prove a direct cause of convulsive action; and the carefully recorded statistics of Dr. Murphy show that the mortality in this disease is much greater when labour has been artificially accelerated than when it has been left to the natural efforts.

In conclusion, I need scarcely say that I have given but an imperfect and incomplete account of a very comprehensive subject. Enough, however, I would fain hope, has been said to furnish ample scope for an interesting and instructive discussion on a question of much importance to obstetricians.

RESTRAINT IN INSANITY.*

By STANLEY HAYNES, M.D., Malvern.

THE propriety of mechanical restriction has lately attracted some attention; it was questioned in the treatment of patients becoming maniacal during variola, and, quite recently, with regard to the treatment of otherwise unmanageable, suicidal, violent, or destructive insane persons.

As this topic is now brought forward for the purpose of eliciting discussion, and the expression of medical opinion upon a *questio vexata* in our profession, I abstain from here noticing the excesses to which mechanical restraint used to be subject and is now carried, or from recording the judgments of authorities in favour of or against it.

As medical men, we must put aside all mere sentimentality in the consideration of this subject, and confine our attention to the inquiry whether our patients will be benefited or injured by the imposition of corporal restriction. To avoid irrelevant discussion, perhaps it will be well to define the meaning of restraint, as applied to our treatment of patients. Restraint is moral, intellectual, medicinal, or corporeal. Moral and intellectual I propose to exclude from this investigation. By medicinal restraint I understand the conditions in which patients can be placed by the administration of narcotics, sedatives, or nauseants. Corporeal restriction is of two kinds—by seclusion, and by mechanical appliances. Seclusion, as a form of restraint, is solitary, undesired confinement; when patients request to be kept apart from others, it is unfair to consider them as restrained. Restraint by some appliance, *i.e.*, restriction of motion in any desired direction by some kind of garment, is effected by means of sheets, camisole (or "strait waistcoat") or glove.

It is to be assumed that all practitioners will agree in the propriety of restraint—other means failing—in surgical cases (*e.g.* when a person has a self-inflicted wound and is striving to pull it open); and it will probably be at once conceded that in some of the maniacal conditions consequent on variola, typhus, and other febrile states, we are justified in mechanically repressing our patients from injuring themselves and others, by fastening a sheet across the patients and under the sides of the beds; such patients are too weak to be kept in bed by the hands of nurses, however careful and gentle. There will be more difference of opinion concerning the restraint of insane persons, the lunacy authorities being, naturally, antagonistic to the principle, and the majority of British asylum superintendents condemning it; their example is being followed by some of the German alienists, and it is to be sincerely hoped mechanical restrictions will soon be as rare in America and on the European continent as here.

As the question now stands, mechanical restraint is the bugbear of lunacy practice; we have rushed from too much restraint to too little, if we are never to use it under any circumstances, as some extremists uphold. We can no more advocate prevalence of physical control than we can of depressing procedures; but there can be no doubt there are some very exceptional cases in which the employment of mechanical restraint is the most advisable method we can adopt, and, therefore, our duty as physicians and men. The system of non-restraint is in fashion, but is it not abused by being pushed too far? How long will it be before we have the inevitable reaction? When a patient is prevented from injuring himself or others by being forcibly held by anyone, he usually has the spirit of opposition raised within him and struggles to be free; the then necessary pressure upon his arms may cause bruises, easily produced and tardy to disappear, but he is restrained quite as much as, or more than, if he had worn some special garment; still, it is not "restraint" requiring to be entered in the Case Book and Medical Journal, and so manual restriction is preferred to mechanical, by which a patient cannot injure himself or others if he be guarded by an attendant.

Some persons appear to entertain a morbid aversion to the use of any mechanical restraint; it used to be so much abused that they seem to dread it could be again, notwithstanding the close inspection the autho-

rities exercise so carefully, and the absence now of all privacy concerning the treatment of the insane. Those who advocate non-restraint at any cost err most needlessly, if they imagine mechanical restraint can be again abused; the honesty, humanity, skill, and watchfulness of British asylum superintendents are sufficient guarantees against so sad a relapse, even if the supervision of the authorities, central and local, were relaxed, and if the importance of medical and public opinion, as expressed by the press, ceased to be duly estimated.

In no case where it can be avoided without harm to the patient should restraint be resorted to; but in some few and otherwise unmanageable cases of suicidal melancholia, of excessive and dangerous violence, it is better to employ some appliance than frequent manual, antimonial, or narcotic means. The "moral" effect produced on a wilfully aggressive or destructive patient by the use of gloves or the camisole is often most salutary and valuable; he finds he can do no harm, and ceases to be a source of apprehension and danger; he feels he is conquered, and is reduced to the similitude of a thrashed bully.

With regard to the curability of the patients, is it not infinitely preferable to see an occasional, but only when really necessary, use of mechanical restriction than to find sedatives, or nauseating doses of antimony, given for the purpose of quieting the patients? By the use of the latter, it may be charmingly easy to keep the obnoxious word "restraint" out of Case-Books and Reports, and the patients can be very much less troublesome, noisy, and expensive; but they are also more incurable. It is better to have curable patients with the censure, if such must be, than incurable ones with the commendation of the authorities and journalists. The medical Commissioners in Lunacy are practical men, experienced in the difficulties met with in the treatment of exceptional cases, and, although adverse to the principle of corporeal restraint, are just, and tolerate it when its necessity and circumstances have been indicated and duly reported. Every physician treating an insane person must consider, "What is best for the patient?" and answer the question in accordance with his resources, and conscientiously; otherwise, he fails in his manifest duty.

NECROSIS OF THE CLAVICLE IN A CHILD.*

By JAMES THOMPSON, M.B., Leamington.

IN April of the present year, I was called to see a child aged 4 years—the last surviving child of a family of six children—of delicate appearance, and with evident constitutional taint. There was no history of any injury. The child complained of pain referred to the sternal end of the clavicle; the joint was swollen and red, and had been so for twenty-four hours before I was called to see it. Movement of the head caused much pain, but the child freely moved the arm herself; the whole clavicle was tender to the touch, and the swelling spread towards the acromial end. The diagnosis given at the time was fracture of the clavicle, with some laceration of the sterno-clavicular joint. It seemed most likely that by some slight and unrecorded injury the bone had been fractured in a child with a scrofulous diathesis and history. The ordinary bandage was applied, and a cold lotion over the seat of injury. This appeared to cause much discomfort, and the child wriggled off the bandage, and moved the arm freely. The swelling and tenderness continued, and three days afterwards there was a severe rigor, with subsequent high temperature (106 deg. in axilla), which pointed to the formation of matter. An abscess formed, which was opened when ripe, and a large quantity of pus evacuated. The child was so restless that it was quite impossible to pass a probe into the abscess to investigate the cause of the formation. Dr. Carter saw the case with me, and after consultation we agreed to poultice and support the child's health, and wait the issue. The general health of the child improved greatly, but the local tenderness continued, and a guarded prognosis was given, stating that under the circumstances it was quite impossible to say what was the actually injured part. The abscess continued to discharge for nearly three weeks, during which time the child could not be induced to keep the arm quiet. I had now quite made up my mind that it was diseased bone with which I had to deal, and I requested permission from the parents to use chloroform, but this was refused; palliatives, stimulants, and support were all that was left. Another week passed over, and then another rigor took place, and another abscess formed one-and-a-half inches below the sterno-clavicular joint. This was opened, and another quantity of matter was evacuated with relief to the general symptoms; three days afterwards I fancied I felt loose bone (with

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* Read before the Surgical Section at the Annual Meeting of the British Medical Association in Birmingham, August 1872.