comparatively novel, the art or science is as old as man and has often been practised by others than divines or doctors. So innumerable are its ramifications that it seems possible to bring within its scope the whole history of human folly, communal as well as individual, and could easily lend itself to the kind of grandiose survey or cloudy generalization that is the antithesis of true history.

It is therefore with something like a shock of pleasure that we greet the publication of a most substantial and scholarly work that approaches the problem with the caution and method of the professional historian.* In a volume that reminds us very much of the series of *English Historical Documents*, in which are gathered together some of the source materials for our national history, Dr. Richard Hunter and Dr. Ida Macalpine have assembled a selection of texts in English illuminating the developing ideas on and changing treatment of mental illness over the three and a quarter centuries before 1860. The sources range widely from Sir Thomas More and James I to Pepys and Defoe, from Descartes and Locke to Samuel Johnson and John Wesley, from Harvey and Hunter to Conolly and Winslow, with Acts of Parliament and other official reports and documents interspersed. The extent of the topics discussed is indicated in the admirable subject index and covers terms and concepts, theory and practice, as well as hospitals, administration, and legal measures. This volume of more than 1,100 pages is indeed a veritable treasure-house, not only for the psychiatrist but also for the historian and the general reader, who may find there the starting-point for many explorations, such as the changing attitudes of society towards the insane, the influence of public opinion on treatment, and the different approach of the general physician to mental illness.

There can be no doubt of the value and interest of the extracts given, and these are enhanced by the thoughtful and penetrating discussion with which each is introduced, underlining the reasons for the selection and the significance of the text in the history of psychiatry. All quotations are taken from the first edition of the work cited, unless for some special reason a subsequent edition has been employed, and most are from the authors' own collection. More than 200 illustrations, usually facsimiles of title-pages, bring vividly before us the period and character of the work discussed.

Typical of the unsuspected things to be found in this volume is the account of John Haygarth's carefully planned and controlled therapeutic trial of the notorious Perkins tractors, carried out at Bath in 1799 and showing that the use of deceptive placebos in such a trial is not as modern as we like to think.

This work, which is beautifully printed and produced, is a must for every library, for though it might possibly be supplemented it can never be superseded. Is it too much to hope that, before some less well qualified writer attempts to build on the foundations they have laid, the authors of this book can be persuaded to employ the knowledge and experience they have gained in the many years spent on its preparation to write a—comparatively—summary account that may be more within the means of the student and the younger member of the profession?

F. N. L. POYNTER.

**Three Hundred Years of Psychiatry, 1535-1860*. By Richard Hunter, M.D., M.R.C.P., D.P.M., and Ida Macalpine, M.D., M.R.C.P. (Pp. 1,107+xxvi; illustrated. 84s.) London, New York, and Toronto: Oxford University Press. 1963.

Special Article

VISITING IN HOSPITAL

BY

SOMERVILLE HASTINGS, M.S., F.R.C.S.

When I was a medical student visitors were allowed in hospital for an hour twice weekly. I still have a vivid picture of patients propped up in bed and clothed in a bright scarlet flannel jacket. Suspended in front of each by a long chain from the ceiling was a transverse wooden handle intended to assist the sufferer to raise himself up in bed. On visiting-days there were anything up to four persons standing or sitting round some of such patients, each firing questions at him in a continuous stream. Meanwhile he looked from one to the other in a bewildered manner wondering which he should try to answer first.

Later on, to avoid such scenes, each patient was given two visitors' tickets, and to the cross-examination of the invalid was added a series of frantic rushes between his bedside and the corridor outside the ward, or the visitors' waiting-room, so that as many as possible of his friends might have the joy of seeing for themselves what the interior of a hospital ward was like.

Recently the Minister of Health has suggested that all general hospitals should follow the example of the more enlightened ones and that in addition to two afternoon visiting-hours a single visitor should be allowed on each of the remaining five days for twenty minutes or half an hour in the evening, and this suggestion has been carried out loyally by most hospitals. Some people are disturbed by the loneliness and isolation of hospital life, especially if alone in a side ward. They are not used to strangers, and in spite of every care and attention long for the visit of their wife or husband or some other near relative. Besides, it may be impossible for some husbands to attend on even one afternoon a week, although an evening visit may be feasible on some if not all of the remaining five days. A wife may long to hear from her husband about the doings of their children and of how things are going on at home. Even if little is said an invalid may be much helped by the gentle touch of a relative or close friend.

Questions for Decision

How long should visiting-hours be? In my view half an hour is generally sufficient. Services in the home by doctor, home nurse, and home-help are better than they were in many cases and are becoming more co-ordinated. Moreover, the association between general practitioners and hospital is becoming more complete and intimate, and it is likely that this will increase. Further there is in many areas an acute shortage of hospital beds. For these and other reasons patients are being discharged earlier, and it follows that many more of those that are retained in hospital are really ill. For such a patient, half an hour is sufficient and a longer period may be rather tiring.

How many visitors should be admitted at one time? In my view rarely more than one. To some perfectly healthy people general conversation is definitely tiring.

and if two visitors are admitted at one time there may be considerable conversation between each and a certain amount of rivalry in attracting the interest of the invalid, and the visits become anything but restful.

The object of visiting is to soothe and encourage the invalid and aid his recovery. It is not to interest or amuse the visitor. Accordingly, bad news should be kept away from the sick-bed as far as may be, but all direct questions should be answered accurately and great care taken to prevent any suspicion that anything is being kept back. The visitor should do most of the talking and report interesting occurrences in the home or among intimate friends of the patient. Even listening to conversation of this sort may be tiring, and the visitor should be prepared to sit quietly without speaking for intervals of some minutes. The custom of bringing fruit or flowers by a visitor to a patient in hospital, though sound in principle, may easily become an imposition. It is encouraged by traders who operate on visiting-days just outside the entrance to a hospital or even within it. But patients welcome visitors for what they are and not for what they bring. No one should be deterred from visiting, therefore, because they have no gift to offer; indeed, too many offerings may be an embarrassment, if not to the patient at least to the hospital staff. Might it not be useful to provide a list of suggestions to visitors, either on the visiting-card or in the form of a notice outside the ward?

Information for Visitors.—It is not always desirable that patients should be told the exact nature of their trouble. Moreover, this may be difficult to explain in a few words, and an insufficient explanation may give rise to much anxiety and suspicion of serious disease that does not really exist. Nevertheless, some responsible relation who can be trusted for discretion ought to know the truth, put in as favourable a light as possible. This is especially important when husband, wife, or child is the occupant of a hospital bed. But to whom is the responsible relation to turn? The sister may not know every detail, and in any case it is not her duty to be catechized on the nature of her patient's trouble. The house-physician or house-surgeon is generally a junior officer who may or may not be fully qualified and who has had no great experience in dealing with people. The consultant-in-charge is a busy man and not likely to be available during visiting-hours. Would it not be useful if the registrar, who is second in command to the consultant and is a person of experience, should be available during a visiting-time once a week, preferably an evening, to answer the very real problems that present themselves to near relatives?

No Visitors.—The prestige importance of visitors must not be forgotten. This is no great matter in acute or short-stay wards, in which it is easy for the patient to explain that his or her relatives and friends are very busy or live a long way off. But in chronic sick wards many of the people are elderly, read but little, and talk to each other mainly about their illnesses or children and grandchildren. I recall that during the war I had occasion to visit old people evacuated from London in a dozen cities of the Midlands. Almost without exception they said that they cared nothing for the bombs but begged to be allowed to return to London to be near their children and grandchildren. The chronic sick feel that if they but rarely have visitors their colleagues in the ward will think there is something lacking in them personally. It is therefore a real act of mercy for well-disposed people to visit them regularly.

Special Report

SYMPOSIUM ON OBESITY

A Symposium on Obesity, organized by William R. Warner & Co. Ltd., was held at the Royal College of Surgeons on Friday, March 29. Professor A. KEKWICK (London), Professor G. BROWNLEE (London), and Professor D. HUBBLE (Birmingham) took the chair for the three sessions. Papers were presented on metabolic abnormalities in obesity, on drugs used in its treatment, and on problems in therapy and prognosis of obesity.

Metabolism and Obesity

Dr. G. C. KENNEDY (Cambridge) stressed the importance of decreased activity as a factor in the production of experimental hypothalamic obesity in rats. A normal rat ran about 20 kilometres a day on a treadmill, but after destruction of the ventromedial nuclei of the hypothalamus activity decreased almost to zero and the animal's weight simultaneously increased. Appetite-suppressing drugs did not stimulate activity in these rats. Occasional disturbances of gonad function were also seen after these hypothalamic lesions, but occurred, too, when the lesions were more anterior. It was probable that the hypothalamus of the rat consisted of overlapping bands rather than discrete functional centres, an antero-posterior band concerned with gonad function and a medio-lateral band affecting appetite and activity.

Dr. M. M. WINBURY (Warner-Lambert Research Institute, New Jersey) described studies on cats with electrodes implanted in the hypothalamus. Electrical stimulation of the lateral nuclei made the cats eat food, even though satiated, and increased their activity. An anorectic drug, chlorphentermine, prevented the feeding response to stimulation, but not the activity. The electrical potentials in the lateral and ventromedial hypothalamic nuclei evoked by stimulation of different areas of the brain were recorded with the use of a computer, and the effect of chlorphentermine studied. In a fasting cat chlorphentermine produced potentials in these nuclei which resemble those associated with a state of satiety, and also modified the effect of hypoglycaemia on the potentials.

Metabolic Abnormalities

Mr. C. L. S. PAWAN (London) reviewed the metabolic abnormalities which may be associated with obesity in man. Obesity was not always simply a quantitative response to calories eaten, since some fat individuals ate less than thin ones. Obesity might indicate a state of "functional under-nutrition" of the cells of the body, to which the organism responded by a decreased expenditure of energy. At the Middlesex Hospital Mr. Pawan and his colleagues had demonstrated a "fat-mobilizing substance" (FMS) present in urine from individuals of normal weight and also from obese patients on a diet providing 90% calories as fat, but absent in such patients when they received a diet with 90% calories as carbohydrates. In mice administration of FMS led to increased excretion of carbon compounds in the urine, but not of expired CO₂; it thus differed in its metabolic effects from thyroxine. Obese patients were abnormally resistant to ketosis, negative nitrogen balance, and the fall in blood sugar and bicarbonate which normally occurred with starvation. ¹⁴C-labelled glucose, palmitate, acetate, and β -hydroxy-butyrate were all metabolized more slowly than normal in obese individuals.

Dr. I. MCLEAN BAIRD (Barnsley) showed that "simple" obesity and Cushing's syndrome sometimes had several features in common, and could be easily confused. Obese patients might have purple striae, amenorrhoea, hypertension, and decreased carbohydrate tolerance. In 20 obese women the urinary excretion of 17-ketogenic steroids had been significantly higher than that of a control group, and