An Address ON THE EXAMINATION AND CERTIFICATION OF MENTAL PATIENTS.

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THE law of England provides that no person shall be deprived of liberty and detained under care and treatment, on the ground of insanity, without either one or two formal certificates by registered medical practitioners, to the effect that the person proposed to be so detained is insane. This legal provision throws on the members of the medical profession a duty always charged with consequences momentous to the patient, and frequently difficult, sometimes even dangerous, to the certifier.

The following remarks are restricted to the examination and diagnosis required by the statutory certificate, and to the writing of the certificate. Everything beyond this is intentionally avoided.

In physical disease the diagnosis depends chiefly on inferences drawn from data furnished to the physician by the direct exercise of his senses on the person of the patient. In mental disease, on the other hand, it turns, to a great extent, on the correct appreciation of conduct. Hence the greater dependence of the mental physician upon information supplied to him by others. In a case of pneumonia the diagnosis does not depend on the history as related by the patient or his friends; but in a case of obscure delusions, or morbid moral perversion, the physician might for a long time search in vain unless his search were guided by what had been told to him about the previous conduct and conversation of his patient. The chief criterion of mental soundness and unsoundness is conduct; and conduct being infinitely various in its kinds, it follows that the symptoms of mental disorder must also be definitely various. It follows also that the examination of mental patients cannot be reduced to a process so systematic and methodical as the examination of those who are suffering from bodily illness. Hence learned judges and other exponents of the law have maintained that the diagnosis of insanity does not require medical knowledge at all, but is merely a matter of what they call "common sense."

But it is possible to do something to lessen these inherent difficulties and to reduce the examination of a mental case to a comparatively orderly method. For the purpose of certification the law only asks to know if the patient is insane. It is obvious that for medical purposes we should want to know a great deal more than this. We should want to know the family history of the patient—whether this is the first attack or not, what is its supposed cause, the clinical variety of the insanity, the accompanying physical symptoms if any, etc. But the law cares for none of these things, and asks no question regarding them. From the legal point of view, mania, melancholia, paranoia, and the rest, are all the same, and their etiology and prognosis are ignored. Only one question is asked—or to speak with perhaps more strict accuracy, two questions included in one—namely, Is this person insane, and is he a proper person to be detained under care and treatment?

Let us consider the investigation under two heads. First, preliminary inquiries; and secondly, the personal interview. But I would remark at the outset that a call to a mental case, especially a first call to a fresh patient, should be regarded as an urgent one and be promptly attended to. This promptness of attention is the more necessary because advice is often not sought until the disease is fully developed and has shown itself by some overt insane act. Any delay in answering a call to a mental case might result in a tragedy of some kind. The conduct of the insane can seldom be reckoned upon, and the next action of the person we have been summoned to see may be homicidal, suicidal, spendthrift, or scandalous.

PRELIMINARY INQUIRIES.

The preliminary inquiries are to be made of the people who have had most opportunities of observing the patient. They will usually be the members of his family or those with whom he has been living, or who are associated with him in his avocations. Ask about previous attacks. If a person has had an attack of mental disorder the chances are that sooner or later he will have another; and if it is found that the patient has been at some former time undoubtedly insane, the probability is greatly strengthened that he is so again. We shall see afterwards how far this fact should be made use of in writing the certificate.

Inquire how the suspected insanity manifests itself. The particular direction of our questions should be towards ascertaining if any change in the disposition and habits of the patient has been observed. This is the most important point in the whole investigation. If the case is a genuine one we shall always find that there has been a change in the direction of what would be called, in the case of a sane and responsible person, moral deterioration. Even when the patient is in a state of philanthropic exaltation and universal benevolence his perception of right and wrong is distorted, and he neglects to be just before being generous. For example, a nursery gardener who reveals his mental derangement by making presents of his most valuable plants, with expressions of effusive gratitude, to customers who have once or twice given him a trifling order, does so at the expense of his family, whom he would soon reduce to want. Or, again, a young lady who devotes herself with intemperate and persistent zeal to charity begging, the antivivisection cause, and humanitarian schemes generally, has been known to make her home a veritable hell to her family, by her violent temper, her utter selfishness, her jealousy, and her genius for mischief-making.

This change towards deterioration will have appeared, we shall find, in one or other of two ways.

1. It may be a complete reversal of the natural disposition and habits. This is the most striking kind, and also the most common; and it is not less real when it is shown in the general habits and conduct, rather than in specific acts that would at once strike a casual spectator as abnormal. It is a change in the nature as a whole. A sober-minded business man who leads a quiet family life becomes restless, he tries to make money by clever bargains, buys articles of which he has little knowledge, thinking to make a handsome profit by reselling them, all the while neglecting the ordinary routine occupation upon which his family and himself depend.

2. The change may not be one of kind, like the last variety, but only a change in degree. A man who was naturally of a reserved and suspicious temper, whose acquaintance was hard to make, who was never the first to hold out his hand for a friendly shake, but always waited till the other man took the initiative, has now become so distrustful that he has barricaded himself into the house, locked the doors, fastened the windows and will see no one.

In cases of doubt and obscurity letters written by the patient often afford valuable evidence of insanity, and should always be included in the preliminary inquiries. It is a curious fact that some insane persons who can converse rationally will reveal their mental state in the letters they write. Nor do I allude to those obviously insane epistles that teem with delusions, outrageous abuse, or revolting obscenity, but to letters that show, or rather indicate, the writer's insanity in a more subtle way. In the letters of people suffering from delusions which they are able to conceal in conversation, there is often a certain oddness in the use of words, in the turn of sentences, and in the use of underlining, capitals, or print letters. At times every spot of the paper up to the very edge is covered with writing as close as the letters can stand; sometimes the lines are crossed and recrossed till they are illegible. Sometimes a letter or postcard is hurriedly scribbled in pencil when there was no occasion either for hurry or the use of pencil. Sometimes a scrap of waste paper—a bit torn from the margin of a newspaper for example—is used to write on. In some letters the insanity of the writer is hinted at in one slight remark only. In a letter written by an insane clergyman to a choir boy there was nothing that indicated insanity except the formal

conclusion, which ran thus: "I am, my dear highness, your obedient servant." A long letter of a man suffering from delusional insanity was quite rational except the postscript, almost illegibly written in a corner of the sheet, and probably an after-thought: "I have to thank my friends for their exertions in my behalf, but they are needless, my little bill being three millions." This was written by a man whose sole means of support for himself and a large family consisted of a moderate pension which would cease at his death. Small "thumb-nail" sketches symbolizing insane ideas are tolerably common. These sketches represent a great variety of objects. Among the most frequent are a crown, a hand, a sword, a star, a wheel, geometrical figures. To sum up: words written in print letters instead of cursive characters, unnecessary capitals and italics, words written in unusual situations on the page or on the outside of the envelope, pencil or pen notes hurriedly scrawled on scraps of waste paper, symbolical sketches—all these have, to the eye of one accustomed to see the correspondence of the insane, an aspect highly significant of delusions.

Besides letters there may be other writings. Many of the insane are fond of committing their private meditations to writing, and will pour out their inmost thoughts upon paper which they carefully preserve. A lady who believes that scriptural prophecies refer to her, that she has been selected to be the mother of a Messiah, and has been commanded to announce the fact to the world, will fill a large chest with insane manuscript on the subject of her delusions, and hoard it with jealous care.

In cases where the alteration in conduct (though sufficiently plain to those who know the patient intimately and are in daily intercourse with him or her) is of a general kind and not marked by acts of an obviously insane character, it is important to obtain the history of some specific action with all its attendant circumstances, and make a careful note of it. The use of such knowledge will be seen when we come to consider the personal interview with the patient. An act of this kind may be found, for example, in needless architectural alterations in the dwelling-house, the pecuniary circumstances being at the time not in a condition to afford them; or in dealing in horses by a man who has no knowledge of this hazardous kind of trade, who has no money to pay for the animals nor anywhere to keep them. Such conduct, though not evidence of insanity abstractly and by itself, may be valuable evidence of it under the circumstances of the case. These circumstances should, therefore, be fully inquired into, so that we may be prepared to hear and judge of the patient's mode of explaining away or defending his actions.

In making these preliminary inquiries, it is essential to preserve a judicial frame of mind, and to regard all that we are told, not as matter to be implicitly believed, but as matter to be weighed and considered.

PERSONAL INTERVIEW.

Having thus obtained as much information as possible from our preliminary inquiries, we next proceed to the personal interview with the patient.

Here a word may be said regarding the use of deceit and stratagem in dealing with the insane. The friends of the patient will sometimes suggest that the medical man should make his visit in some other character than his professional one, in order to avoid exciting the suspicion, anger, or violence of the patient. It may be doubted whether a case ever occurs where such a course is really required, and it is beyond all doubt that in the vast majority of cases there is not only no need for trickery of any kind, but the strongest reasons against it. There is nothing that insane people so keenly resent as deception, nothing that so strongly confirms their morbid suspicions, and nothing that makes their subsequent management so difficult. Our object should be to show the patient, and if possible induce him to believe, that everything is being done openly and above board, and in his best interests. The terrible scenes so greatly dreaded by timid relatives will usually be found non-existent when the situation is faced with tact and resolution. In those exceptional cases where there is actual physical danger, as when a lunatic has armed himself with a revolver and declares that he will do for any doctor who comes near him, the proper course is to throw the responsibility on the friends, and

require them to make arrangements for our safety before visiting the patient. One obvious advantage of making the visit in our professional character is that we shall be entitled to speak to the patient about his health, and ask him questions which would be resented as impertinent if they came from a layman.

Should a second person be present during the interview? That will depend on the nature of the case. Anyone who can help to overcome the reticence of a suspicious patient is useful. If we are not the usual medical attendant and are new to the patient it may be a great help to have the family doctor present. He has been familiar with the case previously, and can say: "Please tell this doctor what you spoke to me about the other day," repeating what the patient had said. The most reticent and distrustful lunatic can hardly avoid making some sort of reply to such an appeal, and once the ice is broken and we have got on the track of the morbid ideas the rest is generally easy. I remember being present when a Commissioner in Lunacy was endeavouring to elicit symptoms of insanity from a patient in an asylum who was new to him and whose derangement was not at first apparent. The patient obstinately refused to be "drawn," and would not commit himself in any way. At last I said: "Very well, I shall relate to the Commissioner what you told me the other day, and if I misrepresent you, please correct me." At first he gave no sign; but as the tale proceeded he said: "You are wrong; that is not it." The Commissioner said: "Then kindly give me your own version." The patient did so, and a few more questions revealed a tissue of delusions. The aid of a second person is thus occasionally of importance. But in some cases it is an impediment, as when there are delusions of suspicion regarding that other person. And we must be careful to remember that a second medical man can be present only if the interview is for the purpose of diagnosis or treatment. If it is for the purpose of certification in cases where two certificates are required, no other practitioner must be present, as we shall see immediately.

The first thing to do is to make a mental note of the aspect, dress, and surroundings of the patient. If he is in a room he has been inhabiting lately, glance round and see if there is anything peculiar about the apartment. Is the furniture in confusion or arranged in some unusual manner? Are there bits of paper or rag stuffed in the keyholes or stuck on the walls? Something unusual in dress is often a clue. A lady wears a thimble on her finger, but there are no other signs of needlework about, and the thimble is on a finger where it is not usually worn. We shall find it is to keep out the electricity with which she is annoyed, and which enters her person through the tip of that finger. A man wears his hat in the room; that also is to keep out the electricity which unseen enemies, who lie concealed in the roof, send through his head in currents. Another man wears a handkerchief tied over his nose, and inquiry reveals that it is to keep out the disease of syphilis, which is injected into his nostrils by people ambuscaded in the house over the way. Neglect of dress is more characteristic of the male than of the female insane, and begins earlier in the disease with men than with women. A man will omit to shave, having been accustomed to shave regularly, or he will leave necktie or bootlaces unfastened, or allow his waistcoat to show smears of food. In delusional cases there is occasionally a certain indescribable oddity of aspect which no sane person, however eccentric, ever shows.

In the greater number of cases insanity alters the facial expression, and our first glance at the face of the patient tells that there is something wrong. The expression of morbid suspicion is often very characteristic, and, even if it should not be present at first, the look of intense suspiciousness that flashes across the countenance during conversation shows that some remark or some question has hit the insane idea.

So much for what to look for when we are introduced to the patient. Now for the conversational part of the examination. It is here that the difficulty we have already mentioned is felt by the practitioner inexperienced in this department of medicine. It is so different from the familiar and systematic auscultation, percussion, and palpation of chest and abdomen. Where and how is he to

begin? What question is he to ask first? If he at once asks the patient, as is sometimes done, what is his age, or whether he knows the month or the day of the week—questions that many persons who are thoroughly insane can answer perfectly well—he does so at the risk of provoking the contemptuous silence of the patient, who thinks himself treated like a child or a fool. Fortunately in the greater number of instances the insanity is so clear that a methodical order of investigation is hardly required. The patient at once betrays his derangement by his manner and conversation, and the object of the interview is attained without further trouble. But every now and again a case of difficulty occurs, which the most thorough examination may fail to unravel. It is in such cases that the value of a methodical research is greatest. In the oral examination the personal equation is an important factor, and will occasionally decide the success or failure of the interview. I recollect a case of delusional insanity in a young man who was examined with a view to certification by two doctors in close succession. The first at once plunged *in medias res*, with the remark, "Well, Mr. —, I understand that you hear voices. Is this true?" "Voices!" said the patient, "certainly not; I never heard voices in my life." This was a bad beginning; and after a prolonged interview only just enough to make a rather weak certificate was elicited. The second practitioner, who followed the first an hour afterwards, had no difficulty in detecting delusions and hallucinations, and in writing a conclusive certificate. The different results of the two examinations were due entirely to the different manner of the two certifiers. The first, by his abruptness, roused the obstinacy of the patient, while the second by his tact disarmed suspicion and gained his confidence. A useful personal gift in the examination of the insane is that of being a good listener. While some insane persons are obstinately silent and reticent, many are not merely willing to talk but are loquacious, tedious, and prolix to an extreme degree. The best way is to listen patiently and attentively as long as may be necessary, only asking a question now and again to make some point clear, which the patient is generally very willing to answer. We often have to listen for a long time to the tiresome narration before we hear anything that can be quoted as clear evidence of insanity, but we are always rewarded at last. It is well known that what is called "a good bedside manner," or even "a good bedside voice," is a trump card in the hand of the general practitioner. The art of setting at his ease a reticent and suspicious mental patient, and so inducing him to "cleanse his bosom of the perilous stuff," will on occasion stand him in quite as good stead; for, contrary to an opinion often held by the lay public, there is no special freemasonry, known only to the initiated, for influencing the insane. The gifts of sympathy, tact, and perseverance that succeed with the sane succeed with the insane also, the only difference being that in the latter case the process is more difficult and the result more uncertain.

To introduce such method and system as the subject admits of, one of two courses may be followed. First, we may take the three classical divisions of mind, *feeling*, *understanding* and *will*, in their various aspects and subdivisions, and investigate each in turn to find how it is deranged. Theoretically this is the scientific course, but in practice the other method is the more satisfactory. This method takes *conduct* as the subject of investigation. It is really from conduct that we infer sanity or insanity; and it is on account of his insane actions or conduct, and not on account of his insane beliefs or delusions, that a person is deprived of liberty and detained under care and treatment.

To investigate conduct systematically it is necessary to parcel it out into departments or fields, the scheme of Herbert Spencer being probably the best for our purpose. He divides human conduct, or the manifestations of human activity, into six departments:

1. Directly self-preservative.
2. Indirectly self-preservative.
3. Reproductive.
4. Social and political.
5. Religious.
6. Recreative.

According to Spencer, this is the order in which the active faculties are acquired by the individual; and when any of them is lost or impaired by disease, the nature and

extent of the disorder will be indicated by the place of the affected faculty in the above evolutionary sequence, the more fundamental the more serious.

The first, or directly self-preservative, activities are the fundamental parts of conduct, and concern the conservation of the individual in the most essential way. The chief of these activities is the taking of food, the satisfying of the need for shelter and warmth, and the avoidance of mechanical injuries. These activities, and the elemental feeling that promotes them (that is, the love of life) may be perverted or weakened or altogether lost. An insane person may crave to die as strongly as one of a healthy mind craves to live, and may act accordingly. The ideas and feelings relating to food, and all the means of physical preservation, may be perverted in endless ways.

The second division, or the indirectly self-preservative conduct, concerns the earning of livelihood by occupation or employment. One of the most common and most important of the signs of insanity is, that a man has become unable to follow his occupation, although he is in good physical health.

The reproductive activities concern the continuation of the species, and comprise all actions subserving that end directly or indirectly, from the slightest of the means used by one sex to attract the other, to the begetting of a child, rearing, educating and starting him in the world. The underlying feelings range from the physical appetite of sex to what is called "love" in its most refined form, and parental affection in its highest and most unselfish degree. These activities and feelings may be impaired, or lost, or exaggerated or perverted. The natural affection of the parent for the child may be lost; sexual appetite may be so perverted that acts are performed of a kind completely contrasting with the natural habits and propensities of the patient. The decorative part of dress has to a large extent a sexual meaning, and the fantastic personal adornments common among the insane, especially among insane women, have often a basis of deranged sexual feeling.

The social and political department concerns man as a gregarious being, as a member of a social and political organization more or less complex in character. This includes all the aptitudes which enable a man to get on agreeably and usefully with his fellow-men. Man is essentially social, and perhaps in no department of conduct is the effect of insanity more apparent than in this; for there is nothing that separates a man from his brethren and drives him in upon himself like insanity. The solitary habits of insane people, their quarrelsomeness, their utter selfishness, and incompatibility of temper on the one hand, or their crazy philanthropy on the other, are of everyday occurrence.

The religious instinct in some form or other is universally present, and in states of insanity this instinct is often the subject of exaggeration or perversion. A familiar case is where a person, generally a woman, starves herself to a skeleton in obedience to delusions of a religious kind. The religious sphere of feeling and activity is one in which delusions arise with great frequency.

Lastly, the recreative activities comprise all the means by which man endeavours to make his life pleasant in the less essential parts. Disordered forms of these are not infrequent, such as exaggerated propensity for sport—horse racing, for example.

It will be found that the adoption of some such scheme as this, and the holding of it steadily in view during the proceedings, is a means of introducing an amount of method into a mental examination which is not otherwise possible. It enables us to prosecute inquiries with a definite goal in view, as well as to conceive a clear clinical picture of the patient's mental condition. Further, it is of material assistance in reducing these pictures to words so as to enable others to realize our conception.

As it is not always possible for the certifier actually to see examples of the insane conduct of the patient, he may have to be satisfied with eliciting the expression of ideas and feelings that are likely to lead, or have already led, to the commission of insane acts. In fact, we are practically never called on to certify a person as insane until his actions have become, in some way or other, abnormal. A man may hold delusions of the most extravagant kind, but if he acts in all respects in the way that society for its own protection requires its members to act, we are not

called upon to certify that he is fit to be detained under care and treatment.

It is best to begin with some general inquiries about the patient's health, saying that his friends have lately been rather anxious on his account. In some cases, especially those with an element of hypochondria, this will at once elicit the expression of delusions. If the patient repudiates the assumption that there is anything the matter with his health in the ordinary sense of the word, we may go on to ask if anything has been troubling or worrying him, explaining that this is really a matter of health. And, if we are to detect insanity, *we must come close to the personal interests of the patient.* An insane person is the centre of the universe to himself, and his diseased feelings and ideas are connected with his own personality. It is useless to question him about social and political matters, or scientific theories, or religious views, unless we can connect them with himself. It is a good plan to tell the patient what you have heard alleged about his recent conduct, and to remark that unless he can give a satisfactory explanation you will be obliged to regard him as not quite well in his mind. A puzzling kind of case is that of the obstinately silent patient who refuses to speak a single word. If we cannot overcome his silence, the only course is to desist for the time and try again another day. Perseverance and tact, reinforced by information gathered in the preliminary inquiries, will seldom fail to succeed sooner or later. And, as we have said, once we have induced the patient to say anything about his insane ideas, the battle is generally as good as won.

It may have seemed, from the tenor of the foregoing remarks, that in cases in which insanity is not easily perceived the investigation resolves itself into a search for delusions. And to a considerable degree this is true. Undoubtedly delusion is proof positive of insanity, though insanity not infrequently exists without delusion.

The essence of an insane delusion is not the fact that the belief is erroneous, *but the fact that the deluded person cannot rectify the false belief when the means of rectification are presented to him.* It thus differs from the mistaken beliefs of sane persons. Many delusions are obviously so because it is impossible that they can be true. Others might possibly be true, though they are not; still others have in them more or less of fact. In these last the insanity lies in the way the idea has grown up in the patient's mind, the way he broods over it and nurses it, the way he reacts to it, that is, the way in which it affects his conduct, and above all in the fact that he is absolutely unable to take any other view.

We will suppose that the investigation is complete in both its stages—the preliminary inquiries and the personal interview. We now undertake the final act to which all this had led, namely, the writing of the certificate.

THE CERTIFICATE.

This must be written in the form prescribed by the statute. Printed skeleton forms* with blanks to be filled up are usually employed, but the certificate may be wholly in manuscript provided the statutory form is adhered to. The first thing to do is to read over attentively the printed form, noting especially the marginal directions. This may seem trivial advice, but, judging from the mistakes frequently made, it is not uncalled for. The printed matter on the fly-leaf should also be read. In this it is laid down that certain relationships of business, blood, or marriage debar from certifying, and it is necessary to make sure that we do not fall under any of the disqualifying clauses. The opening part of the document is a preamble, the purpose of which is the identification of the person whose certification is contemplated. It runs as follows:

"In the matter of" (fill in the full name, Christian, middle, and surname; for example, John George Wilson Brown), "of" Insert in the space (a) the residence in full—that is, the number and name of the street, if in a town; or if in the country, the vicarage, manor house, school house, farm house, or the like; and in the next blank (b) the county, city, or borough. Lastly, in space (c)

* All the necessary documents, Order, Petition and Medical Certificates, can be obtained at the various institutions for the insane, public and private. Messrs. Shaw and Sons, Fetter Lane, London, E.C., will send a set of Reception Papers for a Private Patient, post free for 9d. This information may be useful in cases in which it is proposed to place a certified patient in "single care" in a private house.

the occupation or profession, "if any," says the marginal direction. The words "if any" mean, that if there is no occupation or profession the space may be left blank; but as the object is the clear identification of the patient, it is best to insert some term—for example, "of independent means," "retired wine merchant," "schoolboy," or the like. In the case of a married woman, write "wife of clergyman," "wife of tradesman," etc. "Gentlewoman" describes an unmarried lady living on her own means; "widow" and "spinster of no occupation" are useful terms. If no positive descriptive term is applicable, it is better to insert the words "of no occupation" rather than leave the space empty. Another reason for inserting some descriptive term is that it shows the certifier has acted with care and has not slurred over the duty in any particular. For the certificate has to satisfy at least a magistrate and the Commissioners in Lunacy, and possibly a judge and jury also; and all these authorities will look at the document with legal eyes, and with a view to ascertaining whether or not the medical man has acted with reasonable care. The concluding words of the preamble—namely, "an alleged lunatic," announce that the occasion of the certificate is insanity, that the insanity of the person just named has been already alleged by others than the certifier, and that it is in consequence of such allegations that the examination has been made and the certificate is about to be written.

Next comes the certificate proper, beginning with the words, "I, the undersigned" (..... space for the name of the certifier in full—for example, Thomas Jones), "do hereby certify as follows." And he certifies under five distinct heads, indicated by Arabic numerals on the left-hand side of the page.

1.

"I am a person registered under the Medical Act, 1858, and I am in the actual practice of the medical profession." It is not enough to be registered; he must also be engaged in the actual practice of the medical profession. This excludes from signing certificates a considerable number of registered practitioners, in addition to those who, as we have seen, are debarred by reason of professional relationships or blood or marriage ties. It would seem to forbid all retired practitioners, and all retired medical officers of the army and navy and other public services who have given up medical work. It would seem also to forbid those professors and lecturers in the medical schools who are entirely occupied in teaching. The certifier must be in actual medical practice of some kind, no matter what; rhinology or dermatology will do.

2.

"On the day of 19" (fill in the day of the month and the year. This is the first of the two dates required in the certificate, and it is the important one—the date, namely, of the examination of the patient. It is the important date, because the petition to the Judicial Authority to make the order for the reception of the patient must be presented within seven clear days of this date, and must be accompanied by the medical certificates. Attention to this vital point is really the duty, not of the certifier, but of the friends of the patient, but they will expect their family doctor to inform them and keep them right in the matter). "At in the of" Insert at (d) place of examination. The marginal direction is here detailed and explicit, and must be followed strictly. A certificate has been declared invalid by a judge because the place of examination was not clearly indicated. The reason is that the patient is not always examined at his own residence. He may be examined while he is away for his health or other cause. He may be examined at the house of the doctor, or even in a cab in the street. In such a case the fact must be so stated; for example, in a cab at Carfax, High Street, in the city of Oxford. The space (e) is for the city, county, or borough. The next provision is very important, and, taken along with the prohibitory enactments regarding professional relationships, blood and marriage ties, is highly characteristic of English lunacy law. "Separately from any other practitioner I personally examined the said....." (repeat name of patient). The leading idea underlying the English Lunacy Acts is not a medical, but a legal one. Insanity is viewed less as a

disease to be diagnosed and treated as other diseases are, than as a danger to the liberty of the subject by furnishing a possible pretext for incarcerating sane people. If, therefore, the two certifying doctors saw the patient in the company of each other, the law is swift to suspect that they might have been conspiring together, having been bribed thereto by interested relatives, to certify as insane an unhappy sane victim and to consign him to a living death within the four walls of a madhouse. Therefore they must see him separately, not only from each other, but also from "any other practitioner." And the two certificates must be on separate sheets of paper. It was declared by a judge that to have them on the same sheet would be enough entirely to nullify the intention of the law. A case is on record where the two doctors called at the house together and left together. They saw the patient separately and thus complied with the letter of the law, but a legal authority stated that nothing could be more calculated to excite suspicion than that the two doctors should be seen to arrive and leave together. *And the second certifier must not see the certificate of the first before he has written his own.* The safest course is for the second practitioner to examine the patient and write his certificate before he sees the first, whom the law expects to be the family medical man. Then, and not before, they can meet and consult about the precise diagnosis, the prognosis, and treatment. It must be stated, however, that the clause applies only to cases where two certificates are required—that is, to all ordinary cases of private patients. It does not apply to the one certificate required by an urgency order, nor to the cases of pauper patients who are certified for county asylums, where also only one certificate is required. "And came to the conclusion that he is," the margin supplies, "a lunatic, an idiot, or a person of unsound mind." One of these terms must be used. In ordinary cases it is usual to say "a person of unsound mind," because that term includes all kinds of mental derangement, and because "lunatic" is an ugly word with painful associations, and shocks the friends of the patient when they see it written in black and white. The term "idiot" would be used in the case of an extreme degree of natural weakness of mind. Then come the words, "And a proper person to be taken charge of and detained under care and treatment." There is an ambiguity in this clause, and two views may be taken as to its meaning. The first is that there are really two facts certified—namely, the fact of the person being insane, and the second fact that he is fit, meaning *bad enough*, to be taken charge of and detained under care and treatment. This would mean that the law recognizes that there may be milder degrees of mental derangement not requiring or justifying detention. This meaning would be brought out by inserting the word "also" or "likewise" after "and," to read thus: "that he is a person of unsound mind and also a proper person," etc. The other possible view is that fitness for detention is implied in the fact of mental unsoundness, that is, that every person of unsound mind is *ipso facto* a proper person for detention. This meaning would be brought out by inserting the word "therefore" after "and," the clause reading "and therefore a proper person," etc. Under the first view it is conceivable that important practical consequences might ensue. A patient who considered that he had been improperly detained might reason thus: "I admit that I was not quite right in my mind, but I absolutely deny that I was bad enough to be shut up, and I shall prosecute the doctor who certified me to be so." Under the second view he could not take up this position. I am not aware that the point has been raised in an actual case, and, as a matter of fact, the question of certification does not arise till the conduct of the patient has become distinctly of an antisocial kind, and it is really the propriety of his compulsory detention that we consider when we write a certificate.

3.

Under this head comes the gist of the certificate—namely, the grounds on which it is given. These are subdivided into two sections, indicated by the italic letters *a* and *b* followed by a space for each section: (*a*) Facts indicating insanity observed by the certifier at the time of examination; and (*b*) facts communicated by

others, or hearsay evidence. "Facts indicating insanity" is the legal expression for symptoms of insanity. The vital facts, without which the certificate is invalid, must have been observed on the day and at the place specified in the second division of the certificate. One would think that this restriction was easily complied with, but it is not infrequently violated. If the certifier is the regular medical attendant and has been in the habit of seeing the patient, he is apt to confound facts that he has observed on former occasions with those observed at the time specified. Indeed this is quite a common fault in certificates. Another mistake is due to the loose mental habit of confounding hearsay evidence with personal observation. "Has not been in bed for three months." "Gets out of bed and wanders about at night half dressed." These facts could only be known to the certifier by hearsay, and therefore should come under the next head. Delusions form an extremely strong fact in a certificate, and when they exist should never be omitted. From the lawyer's point of view delusions are the strongest fact that can be quoted, and certainly an undoubted delusion is proof of insanity, though we who study insanity as disease know that it may, and frequently does, exist without delusions. It is not enough to mention the general fact that there are delusions, examples must be given. Thus, "He entertains delusions; for example, he asserts that," etc. Some delusions are such on the face of them, and need only be quoted without comment, as when a man states that he is the Holy Ghost; on the other hand, many might possibly be true, and in that case the fact of their falsity should be carefully stated. For example, "He asserts that he is financially ruined, which I am informed by his wife and his partner, who are thoroughly acquainted with his affairs, is absolutely untrue, but nothing that can be done or said shakes his belief." This last remark sets forth the essential feature of a delusion—namely, its incorrigibility. Not only might some delusions possibly be true, but some have actually a basis in fact. In these cases we must be very careful to state the grounds on which we consider it a symptom of insanity. Say, for example: "The effect on his mind is quite out of proportion to the cause. He says he cannot follow his occupation for thinking about it, and he appears to be quite unable to banish it from his mind." When there are no distinct delusions the emotional condition, whether depressed or exalted, will furnish a fact. "He appeared to be dull and listless." "He spoke only when questioned, and then very briefly, and in an almost inaudible undertone. I could discover no adequate or rational cause for this condition, which I believe he is unable to shake off." Or, in the opposite state: "He was garrulous in a high degree; and, although I am a total stranger to him, he began at once to talk to me in an unbecoming manner about delicate family affairs and about his sexual feelings, showing in such matters an absence of normal reticence, which I believe he is unable to exercise." If, however, we have known the patient previously, we would say: "From my previous acquaintance with him I know such conversation to be quite contrary to his natural habit." The words "excitement" and "excited," like the word "delusion," should not be used without specifying some example. State if the movements or the speech were excited, and how. Besides the mental state some sample of abnormal conduct should be given if possible, and at the interview there will generally have been something observed either of a positive or negative character, such as: "Did not rise to receive me or to show me out, but sat with his head sunk on his chest, picking his fingers and fumbling with his buttons."

A difficult kind of case to give a convincing picture of in a certificate is one where the symptoms are chiefly of a negative kind. But if we have any previous knowledge of the patient we shall generally be able to say that there is a change. Sometimes we can say that natural peculiarities with which we are familiar from our knowledge of the patient have become greatly exaggerated or perverted beyond his power of control, or lost beyond recovery.

In addition to the facts observed at the time of certification, the certifier is allowed to add in a separate paragraph any that he may have observed on previous occasions, if he thinks that by so doing he can strengthen his certificate. But, as we have already stated, the vital facts must be observed on the day named as that of the examination.

So much for the first half of the certificate. The second half consists of facts communicated by others, or hearsay evidence. This part is not essential, and a certificate is valid without it. But in most cases it is advisable to fill it in with as much care as the first part, especially if the certifier has not been able to quote any very marked instances of abnormal conduct, and has been obliged to state purely mental conditions, such as delusions. Those who have been lately in the company of the patient are certain to be able to give information of some insane act or acts, perhaps of a dangerous or alarming kind, and these acts should always be quoted. The marginal direction is explicit in requiring the names and christian names, "if known," of the informants, with their addresses and descriptions. It is curious to notice how often this plain direction is disregarded. Indeed, it is almost the rule to find an incomplete statement of the names and descriptions of the informants, although the marginal direction stands clear under the eye of the certifier. The reason of the requirement is that, if any question or proceeding should in future arise out of the certificate, the informants may be identified. It is therefore for the certifier's own manifest interest to record clearly those who can corroborate his allegations if necessary.

Having said this much about what should appear in a certificate, I will now advert to some things that should not appear. Occasionally facts are stated that go to indicate, not insanity, but sanity. For example: "I found him lying quietly in bed." "I cannot find any distinct delusion." "He does not appear to have delusions." "Says he is quite willing to follow the advice of his medical attendant." In such cases the certifier either appears to have forgotten that what is required is merely facts indicating insanity, and not a complete clinical account of the case; or, being aware that what he is doing involves some risk to himself, as if he were writing a libellous attack, he may think that his safety lies in saying as little as possible, or in adding extenuating circumstances for the patient's benefit. But the very reverse is the truth, and the safety of the certifier lies in giving facts of unassailable strength. Technical terms of medical nomenclature, such as "mania," "melancholia," "delusional insanity," should not be used. We must always remember that we are writing to satisfy lawyers and not medical men. A statement that the patient is suffering from melancholia or mania is quite useless by itself. What is required is not a categorical assertion that the patient is suffering from this, that, or the other kind of insanity, but the facts which, in the opinion of the certifier, indicate that he is insane, no matter of what kind the insanity is. Facts that do not always and necessarily indicate insanity should never be given without a statement showing that they do indicate it in the particular case. "Has strong sexual feelings" were the opening words of a certificate in the case of a lady who showed other symptoms of insanity of a much more obvious character. To have strong feelings of any kind is not, *per se*, a fact indicating insanity. If, however, the statement had run in some such manner as follows it would have been good: "Though she is a lady of education and refinement she appears to be quite unable to restrain the outward manifestations of strong sexual feelings; and the sense of shame and decency proper to one in her station of life and to her own natural character appears to have no influence." These qualifications, however, did not apply to the case, and it weakens a certificate rather than strengthens it, to pile on minor and non-essential particulars when absolutely conclusive facts can be given. Under the second head, of hearsay evidence, the fact that there has been a previous attack is sometimes stated. This had better be omitted. If a complete account of the case for medical purposes were required the fact of a previous attack would be an important one. But suppose that in cross-examination we were asked, "Do you mean to say that because he had an insane attack five years ago he must be insane to-day?" we would be obliged to answer, No; and the obvious comment would be, "Then why do you quote the fact? It looks very much as if you were raking up every adverse circumstance possible, and trying to get up a case against this person in order to shut him up in an asylum." This would give a jury an unfavourable impression of the certifier and his certificate. The quoting of previous

attacks might possibly be defended on the ground that, taken along with other evidence, it has a corroborative value. This is no doubt true, but for the reason given we think it is best to rely on the symptoms of the attack for which the certificate is written. Moreover, the symptoms in recurrent attacks are generally of a distinct kind, rendering the corroborative evidence of previous insanity superfluous.

Physical symptoms should not be given. The following are examples in point: "Some tremors of the lips at first." "Fell into a chair in a state resembling catalepsy. No convulsions." "Is greatly emaciated." Such symptoms are quite irrelevant.

There are two special forms of insanity that may be noticed in this connexion—namely, general paralysis and epileptic insanity. In a case of general paralysis I have seen a certificate that consisted almost entirely of physical symptoms—the unequal pupils, the slurred speech, etc.—accompanied by the statement that in the certifier's opinion the patient was suffering from general paralysis. Such a certificate might perhaps be defended on the ground that the physical signs that establish the presence of general paralysis always imply insanity. But it is for his insanity, and not for his physical disease, that the patient is certified and detained under care and treatment, and in general paralysis there are always mental symptoms that can be quoted.

In epileptic insanity the epileptic fits are sometimes stated. But it is for the insanity, and not for the epilepsy, that the certificate is given, and the existence of epilepsy does not necessarily imply insanity. The epilepsy could not, of course, be stated under the first head unless there had been a seizure in the certifier's presence at the time of examination.

A word about the literary form of the certificate. It should be written in the indicative mood: "He says so and so," or "He does so and so," and it should be expressed in sentences properly constructed and punctuated. One sometimes sees certificates where the facts are stated as "delusions, incoherence, excitement," without a connecting or explanatory word. Put in this bald form the statement has very little value. Under the second head be careful about the use of pronouns—"he," "she," "his," "him," "her." In some certificates this head is open to three or four different interpretations, and it is almost impossible to make out who is who. Sometimes it looks as if it were the informants who showed symptoms of insanity, as in the following examples from the two certificates in the same case: In one, "F. R. S., an attendant at the Warneford Asylum, informs me that his memory is very defective," etc. In the other, "Dr. —, assistant medical officer, the Warneford, Oxford, stated that he is suffering from General Paralysis of the insane, that he is mentally weak, simple, and childish," etc. Repeat the name of the patient instead of using a pronoun. Thus: "— informs me that — (patient's name) is suffering from great defect of memory," etc.

Guard against verbosity. It is no sign of strength in a certificate, but rather of weakness, to write more than is necessary. And it is clear from the space in the printed form that the Act does not contemplate long certificates. The best and strongest certificates that I have seen have been of quite moderate length. I have known a certificate in a severe case of acute mania where absolute proof of insanity could have been put in four lines, to overflow the allotted space in the blank form and run down the margins for a couple of inches. In another case, one of general paralysis where the diagnosis was clear, the certificate filled not only the allotted space, the margins, and the foot of the page, but also the entire vacant page over the leaf. Nine-tenths of this certificate was irrelevant matter. A lawyer's comment on such certificates would be, "This doctor is trying to bolster up a weak case by writing a long story about it." It is a good plan to make a draft of the certificate on a separate paper and revise it before filling it in on the printed form. In this way undue length can be avoided, and the certificate improved in various respects.

4.

"The said" (here repeat the name of patient), "appeared to me to be [or not to be, as the case may be] in a fit condition of bodily health to be removed to an asylum,

"hospital, or licensed house." Inquiry should be made as to whether it has been necessary to forcibly hold the patient down or to struggle with him or restrain him by mechanical means. Also as to whether he has lately had falls or other accidents. If any of these events have happened, a physical examination should be made. It is a most unpleasant thing for all concerned, when a patient is discovered on his arrival at the asylum to have broken ribs or severe, perhaps fatal, internal injuries, or to be suffering from small-pox or other infectious fever. This section throws on the certifier direct responsibility for the detection of such conditions and for proper precautions being taken.

5.

The fifth head certifies that the medical man has at first read the section of the Act (printed at the foot of the page), in terms of which it is a misdemeanour to make any wilful misstatement in this or any other report or certificate under the Act. Then sign, as required, with full postal address, and finally insert the date—that is, the date on which the certificate is written. This is usually the same as the date on which the examination of the patient was made, but it need not be so. The petition to the Judicial Authority, which must be accompanied by the certificates, must be made within seven clear days of the date of the examination of the patient, and the certificate may be written any time within that period; but the usual course, and by far the best, is to write the certificate immediately after the examination is made. If that is not done, the memory alone should never be trusted to, but the facts indicating insanity should at once be written down, dated, and kept till the certificate is drawn out.

Lastly, read the whole document carefully over, and see if it hangs together from first to last as a logically consecutive whole. Note particularly if all the marginal directions have been complied with. A very careful man will make a copy of his certificate and preserve it. It is but too well known that a medical man who signs a certificate of insanity does so at his peril. Some twenty years ago prosecutions of doctors by patients whom they had certified were so numerous, that the entire medical profession in England was within measurable distance of striking against this duty, and refusing to touch lunacy certificates under any circumstances. Letters seriously suggesting this course appeared in the medical journals.

In the Act of 1890, still in force, two sections were inserted, designed to afford protection to medical certifiers and others. Owing to this the danger is now distinctly less, but it cannot be said to have disappeared altogether. Section 330 provides that an action may be stayed upon summary application to the High Court or a judge thereof, if the court or judge shall be satisfied that there is no reasonable ground for alleged want of good faith or reasonable care, and upon such terms as to costs as the court or judge may think fit. Section 331 provides that, unless an action is brought within twelve months after the release of the party bringing the action and in the county or borough where the cause of action arose, judgement shall be given for the defendant. By the first of these sections the duty of proving good faith and reasonable care falls on the defendant, and a judge may refuse to give effect to the protective sections and allow the action to proceed. This was actually done in the case of *Carpenter v. Dukes* in 1891. Even if the action is stayed the doctor may have to pay his own costs, besides suffering cruel anxiety and worry. There has been, however, for a number of years no prosecution by a patient of the doctor who had certified him.

It is to be feared that we medical men do not always realize the importance of a strict adherence to business forms, while lawyers, on the other hand, may seem to us to exaggerate it. Now, if a judge on inspection of a certificate that had formed the ground of an action found violations of the clear marginal directions, or facts that do not necessarily indicate insanity set down without remark, or the handwriting careless and almost illegible, or the grammar loose and punctuation nowhere, would he not be apt to infer a want of "reasonable care," and hesitate, perhaps refuse, to stay the action? Kindly people of the old-fashioned sort are wont to say of their family doctor that he is "a careful man," meaning thereby to give him a high degree of praise. In few of his professional actions has he greater need of the excellent quality of carefulness than in writing a certificate of insanity.

CATS AS PLAGUE PREVENTERS.

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IN the article which appeared in the *BRITISH MEDICAL JOURNAL* on May 30th I gave reasons for thinking that the best way to prevent plague in India is by keeping cats. That paper was based mainly on observations which had been made in previous years. During the past cold season we have had another epidemic, which, although comparatively mild, has afforded very good opportunities of observing whether and how far cats are likely to prevent plague. I mentioned in the former paper that there are some castes who are very willing to keep cats, as the Mohammedans, and that there are others who are not willing to keep cats, for example, Bhowani Dhers and Jains. Now if we wanted to make an experiment with a view to finding out how far cats would prevent plague, the conditions would be very much the same as those that we actually found in existence here. We had groups of people who keep cats, others who do not keep cats, and the epidemic of plague spread in five out of six of the Taluqs into which the district is divided. Plague occurred in 54 towns and villages, and there were altogether 1,704 deaths, which would give a ratio of slightly more than 2 per 1,000 of the population. Investigations were made in most of the towns and villages where cases occurred, by assistant surgeons and hospital assistants, patwaris (native surveyors), police, vaccinators, and others, and I was able myself to verify a good many of these investigations in a general way.

ARGUMENT ON GENERAL GROUNDS.

Let us suppose that any reader of this paper heard of plague for the first time, that he was told on good authority that the epidemic is entirely due to rats, and that a suggestion had been made that the best way to keep away rats is by keeping cats—he would probably say that this seems to be a common-sense way of dealing with the problem. If you then tell him that in India the majority of Hindus object on religious grounds to killing rats with traps or poison, but that all Mohammedans and well over 90 per cent. of the Hindus are willing to keep cats, that with a large number it is almost a religious duty to keep a cat, that it is our policy in India to give strict consideration to the wishes, traditions, and religious ideas of the people, he would, I think, be fully convinced that it is a very sound policy to recommend the people to keep cats for preventing plague; and he would probably go further, and say that it seems very curious that there should be any hesitation in regard to adopting this method. But the actual case is not so simple as this. We have had plague epidemics going on for twelve years, and we have many recommendations made and carried out for a year or two until they were proved to be ineffectual; so that now, when any new suggestion is made, however simple it may be, people are inclined to think that it will meet the same fate as other methods which have preceded it. A large amount of evidence has been collected, and I propose to review it by contrasting villages, then groups of houses (mohullas), and then give some illustrations to show that houses with cats are less liable to be infected with plague.

EVIDENCE FROM VILLAGES.

Hospital Assistant Shian Behari Lal of Daryapur Taluq gives several instances like the following: A, B, and C are three villages. Plague has occurred in A and C, but not in B, which lies between the other two; and on inquiry he finds that the cat percentage is high in B, but not in the other two. (The cat percentage is the number of cats to a hundred houses.)

Hospital Assistant Azimuddin of Badnera states that plague occurred in Dhaba village, but not in any of six adjacent villages. In Dhaba the cat percentage was low, but varied from 32 to 75 in the other villages. Many of the people in Dhaba are Bhowani Dhers (who do not keep cats), and they suffered most from plague; but in this same village there is a mohulla which is occupied by Telis, who had 9 cats to 19 houses, and they were quite free from plague, although they did not leave the village.

Hospital Assistant Paranjpe at Chandur Bazar mentions four villages in which plague occurred, and in the