

this time there was no improvement that she could see. On June 6 the fossæ were cleared of a mass of soft degenerate tissue that bled as freely as at the average adenoid operation. Within twenty-four hours the right ear became dry and has remained so. The left ear showed possibly two or three drops of pus. Although the right ear has been dry only two weeks it followed immediately the clearing of the fossæ, after treatment had been ineffectual for years.

In chronic secretory otitis media, giving a history of stuffiness in the ear, fluctuating hearing, especially in damp weather, low pitched tinnitus and recurring unilateral salpingitis, there is always degenerate tissue in the corresponding fossa of Rosenmueller. This cannot be seen in every case with a posterior mirror, and under such conditions a digital examination is necessary. This observation the author has verified in several hundred cases.

Of special interest to general medicine, as well as to otology, is the work that has been done by Wood, Groeber and Goodale on diseased tonsillar crypts. These exist very often in adults as well as in children and has led to the later operation of removing the entire tonsil with its capsule intact. The ordinary examination may not reveal their presence unless the anterior pillow is drawn forward. When present, these pockets of pus have a decidedly harmful influence upon the middle ear. Improved methods of examination have shown that many are the seat of tubercular infection, as pointed out by Robertson and others. Experiments on animals show that not only do we get an adenitis from toxin absorption, but that infective material may pass directly to the mediastinal glands and the deeper lymphatics. This would lead us to a careful examination for cryptic disease of the tonsils in all cases in which the serous membranes of the heart, pleura and joints are affected as well as such indefinite troubles as rheumatism.

While I have emphasized the local causes which are open to direct inspection and treatment and are active in the majority of cases, no review of the field that did not take into consideration the influence of the kidney, heart, arteriosclerosis, general metabolism, and, in fact, of every organ of the body would be worthy of the science of otology as we now understand it.

With the advances made in our knowledge of the pathology of the middle ear we no longer give our entire attention to the end results after the hearing function has been seriously impaired or wholly lost, but take active measures to prevent the occurrence or check the advance of acute or chronic inflammatory conditions that were its original cause. In other words, the aurist must be a practical rhinologist.

The surgery of the middle ear and mastoid has advanced from the simple Wilde incision over the mastoid to the application of the general surgical principle: Follow and remove the diseased tissue as far as it may lead. To preserve the hearing function we must know not only what to do, but, what is of quite as much importance, when to do it. Operations for diseased ossicles, sinus throm-

bosis, extradural and brain abscesses, the radical mastoid, etc., are too much outside the domain of general practice to be of interest. One of the more recent and striking advances is the operation for opening and draining of the labyrinth, which promises to develop into a successful and regular procedure.

In the crude and partial outline of the wide field covered by the subject of this paper it has been the purpose of the author to show that otology advances by the help of every worker in general medicine and the allied sciences, that the field is constantly widening and that the specialist and internist should work more together and in a spirit of helpfulness for the common cause. With the perfection of new operations requiring special technic and skill, the otologist will be fully occupied, and many of the procedures now within his domain will become the ordinary routine of the progressive general practitioner.

## RESTRAINT INSTEAD OF TREATMENT.

### A RELIC OF MEDIEVAL TIMES IN OUR PRESENT HOSPITALS FOR THE INSANE.

BY L. VERNON BRIGGS, M.D., BOSTON,

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THE question of restraint, as still used in insane hospitals, has been, and is, overlooked by most physicians and reformers. This is not so in every instance, for in a few hospitals in the United States, and hardly more in Europe, enlightened men have done away with this abuse, the most striking examples in Massachusetts being Dr. Charles W. Page's and Dr. John A. Houston's abolishment of restraint at Danvers and Northampton respectively, the latter not even using hypnotics in any form, not even bromides.

There are, strictly speaking, three forms of restraint: Restraint by different kinds of mechanical apparatus, restraint by seclusion (solitary confinement in an unfurnished room), and therapeutic restraint (restraint by drugs). It would quite appall us if we knew the extent to which these different restraints are employed in our own institutions.

It is evident to any one who has intelligently studied the conditions of the insane, that there is very little treatment and decidedly too much restraint. Fifty years ago it was not expected that an insane person would have much more than board and restraint. If they did not hurt themselves or other people, the public seemed to be satisfied. The same conditions exist as to a greater part of our insane to-day. It seems to me that legislation is sadly needed to abolish restraint, excepting as a life-saving measure, but if this is impossible, then to regulate the amount of restraint used, the conditions under which it shall be used, and that each individual case shall have the same amount of medical care and supervision as in any other disease.

More physicians should be assigned to the care of our insane institutions; women nurses should, to a greater extent, replace male attendants. If the barbarous custom of restraint has got to be continued, all appliances should be kept in the office and under the lock and key of the superintendent, who should see every case and decide whether restraint is necessary and make a record of the kind and amount and different forms of restraint used. This should apply not only to our state institutions for the insane, but to our general hospitals and private hospitals. Until this or some better plan is adopted, we cannot help having a repetition of the Boston Insane Hospital affair and similar abuses in some of our other insane institutions during the last few years.

Women nurses are used now in many of the men's wards of the insane hospitals of this country. Charles R. Bancroft, M.D., Medical Superintendent of the New Hampshire State Hospital, in a paper read at the sixty-second annual meeting of the American Medico-Psychological Association, Boston, June, 1906, on "Women as Nurses for Men in Insane Hospitals," lays special stress on the desirability of women nurses around convalescent male patients. In wards for the physically sick and infirm, he says: "The nursing is better done by women than men. Women can give the graceful touches so comforting to the sick; they will keep the beds cleaner, the sheets more free from wrinkles, the wards more attractive, than is possible with the average male attendant."

The report of the Illinois Asylum for the Incurable Insane at Bartonville says: "As fast as male attendants retire from the service, women are substituted, with the result that six hundred of the male inmates are now cared for by women. The improvement in the character and habits of the men has attracted favorable attention, and the better care they are receiving has caused a decided improvement in their condition, especially in the infirmaries."

The Committee on Lunacy of Pennsylvania, in its report for the year 1904, says that "during the year there has been consummated a plan that at the time of presentation of the last annual report was in progress of preparation. This was the introduction of the woman nurse into the wards allotted to insane men. Though this was no new thing in some prominent hospitals throughout the country, it was a new departure for our own state, where there was upon the part of some superintendents grave doubts as to the success, and even pronounced opposition to the project. Why such feeling should exist is rather a mystery, as the softening, refining influence of woman, with her gentle and soothing touch which has proved so efficacious in the general hospitals for the sick, should minister with equal advantage to certain classes of unfortunate demented who, although denizens of the realms of hallucinations and delusions, are yet amenable to kindness and gentle ministration. This has been proved true in the State Hospital at Norris-

town, where, to a partial extent, women nurses have been introduced as caretakers of men, and also in the hospital at Warren, where, to a more limited degree, the plan has been adopted."

In the *Medical Times* of January, 1908, Dr. A. P. Williamson, Superintendent of the State Hospital, Patton, Cal., says: "A hospital for the insane which makes an effort to keep abreast of the times and to adopt the most progressive methods is no longer an asylum to which the mentally disturbed can be sent for custodial care, but it is an institution in which nursing, good diet and proper medication are given the patient. State hospitals are not hospitals only in name, but they are establishments where hospital methods only prevail and where, too, the female nurse is gradually displacing the male attendant. A modern hospital for the insane is an institution in which the acute and recent cases of functional psychoses will have the best chance for rapid recovery, and where the chronic and organic forms may receive such care as will make their lives worth living, and where their mental and physical comfort will receive constant and solicitous care. Thus a properly organized hospital for the insane at the present time consists primarily of a series of laboratories—a physiological laboratory for a study of the manner in which all the organs of the body carry on their respective functions; a clinical laboratory for the separation of physiological from pathological manifestations presented by various parts of the body, and the determination of the degree to which certain organs are carrying on their physiological functions, modified by the presence of pathological conditions; a psychological laboratory for the study of the mental phenomena presented and the determination of the psychological condition of the patient; a well-equipped pathological and bacteriological laboratory in which specimens may be examined and their morphology determined; and last, but by no means least, a thoroughly well-equipped, well-lighted and modern operating room where pathological conditions may be removed and where physical deformities may be corrected. The existence of such laboratories, and the systematic study of the human body, from a physical as well as from a mental side, is what differentiates the modern hospital from the ancient lunatic asylum, which the general public is so loath to discard."

Dr. Charles G. Wagner, Superintendent of the Binghamton State Hospital, Binghamton, N. Y., in a paper read before the State Medical Society at Albany, N. Y., Jan. 27, 1903, on "The Care of the Insane," says: "Occasionally we have patients who do not yield to mild sedatives or even to such hypnotics as the bromides, chloral, sulphonal, hyosine, etc. Formerly such patients were confined in cells, put in straight jackets, muffs, belts and wristlets or mittens, and otherwise harshly treated; but now all such devices are regarded as barbarous, and, instead, we employ trained nurses educated for the special

duties they have to perform. These nurses, through the exercise of kind and gentle discipline and ever-watchful care, have happily demonstrated that the modern humane methods are infinitely superior to the old way, where force was the dominating factor of asylum treatment. The treatment of the insane to-day, briefly summed up, may be said to be the provision of pleasant and sanitary surroundings, good nursing, proper medical attendance, suitable diet, entertainment and congenial occupation."

Superintendent H. B. Carriel, M.D., of the Illinois Central Hospital for the Insane, in his report of July 1, 1908, says that "during the past two years restraint has been practically abolished."

At a practical talk on mental diseases at the fifty-fourth annual session of the Kentucky State Medical Association, held at Louisville, Oct. 19, 1909, Dr. W. F. Boggess, of Louisville, said that no mechanical restraint is now used there. He says: "In the care of the insane we have evolved from the day when mad men were treated as such and confined with chains and staples, fed through holes in doors, to the present time, when the insane are treated as sick people. No mechanical restraint is used."

George C. Shattuck, M.D., in a letter to the *BOSTON MEDICAL AND SURGICAL JOURNAL*, under date of Berlin, April 30, 1908, on the subject "Recent Hospital Construction," says of the Virchow Hospital that "delirious or noisy patients from all parts of the hospital are sent to a ward designed for this purpose. It has small rooms for one or two patients each. Instead of using bedsteads, the mattresses are laid flat upon the floor. Box-like padded beds are at hand, but are rarely used, and tying is never resorted to."

On May 17, 1904, Charles W. Page, M.D., of Danvers, read a paper on "Mechanical Restraint and Seclusion of Insane Persons" at the State Board of Insanity Conference, State House, Boston. He went carefully into the history of releasing insane people from chains and confinement. Philippe Pinel, Superintendent of Bicêtre, the great Paris asylum for incurable insane men, was the first to start this movement. His influence has been felt ever since. When Pinel entered the asylum with M. Couthou, a member of the Commune, they were greeted, it is said, "by the yells and exclamations of three hundred maniacs, who mingled the clanking of their chains with the uproar of their voices." This horrible condition of things had existed indefinitely, without a recorded protest from political officials, church authorities or friendly philanthropists. Public opinion had come to regard such conditions as inevitable, and yet we all know to-day that the shocking features of that gloomy Paris prison asylum were due entirely to ignorance and "man's inhumanity to man." Pinel alone held such an opinion at that time, and when he requested permission of the government to do away with "the chains, iron cages and brutal keepers" he was generally regarded as a reckless visionary, almost an insane man himself. Never-

theless, he removed the chains from some fifty men at once, and the others subsequently, without a resulting accident or untoward event. Owing, no doubt, in part to unsettled political conditions in France at that time, this epoch-making dramatic incident in the world's progress of humanity was not widely known or duly appreciated until after many years had elapsed. Meantime, an English Quaker, William Tuke, becoming sorely distressed with the depleting and repressive methods to which the insane in the government asylums of Great Britain were subjected, founded at York, England, and at his own expense, a hospital for the insane where lunatics would be treated as sick people, where gentleness and patience would, under all conditions, be exercised toward them. These humane methods were not adopted in any prevailing form in English institutions prior to 1838, when, at the Lincoln Asylum, Dr. Gardner Hill, seconded by Dr. Charlesworth, endeavored to absolutely abolish mechanical restraint. But their convictions were regarded as too radical by the authorities above them and, as a consequence, they lost their situations as asylum officers. Yet the time for a revolution in lunatic hospital management was ripe, and the requisite man, with masterful endowments, was at hand. In the following year, 1839, Dr. John Conolly, without previous experience in such work, assumed control of the lunatic asylum at Hanwell, containing over eight hundred patients. For some years previous this asylum had been managed upon lines which were conspicuously mild for those days. In fact, "it was deservedly considered one of the best-managed asylums in England," and yet Dr. Conolly found there forty patients subjected to mechanical restraint, and, designed for such use, about six hundred instruments of one kind and another, half being leg locks and handcuffs, with forty coercion chairs. All these he collected in one room, which was called the museum, and from that time no patient in Hanwell was subjected to mechanical restraint. Dr. Page, in his annual report for 1897, Danvers Insane Asylum, says: "I am aware that many persons regard non-restraint in lunatic hospitals as a fad of enthusiasts. I often hear this subject discussed in such terms or dismissed with such indifference that I infer comparatively few physicians, even, view this question from our standpoint, and, therefore, deem it proper to explain why mechanical restraint is abolished at Danvers. Mechanical restraint may be and certainly is used occasionally upon patients in general hospitals with no injurious consequences, but conditions in general hospitals and lunatic hospitals are so dissimilar this fact proves little. I formerly permitted the use of restraining apparatus upon patients, endeavoring to limit its use to rare and exceptional cases. While working under this policy I not only found it difficult to decide upon cases and to convince the nurses that restraint was seldom necessary, but every exception in favor of mechanical restraint seemed to weaken the courage

and resolution of the nurses, as well as to diminish my influence and control over them. Then, too, as long as nurses understood that straps and jackets could be employed as final measures, they not only relinquished mild efforts too quickly, but were inclined to assume a dictatorial, aggressive manner towards patients upon slight occasions; and this spirit of coercion as evinced by the nurse in his or her attitude towards the patient was, according to my observation, the starting point of the trouble with refractory patients in the great majority of cases. Now that mechanical restraint is discarded, the nurses understand that they will be regarded as incompetent unless they can manage the patients in their charge without resort to violent measures, seclusion and restraint. Intelligent nurses do not complain of such restrictions. They appear ambitious to demonstrate that a trained nurse can manage the insane without the fetters and instruments which are relied upon in such cases by the unprofessional keeper. Certainly the non-restraint rule has advanced a kindly and humane spirit in our wards as no other measures could have done. Nurses have no temptation or power to control patients by threats of punishment. Under such conditions, whatever native tact, art and persuasive powers the nurse may possess are rapidly developed, and, as a result, more sympathetic, friendly relations are early established between nurse and patient, and the common annoyance and irritations formerly experienced by both parties are largely avoided. The beneficial effects thus ensuing, when considered in the aggregate, are of such magnitude, I am resolved that the non-restraint rule shall not be broken, except as a last resort, as a life-saving measure. Since that time, I have been responsible for the custody and treatment of more than six thousand insane persons, not one of whom was restrained by mechanical appliances by my orders or within my knowledge." Dr. Page goes on to say that seclusion is another form of restraint more harmful to the mind than many of the apparently more brutal restraints now used.

Dr. Wade, of the Maryland Hospital for the Insane, recently told me that he uses no restraint and that he never shuts a patient up alone for more than two hours. This is not the case in all the Maryland hospitals, and they are to-day struggling with the problem of the removal of the insane from the almshouses, where restraint is used in all its forms. At the conference held there on Nov. 10 last, at which I was asked to speak, there were displayed a series of photographs, recently taken, to show the forms of restraint in actual use, and the unsanitary quarters occupied by these mentally ill people. That the abuses of restraint and violence may be used without the knowledge of the physicians in charge has been illustrated over and over again, and more recently in one of our own hospitals.

It is encouraging to hear from Dr. Owen Copp, the secretary and executive officer of the Massachusetts State Board of Insanity, that restraint has been reduced 50% in the Massachusetts

state hospitals for the insane, and 84% in the Boston State Hospital during the past year, but Massachusetts should not stop here. She should lead the way in abolishing restraint and not allow her sister states to get ahead of her in that as they have in the care of the incipient insane.

## VARICOCELE: AN ANALYSIS OF FOUR HUNDRED AND THREE CASES.

BY J. DELLINGER BARNEY, M.D., BOSTON.

VARICOCELE is a disease which has occupied the attention of medical writers from Celsus himself down to those of the present day. After all these years its etiology is still unsettled and its treatment far from ideal. Any light which can be thrown on the disease and its cure should, therefore, be welcomed, even though the literature fairly bristles with articles with this title.

The following figures are based on an analysis of 403 cases taken from the records of the Massachusetts General Hospital. In many respects they do not differ much from the figures obtained in other communities. But the fact that they are derived from a local source, and that they were operated on by many different local surgeons, gives more than anything can a correct idea of the disease and the results of our methods of treating it as met with in this community.

It is regrettable that the incompleteness of the records do not permit every desired fact to be noted in every case, but here again this condition is encountered probably throughout the hospital world, and this particular set of figures is representative of our conditions here as fairly as other figures are of other localities.

Before discussing the end results of operation for varicocele, I shall enumerate briefly the symptoms and other conditions met with in this disease as derived from the material at my command.

### AGE.

The age at time of entrance to the hospital was noted in practically every case. In order to make a long story short, the following chart (Fig. 1) has been plotted, showing graphically the age at which such cases are most often seen (i. e., seek treatment).

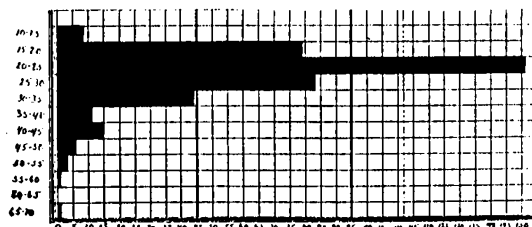


Fig. 1.

Showing age when seen on co-ordinate line and number of cases on abscissa line.

Note that the disease jumps at once to the years between twenty and twenty-five and almost as rapidly declines, so that cases occurring a decade before or after this period are rather un-