaint.—This, in the majority, was of pain and stiffness in the back and legs. With this mention was often made of the crippling and general weakness. A few laid especial emphasis on the pain.

Onset.—The age of this was:

1 to 10.....	2	41 to 50.....	1
11 to 20.....	10	51 to 60.....	2
21 to 30.....	4	61 to 70.....	1
31 to 40.....	2		

Only 7 cases were admitted below the age of 30 years, but in 16 the onset was before 30. The onset in a few over the age of 50 is to be noted. The early age at onset in so many of the cases is striking.

The onset in the 13 spinal cases was gradual in 11 and sudden in 1, with one doubtful. In two of these there was a history of previous acute attacks of polyarthritis which subsided and left apparently no damage. These are exceedingly interesting. One may be noted briefly:

No. 61.—J. H., white, male, aged 45, was admitted complaining of stiffness of the back. There was a history of arthritis deformans in his family. From childhood he had at times some arthritis. With these attacks he was usually laid up, but never for very long. At 28 he had his first severe attack. This involved many joints and he was two months in bed. He recovered gradually and was well for seven years, when he had another attack with many joints involved, and the neck slightly. Three years and five years later there were subsequent attacks, in the last one his

^s. To prevent confusion it is convenient to refer to these two classes as the "spinal" and "mixed" cases.