

be beneficial if the general medical profession comes to realize that the interests of the patient require the stopping of both glycosuria and ketonuria, and that it is possible to stop these things within a very few days.

Taking up the patient's side of the matter, it can be said that no one has yet refused to take the treatment. The treatment is rigorous, especially in severe cases, but every patient has reported increased comfort, and has preferred to endure the low diet rather than to return to what he suffered before beginning treatment. Gastro-intestinal troubles are absent. The patients have shown none of the carbohydrate hunger which is supposed to belong to diabetes. When asked what they would like to have added to the diet, they have said bacon more often than bread. In view of the opportunity to choose patients, the question arises as to what sort should be selected. The choice might be limited to intelligent, well-to-do, careful persons, and thus an attempt made to show what can be done under ideal conditions. This might be called an unfair test, since most physicians and hospitals cannot thus select their patients. Therefore up to the present, patients have been selected solely on the basis of severity, without regard to character, intelligence, or surroundings. Also, it could be arranged to keep all these patients by themselves. But since some hospitals cannot do this, most of our patients are now kept in wards along with cardiac and other cases, where they might steal food if they tried hard enough, and where they can see trays of bread and desserts going to other patients. These are conditions which they must face when they leave the hospital, and they might as well be accustomed to them. There has been practically no trouble on this account. By taking patients who are poor, ignorant, careless, and lacking in self-control, it is made certain that our statistics will suffer. Some of these patients will promptly relapse, and others will drop out of sight and never be heard from again. These conditions must all be faced, in order to learn what can be done with the ordinary run of patients. The ultimate results will fall easily into two groups. When the patients follow instructions carefully, we shall learn what happens under good conditions. If they go downhill under these conditions, the scientific factor will be at fault; this will be the test of it. But when the patients fail to obey instructions and proceed to eat bread and potatoes, this will have nothing to do with the theory of the subject, and will represent merely a failure of the human factor.

It will be of interest to know whether our method can help this factor. Most patients of all classes desire to live, and desire to be free from the symptoms that trouble them. Our severe cases have nearly all been told elsewhere that they must die, and even the milder ones generally have a wholesome fear of the word diabetes. It seems to make a very good beginning when they are told that their glycosuria will cease

within a few days; that they have not a mysterious fatal disease, but merely the weakness of a bodily function, like a weak stomach, and that it is entirely their own responsibility to live or die. Even for the patients who could be cleared up within a few weeks or months by the older methods, it seems an advantage to clear up the urine within a few days, and devote the remaining time to getting the patient accustomed to his diet and teaching him to take care of himself. On leaving the hospital, the patient is given orders as follows: to save and test his urine every day by Benedict's method, which even the ignorant can learn; if sugar appears, to check it instantly by a fast-day and then reduce his diet somewhat; to take a fast-day in bed at stated intervals, generally once in two to four weeks, even if sugar does not appear; to live on a diet of certain articles of food in certain approximate quantities; and instead of weighing the diet, to weigh himself at least once a week, and never let his weight rise above a stated figure. This figure is always below his original maximum weight, and is made lower in proportion to the severity of the diabetes.

As mentioned before, only the immediate results are stated as facts, and time must decide concerning the permanent value of the method.

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- ¹¹ Fraudulent gluten breads are also a frequent cause of glycosuria. For reliable brands, see analyses of diabetic foods in the 1913 report of the Connecticut Agricultural Experiment Station.

SOME PERILS CONFRONTING STATE CARE OF THE INSANE.*

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THE purpose of this paper is to call attention to old evils appearing in more virulent form at the present time. The centralized management of all state institutions, quite popular throughout the country, makes a brief review of the history of the public care of the insane both pertinent and instructive. The history may be roughly divided into three periods: first that of

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neglect, second of mixed care, and third of state care.

The period of neglect began in early Colonial times and extended through the first days of the republic to the beginning of the nineteenth century. The failure to properly provide for the insane during these early years may be attributed to infrequency of the disease, and profound misconception of its real nature rather than any lack of the true spirit of charity. In the very earliest Colonial days one may possibly trace a certain portion of this indifference to the austere religious conception of life characteristic of the Puritan. These serious religionists may have regarded the misfortunes of the insane as a judgment of God upon some moral perversity or short-coming. It is conceivable that their mental attitude may have curbed any feelings of sympathy which might naturally be awakened by the sufferings of the mentally afflicted.

Probably infrequency of the disease during the Colonial period was the most prominent underlying factor in this early neglect of the insane. During this period there were few insane, not merely because there was a sparse population, but because the early colonists were strong virile men and women. There were few weaklings. These first settlers were both mentally and physically the best equipped of their race. They were the ambitious adventurous pioneers, anxious to secure for themselves larger liberty in a new land. The very qualities of mind and body that led them to renounce the easier life in their native land and endure the privations and hardships of a new and unsettled wilderness were inconsistent with brain weakness. Insanity was rare because these earlier inhabitants for the most part possessed sound minds in sound bodies. Apparently mental defect was so infrequent that communities regarded as freaks such sporadic cases as did occur, rather than mentally diseased persons whose maladies might reappear in others and require special care. This disregard of insanity was a logical result of the prevailing misconception of its real nature. Consequently defective and insane persons of the early Colonial period were, if poor, allowed to roam at large with little or no care. Among families of means such cases were segregated and cared for at home as well as circumstances would admit.

Eventually the increasing number of mentally diseased persons made some sort of recognition imperative both for their own safety and that of the community. It was evident that public care in some form must be adopted. The problem, being a local one, its solution was sought within the conventional boundaries of the township. The town officials were called upon to care for their own insane as best they could, in the poorhouse or other extemporized way.

In some states, especially the less populous, the town system of care was felt to be inadequate. The numerically small town and the

town with limited finances found the expense burdensome; they could not provide suitable and in some instances even decent care. As facilities for intercommunication multiplied, the mutual interests and common relationship between towns in the same county became more manifest, with the resulting conviction that the county could furnish better care for all the insane within its boundaries than the towns acting independently. In these states county farms with large acreage and many buildings were established, and the old town poorhouses were closed. The result was greatly improved care of the insane. The larger unit not only provided better care, but under this system there was a diminished feeling of disgrace in the mind of the recipient of this form of public charity. The closer the donor to the beneficiary, the more intimate the personal relationship between the two, the more keenly does the recipient feel his misfortune.

As has been said, the period of mixed care, roughly speaking, began in the early days of the nineteenth century. With few exceptions, at that time the majority of the insane were maintained at the expense of the towns. Town care was generally accepted as the only method of public provision for the dependent insane. Early in the nineteenth century an awakening to the needs of the insane appeared. Partial state care was advocated, a method which received staunch support in Miss Dorothea Dix. The movement spread throughout the country, and state institutions appeared throughout the land. While these were nominally state institutions, no attempt was made to provide within their walls for all the insane in any state, nor was entire state support of all the patients admitted contemplated at that time. During this period of mixed care the dependent insane were supported and cared for by the town, the county, and the state in the three different classes of institutions enumerated.

During all these years experience was demonstrating that in the field of public charities and corrections the state is better fitted for the administration of the complex problems involved in the care of the insane. It is now generally conceded that of the three administrative units—town or city, county, and state—the latter is the one best equipped for the successful care of the insane, involving as it does intricate questions of treatment, prevention, after-care and scientific research. The slow evolution of state care from the remote days of neglect is evidence of the soundness of the consummation attained. The principle of state care achieved only after years of experience and mature conviction is unquestionably logical and correct.

When the asylums, as they were formerly called, were first established, their management was modeled after that of the general hospital, viz., boards of unsalaried trustees, whose only compensation was their travelling expenses.

The governors of the several states selected for these positions, business, professional, and scientific men, whose interest in the work would be assured irrespective of any remuneration. This plan has always proved most satisfactory in the government of either public or private charitable institutions. Partisan political affiliation played no part in the selection of these trustees. The result was a disinterested service freely given by men of the highest ability. The very fact that there was "nothing in it," in the sordid political sense, kept away "grafters" and secured permanency of service. At first only men were appointed on these boards, but later and long before the present feminist movement began the need of women's assistance was realized and two or more women were almost invariably represented in the personnel of the boards. The advantages accruing to the state from this form of institutional polity are economy to the state, continuity of service, elimination of politics from the conduct of state charities, and a certain definite zeal and interest in the work that comes from the intimate personal association existing between the superintendent, his medical staff, and the managers of the institution. The more impersonal and the farther removed from the daily life of the hospital is the board of managers, the less the interest and the more mechanical becomes the service. The more intimate the personal relationship between a local board of interested trustees and the superintendent and his patients, the more positive will be the impression upon the hospital. In fact, the successful hospital is the reflection of the character and devotion of its board of managers and their superintendent. Hospitals, like persons, have an individuality, which, after all, is merely the expression of the devotion, enthusiasm, and experience of those in charge.

The government of the state's charitable institutions by unsalaried boards of trustees has the distinct advantage of stimulating a general public interest in such charities. Undoubtedly this idea primarily suggested the management of the general hospitals by unpaid trustees. Society does and should take an interest in the benevolences of the state. Such interest should be fostered and utilized in every possible way. If professional and business men, or those with leisure and large experience in charitable work, are willing to devote their time and energy without remuneration to the administration of our public charities, by all means should such service be accepted and encouraged by the state as a civic obligation of its citizens. Not only is economy secured to the state by such gratuitous service, but a zeal and spirit of devotion is attained that is invaluable. One of the chief objections to the old town and county care of the insane under partisan political appointees was the indifferent service rendered by such management. Scientific study, proper classification of patients, and intelligent care were too often

sacrificed to a spirit of petty political economies, which lost sight of the real purpose of the charity.

Within recent years an entirely different system of institutional polity has arisen. Under this method all the state's charitable and penal institutions are placed under the management of central boards of control, with offices at the state house. The local boards of trustees, who met at the institution over which they were appointed, are abolished. The board of control usually consists of three members, who have salaries and are appointed with some reference to their party political affiliations. Women are not represented on these boards and consequently are not represented in the management of any of the state institutions. The new system, beginning in the West, has recently moved rapidly eastward, and for obvious reasons has become quite popular with the politicians. A fancied economic saving to the state has, however, prejudiced many well-meaning persons in its favor. Misled by specious reasoning, based on a somewhat illusory theory that administration of the state's charities by a board of control is founded on sound business principles and that a great saving to the state is to be thereby effected, these very fair-minded persons hastily subscribe to the new doctrine without sufficient reflection as to whether the new polity is really economical and most desirable in the long run for the administration of the state's charities. It may be well to consider carefully the merits and demerits of a system which threatens to abolish an institutional polity that has had the sanction of time and experience and which still is the only recognized form of institutional management in all private charities. With the general acceptance of this principle of state care of all dependents, attention has been directed as never before to the magnitude of the expense involved. This expense was not as noticeable when divided among counties and towns, but when presented in the aggregate in a single lump sum looms up as one of the largest financial burdens that the state has to carry. Central supervision over this expenditure is both logical and necessary. The principle of centralization in business management is sound and there is no reason why a state in the direction of its charities should not be guided to a certain extent by the same economic considerations that prevail in the business world. At the same time there is a difference in the final purposes of a large business organization like the Standard Oil or the U. S. Steel Corporation, whose sole ambition is financial return to stockholders, and the charities of a state, whose chief mission is the alleviation of human suffering. In the attempt to centralize the management of all state charitable institutions there is a real danger that the original mission of these charities may be sacrificed to an arbitrary and mechanical business theory. Economic administration of

the state's charities is only one side of the equation. As at present constituted, boards of control attempt a double service for the state,—fiscal supervision and administrative control of the institutions. These two functions, although closely related, need not necessarily be imposed upon the same board. While the steadily increasing cost of maintenance renders fiscal supervision by the state necessary, it does not follow that administration of the institutions can be more economically or more satisfactorily conducted by central boards of control than by carefully selected unpaid boards of trustees.

In the management of the state's charitable institutions we find then that fiscal supervision and administrative control are the two desiderata. The problem is to so correlate these two phases of institutional polity that the best interests of the wards of the state may be conserved with the least possible expense to the state. In the new system of centralization the fulfilment of this double obligation is placed upon the board of control. The wisdom of this course is questionable. While centralization may be desirable in the control of expenditures and possibly in the purchase of supplies, its application to the administrative detail of the institutions may be unfortunate.

With certain slight differences in the various Western states, boards of control as originally devised were composed of three members, with salaries of \$3500 each, or thereabout. These boards appointed the superintendents and purchasing agents for the institutions, and assumed the administrative and advisory functions that formerly belonged to the trustees. These boards had exclusive control over the finances and management of the penal and charitable institutions of the states. In many states local boards of visitors were appointed without pay except for traveling expenses, a sort of concession for the removal of the trustees. Women were represented on the board of visitors. It is significant, however, that these visitors are not responsible for the management of the institution, practically have no authority and naturally lack initiative. These visitors are practically figure heads, replacing the former trustees. The distinguishing characteristics of the new system are the central government of the institutions in both their physical and financial aspects, the divorce of the business and medical management of the hospital, and the obliteration of the individuality of the several institutions.

With presumably economical intention many modifications of this original scheme have appeared without, however, increasing the efficiency. In New Hampshire a board of control has been appointed with the purchasing agent as a member. This purchasing agent receives a substantial salary and devotes his entire time to the work, while the other members receive a *per diem* remuneration and devote such time as in their judgment seems advisable. Modi-

fications of the original plan in the interest of economy are questionable. It would seem advisable that if management by a board of control is adopted the members of the board should devote their entire time to the work, even though the expense is larger.

In still another state the following rather complicated plan has been proposed which would certainly have the merit of providing many salaried officials with positions involving large expense. This plan provides a central board consisting of five members with salaries of \$1000 each, whose functions are general and advisory. The central board appoints a director. This director must command a large salary, for he is endowed with vast powers, including the appointment of four assistant executive secretaries with large salaries, a business agent, the superintendents of the several institutions, as well as supervision and control over everything pertaining to the administrative and financial affairs of the hospitals, including all new construction. Under the director the four executive secretaries come into immediate contact with the details of the institutions, in a way replacing the former unpaid trustees. The business agent executes the orders of the director and appoints a purchasing agent, with offices, clerical force, and facilities for purchasing and storing supplies. Last, is an unpaid board of visitors, who have no authority except that of listening to complaints, which they cannot correct personally, but may report to the central board. This somewhat involved plan provides control galore. First a central board, second a director, third four executive secretaries, fourth a business agent, and fifth a purchasing agent with expensive offices, clerical force and storehouses. This plan, much more complicated than any previous method, is the latest academic creation of the professional efficiency expert. It is difficult to see how either efficiency or economy can be secured through such a complex and expensive organization. Whatever modifications of the original plan of centralized control may have been adopted, the ultimate purpose has been the withdrawal of local management from the institutions and the substitution of a central board with plenary, fiscal, and administrative power. Assuming that these two functions can be separated, what are the objections to administrative management of state institutions by a central board? First, too many and varied duties are imposed upon a single board. It is questionable whether three or even five officials at a central office can be of as great service to the charitable and penal institutions as local boards of trustees in close touch with individual institutions. The amount of time which a central board can give to the administrative details of many institutions of diverse character, situated in widely separated localities, must of necessity be quite limited. The problems vary greatly in the different institutions. Those of the feeble-minded

schools are not identical with those of the insane hospitals. Even the institutions for the insane differ among themselves. The hospitals for the acute, the chronic, and the criminal insane present peculiar and special problems, whose solution demands more time than a single central board has at its command. Neither can these special questions be satisfactorily settled by a board of visitors upon whom rests no final responsibility. What incentive or satisfaction can a board of visitors experience who feel they have no responsibility and who do not know that their suggestions or advice will be heeded by the real managers?

Second, lack of sympathy between the central board and the various hospitals. Successful administration of hospitals and charitable institutions depends directly on the active sympathy and personal interest of their boards of managers. Such interest can only be secured by intimate personal contact, frequent visitation, and close familiarity with the inner working of the hospital, and acquaintance with the actual needs of the patients. Weekly conferences at some central office between the superintendents and the board of control are not as helpful and stimulating to the superintendent as were the frequent visitations of the trustees and their meetings at the hospital, with free opportunity for consultation and helpful suggestion. A central board of control, with many duties and numerous widely separated institutions for visitation and supervision, must give brief and perfunctory service to each. The very fact that it is physically impossible for the board to give the necessary time to the several hospitals renders the service mechanical, and deprives the superintendent of the advice and consultation he so much needs. It is doubtful whether a board of control, visiting many institutions, can ever be in as close sympathy with the work of any particular institution as a local board of trustees who are devoting their time to the service of that institution alone.

Third, the elimination of women from any participation in the management of the hospitals. The principle is now firmly established that women should be represented on the boards of managers of any institution caring for women and children. Whether it is because members of boards of control are really political appointees, or because women are not supposed to be equal to the larger duties attaching to this service, it is significant that whenever trustees of state hospitals have been replaced by a central board of control, women have not been represented in the new management. In some states women have been relegated to the inconsequential boards of visitors, which really means that they have been removed from all actual participation in the activities of the hospitals.

Fourth, the possibility of politics entering the management of state charities. Under this system, the danger is always imminent that par-

tisan political preference may determine the personnel of the official board directing the state's charities. Government of state institutions by boards of trustees possessed this one great merit, that the men and women composing these boards were selected solely because of their fitness, without any reference to their political affiliations. General fitness and adaptability for the work and not political patronage should determine the selection of men for these positions. It is willingly conceded that most excellent men have been and still are being appointed on these boards of control, but the possibility that political considerations may at any time influence their selection is a menace. State charities should be as free from political interference as private charities. Fifth, the principle that the medical administration must be separate and distinct from the business administration, is not sound in theory nor beneficent in practice. In institutions ministering to human illness or defect the medical and the business relations are so intimate that complete separation is not possible without defeat or impairment of the very work for which these institutions stand. Any plan that seeks the divorce of the medical from the business administration is in danger of commercializing charity. The state hospitals for the past twenty-five years have been steadily assimilating the true hospital spirit. Treatment has been assuming greater prominence. The old almshouse treatment of insanity, based on economy carried to parsimony, has well nigh disappeared. The state hospitals have entirely reformed these obsolete methods. Trained nursing, carefully prepared dietaries, study of individual cases with proper treatment, both medicinal, psycho-therapeutic, and hydropathic, industrial employment, pathological research, prophylaxis, field work, and after-care all enter into the work of the hospitals, and are all essential medical questions. Any attempt to isolate and withdraw these activities from the business administration of the hospital is impossible. The general hospitals have long since demonstrated that the medical and the business administration cannot be separated without detriment to the usefulness of the hospital. From this let it not be argued that extravagance will follow, nor that it is desirable or necessary. The real problem is, how the business and the medical administrations may be correlated, and some workable plan devised by which the mission of the hospitals may be efficiently and economically realized.

It is not absolutely certain that central purchasing by a single purchasing agent is as economical as local purchasing by the institutions under competitive bids with central fiscal supervision and audit. The purchasing of supplies for a hospital is not identical with the purchase of supplies for a large railway or mercantile corporation. The character of many of the goods used in hospitals, the danger of dete-

rioration, and the expense of central storage and distribution render the economy of this method doubtful. Such plan can only be economical in large states with many institutions of a single class, and even then is of doubtful value.

In his exhaustive analysis of the "Methods of Fiscal Control of State Institutions" made for the State Charities Aid Association of New York State, Henry C. Wright finds that of the three methods of supervision studied, namely, those of New York, Iowa, and Indiana, the greater saving was in Indiana, in which state the institutions are managed by local boards of trustees under the supervision of a state board of charities. "The larger costs noted in connection with New York and Iowa are, in large measure, the cost of supervision of details of the administration of the institutions, which, in Indiana, remains in the hands of the superintendents of the institutions. These details are handled as satisfactorily by the superintendents in Indiana as by the central supervising officers in New York and Iowa." Undoubtedly in this statement lies the exact truth,—any theoretical saving by central administration is more than offset by the increased expense of maintaining the system.

There is no reason why, under a well-devised plan of coöperative and competitive buying, the institutions cannot purchase goods of the same quality as economically as a central purchasing agent. It is easily possible for a man, intent on buying only the cheapest goods, and unfamiliar with institutional requirements, to purchase inferior articles, the attempted use of which will cripple the efficiency of the institution. In a hospital the judgment of an experienced medical superintendent may be wiser than that of a lay buyer, unfamiliar with the real needs of the institution. On this point Mr. Wright says: "It seems difficult for the fiscal supervisor to bear in mind that the primary function of the institutions under his charge is, where possible, to heal and reform. There is a mass of evidence which will make it appear that his first concern is for small economies rather than for efficiency in operation."

In those states where boards of control have been or are about to be established, many of the evils of such a system can be forestalled by having at least one woman on the board, by holding stated meetings of the board at the various institutions at least once a month, by making the purchasing agent, where such an official exists, an agent and not a member of the board, and by legislation requiring the board to give their entire time to the work, with such remuneration as will secure an able and efficient personnel. Merit and experience, and not partisan political influence should determine the selection of the membership. The presence of a woman on a board of managers having the custody of women inmates in various institutions is most desirable.

In countless administrative matters her experience and point of view may prove most helpful. Her active presence in meetings would contribute greatly toward removing the charge and danger of political bias. By holding regular monthly meetings at the institutions, the board comes into more intimate and personal relations with the institutions and their work than when board meetings are held at a central place, as the State House. The management of the institutions in consultation with the board of control, and not the purchasing agent, should standardize and determine the selection of goods, not an independent buyer whose sole aim may be price, not quality, and who personally may be quite unfamiliar with the actual needs of the institution.

In Maryland a most admirable system of co-operative buying has been adopted in the state institutions. According to this plan the hospitals have a central bureau, to which all requisitions are sent at stated times. All institutional supplies are standardized and samples are on exhibition at this office. From this office advertisements for proposals are sent out and contracts signed with the lowest bidders. Little expense is entailed under this method, and the institutions secure the class of goods they require at the lowest possible cost.

The peril that at the present time menaces state care of the insane is excess of control. The institutions and the officers who manage them may become so hampered by petty supervision as to lose efficiency in operation and management. Just as the overtrained athlete loses his spirit and his nerve at the crucial moment, so will the hospitals under excess of control forfeit the true hospital spirit and the initiative that formerly prevailed. There is danger that they will become mere receptacles for housing and feeding large numbers of inmates without showing any very great financial saving for the state, thereby losing sight of the scientific and therapeutic aims for which these institutions stand.

After all why is this expensive machinery of control necessary, unless to provide many more high-salaried officials? Mr. Wright in his report with great justice states that what the institutions and the superintendents most need is advice of experts, uniformity of accounting and reporting, and standardization, as far as is possible, of all hospital supplies. The securing of these considerations does not require complicated and expensive supervisory boards. What is really needed is central fiscal supervision, with as large a degree of local independence as is necessary to secure efficiency and economy.

Mr. Wright's recommendations contain much that will appeal to the trained institutional worker. A central supervising board, serving without pay, and having "function of inspection, recommendation, and advice, combined with a partial power of control." This board to have as salaried secretary a man of "marked

ability," and familiar with institution requirements, and also empowered to employ experts, as they may be needed to give advice on all matters pertaining to the life and well-being of the institutions. Boards of managers with women representatives appointed for each institution by the governor. Advisory relations to exist between the supervising board and the managers. Stated conferences between the superintendents and the managers. Joint purchasing of supplies with such expert advice and laboratory tests as the supervising board may deem necessary. Under some such general scheme the state will maintain control over all expenditures, its interest in and direction of its charities will be attained with the smallest possible outlay. Individual civic responsibility to the state will be secured through volunteer workers. Public charities and correction will not be imperilled by partisan political interests. Efficiency, economy, continuity, and permanence of service will characterize the management of our state institutions.

THE PRE-OPERATIVE DIAGNOSIS OF TUBERCULAR MESENTERIC AND RETROPERITONEAL GLANDS.

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WITH the advent of greater perfection in the technic of the Roentgen ray examination and diagnosis of abdominal conditions there is still felt the need of greater refinement of diagnosis of the acute conditions, especially of the right lower quadrant.

The clinical investigation undertaken in this paper was stimulated by the recent occurrence in the author's practice of several cases strongly simulating appendicitis and distinctly of the operative type, but which on opening the abdomen, were found to be what I think we can properly term the acute fulminating type of retroperitoneal or mesenteric adenitis of tubercular origin.

The attempt is made in this paper through the analysis of a series of autopsy and clinical records to throw some additional light on the pre-operative diagnosis of this condition,—primary retroperitoneal and mesenteric tubercular adenitis.

The type of this disease, which is secondary to general or intestinal tuberculosis, is not considered in this paper, but only that type which has recently come to be recognized as a definite and separate clinical entity, but which so often simulates and is mistaken for the acute conditions occurring in the right lower quadrant of the abdomen.

This type of case occurs quite frequently in

both private and hospital practice, especially in children and young adults.

Clinical surgical experience shows that there are certain cases which present a definite picture of an acute right lower quadrant condition, most often simulating appendicitis, which on operation show a normal or slightly congested appendix and no other pathology than masses of retroperitoneal glands in various stages of enlargement and in which no other tubercular foci can be found anywhere in the body on most careful examination.

These isolated glands or groups of glands may occur anywhere in the mesentery, but are most commonly found in the ileo-cecal region.

Corner, who seems to have had considerable experience with this class of case, and to whose papers many references are made in the literature, thinks that there is a physiologic reason for this location in the comparative stasis of the products of digestion in a mildly alkaline medium at this site; a condition which favors the passage of tubercle bacilli through the intact mucous membrane of the bowel.

Corner also believes that tuberculous mesenteric glands are to be found in practically every child in which an abdominal operation is necessary. This great frequency and the fact that glandular (non-tubercular) enlargement is so common in other regions of the body in children coincident with any pathologic condition, makes the raising of the question of the tubercular nature of these glands in children a pointed one.

There are many reported instances in which the removal of an apparently normal or only slightly congested appendix was followed by the subsidence of all symptoms and even by the disappearance of glandular enlargements. And whether we grant that this mesenteric adenitis, in very young children, is of tubercular origin or whether it be a simple adenitis so common in all inflammatory or other conditions in young children, the facts still remain that this type of disease often does produce a chain of acute right lower abdominal symptoms of such a type as generally to demand surgical intervention. It seems arguable to the writer that as these glands are so commonly found in many conditions in young children, for which the abdomen is opened, and as these children ultimately go on to complete recovery from their surgical condition and do not suffer in the future from further enlargement of these glands, therefore we may believe that a mesenteric adenitis is a common condition in children, from which they recover spontaneously, also from which it is the exception rather than the rule to have symptoms; that these are probably more likely to be of inflammatory than tubercular origin and from which they may be expected to recover without further morbidity.

When we discuss this condition in adults, however, it seems reasonable to suppose that glands which have persisted since childhood or have developed recently are much more likely to