A Discussion

ON

THE REPORT OF THE LUNACY COMMISSION
(ENGLAND).THE PROVISIONAL TREATMENT ORDER OF
THE ROYAL COMMISSION.*

BY

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THE lunacy laws of England and of Scotland are in urgent need of amendment. The parent Act for Scotland dates back to 1857, since when great changes affecting its serviceableness have taken place in the social life of the country as well as in the scientific world. It, however, definitely recognizes the paramount position of the medical profession in the treatment of mental diseases, for under its provisions no layman or magistrate is called upon to interview the patient before he is placed in a mental hospital, and no layman or committee is held to be responsible for his removal when recovered. Medical men discharge these and all similar duties, and to this feature must be ascribed the success of the Scottish system. It has gained the confidence of the people; and in place of misgivings and suspicion, there is pride in our mental hospitals and in their management. No case of improper detention has ever been recorded in the law courts. The 1857 Act has served its day and generation well, and its principle of medical responsibility is in Scotland established for ever.

The principal Act for England was passed in 1890, and from the legal and administrative points of view it is a complete, logical, and accurately drafted instrument. Its very perfection in these respects has been a calamity to the person sick in mind. That the treatment of insanity is primarily a medical question, that insanity being a disease like other diseases must be treated and treated early if its cure is to be effected, were minor considerations in the framing of this Act. They were overshadowed by problems connected with the liberty of the subject and with the haunting fear of improper detention, which loomed so ominously in the minds of law-makers. Thus, as has happened so often, an Act designed for the welfare of the insane person has turned out in practice to be to his detriment; and laws enacted with the object of reducing the sum of human misery have, in fact, increased it.

The Recommendations of the Royal Commission.

The present is an opportune time to discuss the problems of lunacy legislation. A thorough and impartial inquiry by a Royal Commission has just been concluded and an exceptionally able report has been presented, pointing out existing defects and making valuable suggestions for the future. One gratifying and immediate result of the investigations made has been to allay all anxiety in the minds of reasonable people as to the improper detention of sane persons in mental hospitals in England. Such cases have not been found, and in future legislation should not be dominated, as it has been in the past, by suspicions and misgivings, which have done so much harm to the persons chiefly interested—namely, the patients.

The following are some findings of the Commission:

1. The Commission did not find a single case in which improper detention had been suffered.
2. Fifty years previously a Select Committee of the House of Commons had also reported the same absence of improper detention.
3. The stigma of certification is acutely felt both by patients and their relatives.
4. Certification should be the last resort and not a preliminary to treatment.

* A paper read in opening a discussion in the Section of Mental Diseases at the Annual Meeting of the British Medical Association in Edinburgh (Friday, July 22nd). Dr. H. C. Marr, a Commissioner of the Board of Control in Scotland, was in the chair.

5. The present facilities for treatment without certification are on a very limited scale and need extensive development.

6. The problem of insanity is essentially a public health problem, to be dealt with on modern public health lines.

7. The keynote of the past has been detention; the keynote of the future should be prevention and treatment.

The problem before us is summed up by the Commission in the following paragraph:

"The lunacy code should be recast with a view to securing that the treatment of mental disorder should approximate as nearly to the treatment of physical ailments as is consistent with the special safeguards which are indispensable when the liberty of the subject is infringed."

According to the Commission the basic classification of cases requiring mental treatment should be—the voluntary and the involuntary.

The arrangements suggested for voluntary treatment are on the whole satisfactory. This form of treatment will ultimately become by far the most popular, and already in the Scottish royal hospitals the admission of voluntary patients paying the higher rates of board amounts to two-thirds of the total number. As the principle of voluntary treatment meets with universal approbation, and differences of opinion exist only on matters of detail, discussion on this subject would serve no useful end at present and is therefore excluded.

With regard to involuntary patients three procedures are recommended by the Commission.

The simplest of these is the Emergency Order signed by a relative, or friend, or public official on one medical recommendation, which, be it noted, is not a certificate of insanity. This order remains in force for seven days. Nothing need be said regarding the emergency order, which is altogether satisfactory.

We now come to the two remaining procedures recommended by the Commission: the Provisional Treatment Order and the Reception Order. These two orders are obtained through the personal intervention of a layman. They differ in three respects.

To obtain the provisional treatment order, one doctor only is called in to advise, instead of two as in the reception order; secondly, the single doctor makes a recommendation in the provisional treatment order, while the two doctors give certificates of insanity in the reception order; and thirdly, the authority of the provisional treatment order lasts from one to six months only, while that of the reception order is indefinite in duration.

The Commission is to be congratulated on adopting the principle in the provisional treatment order that an insane patient whose recovery is expected may be detained and treated on the recommendation of a doctor, without being certified to be insane, thus relieving the patient and his relatives of the stigma of certification, which is felt by them so acutely.

The provisional treatment order is supported by the recommendation of one doctor only; this is a mistake, for in so important "a matter which is the most difficult, delicate, and indefinite in the whole range of medical practice," according to Mr. Justice McCardie, two doctors should without doubt be consulted. In every great profession there may be a weak or an unworthy member; doctors, like other human beings, suffer in health and may make mistakes or be deceived, but the possibility of two doctors falling simultaneously into one or other of these categories, or of acting in collusion is a very remote contingency. As a safeguard and as a second witness or observer merely, apart from the value of another medical opinion, the employment of a second doctor must meet with the approval of everyone. Light may be thrown on the failure to recommend two doctors by question 4055: "Do you think a second certificate of sufficient importance as a safeguard to justify the expense in pauper cases?" Two medical certificates have been employed in all pauper cases in Scotland, a much poorer country, for seventy years, and should be employed in England in all such cases as well. Moreover, the provisional order applies to private cases as well as to paupers. A niggardly economy where the liberty of the subject is concerned is indefensible, but it is particularly objectionable to the medical profession when the failure to employ a second

doctor is, as we believe, partly responsible for the repeated visitations of a sick person by laymen, and these will certainly not make for economy.

Another very debatable point is the basis upon which the two classes of patient—namely, those to be placed under the provisional order, and those to be placed under the reception order respectively—are to be selected. This involves the question of prognosis, notoriously the most difficult and uncertain problem in psychiatry. It has to be solved in the first place by the general practitioner, who can scarcely be expected to have the necessary experience; and secondly, by the justice, who has had no medical training at all. The provisional treatment order applies to those cases only in which "there is a prognosis of early recovery"; and the reception order applies to those patients only who are not likely to recover within six months. Those who have already been under provisional treatment for six months naturally come under the second category.

The difficulty regarding prognosis may be illustrated by a recent experience. A very eminent surgeon treating a melancholic patient regarded the prognosis of the mental condition as hopeless, because the patient was intensely suicidal. A suicidal tendency is the most anxious symptom a patient can exhibit; but as regards prognosis it is of no more significance than an ingrowing toe-nail. The surgeon was astonished when he was told this truth, but he now knows better, for he saw the patient make a rapid recovery.

A justice under similar circumstances might very naturally make the same blunder and refuse to sign the provisional treatment order. It is obvious that prognostication and forecasting the date of recovery is not one of the easiest tasks in psychiatry, and should not have been selected in sorting out provisional treatment cases from reception order cases, even though it is desired, and very properly desired, that all patients who make early recoveries should receive the benefit of the provisional treatment order.

The happiest laws regulating practical affairs are not the fine product of a learning that flourishes in studies and in libraries; they are slowly fashioned by the friction of circumstance and the shock of facts in the rude school of experience. Were the recommendations of the Commission regarding involuntary patients passed into law every doctor would place every patient not hopelessly and incurably insane under the provisional treatment order. What experienced doctor will give a grave prognosis at the beginning of an obscure illness? If thirty-five years ago Sir Thomas Clouston objected to the name of "dementia praecox," simply because of the malign influence of a pessimistic nomenclature on the endeavours of the physician, what are we to think of the evil consequences of a serious prognosis given solemnly on oath as a preliminary to treatment? When remedies are forthcoming for incurable and fatal diseases like general paralysis of the insane, what doctor, in the early stage of any illness, in cold blood, is, in vulgar language, going "to throw up the sponge"? Every successful doctor is an optimist; to be anything else is fatal to the prospects of his patients and to his own success. Gloomy deans may have a vogue, but not gloomy doctors. A gloomy outlook injures the patient directly, and it also does so indirectly by depressing the relatives and by creating an atmosphere of anxiety. It may be safely assumed, if the recommendations of the Commission be passed into law, that every patient not a chronic or absolutely hopeless case will receive the benefit of the doubt and will be treated under the provisional treatment order. In other words, all recent and recoverable cases of mental disorder will be given the chance of recovering within six months without being certified and registered as lunatics—"an excellent thing." No harm is done if incurable cases by mistake also enjoy this privilege; for it is clearly better to err on the side of granting it to too many than to too few. The intolerable self-reproaches and the awkwardness of the situation of a family doctor who, under the reception order, certified as insane a patient who made a perfect recovery in the course of three or four months, may be left to the imagination.

There is no doubt the Commission had the Scottish Schedule G in mind when it designed the provisional treatment order, for the powers granted for six months under this schedule can be applied to the treatment of a patient when "the malady is not confirmed" and "with a view to his recovery." This condition is better expressed in Schedule G than in the recommendation of the Commission, for the intention can always be honestly remedial, however faintly hopeful the outlook, and there need be no strain placed on the conscience by a declaration on oath that recovery is likely to take place within six months, when the outlook is quite uncertain and when a definite diagnosis has not been made. Seeing that similar results can be obtained in a simpler, surer, and more honest way than by speculative prognosis and hazardous assessment of the date of recovery, it would be better to drop the dubious procedure of prognostication altogether and give every patient, not a chronic and absolutely hopeless case, the benefit of the provisional treatment order for six months, provided he be treated "with a view to recovery."

The Provisional Treatment Order.

After a patient has been treated under a provisional treatment order for six months and is not likely to recover soon, and in obviously incurable and chronic cases, full certification of insanity and a reception order is a procedure to which no objection can be taken, seeing that custodial and not remedial treatment is its main object. If a patient under a provisional order has not recovered within six months, but is expected to recover soon, it should be possible, with the approval of the Board of Control or other competent authority, to extend the duration of the provisional order to a year, or even longer.

We note, with profound regret, that the justice, a layman, must intervene personally in order that temporary medical treatment may be obtained under the provisional treatment order. Quasi-medical duties and responsibilities are also imposed upon him. Such a recommendation is astonishing in a report that records no case of improper detention and that breathes medical aspirations and professes therapeutic and preventive ideals on almost every page. It is clear from the evidence submitted to the Commission that unmedical legal procedures have in the past been the chief impediment to early treatment and have prohibited preventive measures altogether. The treatment to be given under the provisional treatment order is only temporary and is essentially remedial; it is quite different from that given under the reception order, which is unlimited and is predominantly custodial. There is therefore less reason for judicial intervention in the provisional treatment order than in the reception order, and this intervention would be still less necessary if two medical men were consulted instead of one.

The judicial authority, we are told, is employed for two reasons. First, as a safeguard against improper detention; and secondly, because it is a principle of English law that the liberty of the subject may not be infringed without the intervention of some judicial authority.

With regard to the first reason—namely, as a safeguard against improper detention—if improper detention ever happens it is never the result of malicious intention. So long as human nature remains as it is, and circumstances seem to conspire, mistakes may occur; but when we recall that miscarriages of justice, such as the Adolph Beck and the Edalgi cases, have occurred even in our courts of law, and that no cases comparable to them have occurred in our mental hospitals, then it must be admitted that the record of the medical profession is beyond all praise and one to be proud of. Further, when we consider that in Scotland for seventy years thousands of insane persons have been placed in mental hospitals without being seen by any magistrate, and that no case of improper detention has ever been found in our courts, it is clear that the honour and vigilance of the medical profession are no mean safeguards.

There is another safeguard not judicial, the value of which the Royal Commission does not appear to have realized—the medical appeal. The subject is in Scotland safeguarded against improper detention in an asylum,

and his liberty made almost impregnable, by the right of appeal to two independent doctors for examination. The judicial authority is the sheriff, whose strictly legal functions will be described later. He considers in private the written medical evidence only and makes no quasi-medical investigations himself, nor does he invade the privacy of the sick-room. His reception order is given wholly on the written opinions expressed by the two medical men first called in, but complete and speedy protection is afforded the patient, should these two have made a mistake, by the right of appeal to two independent doctors for examination. This right is enjoyed by the patient, by any relative, by any friend, by the sheriff, and by the General Board of Control, so the machinery can be easily set in motion and in many ways. A patient is detained in a mental hospital on the certificates of two doctors, and what two medical men have done, two others can undo, if wrong has been done or a mistake has been made. If the first opinions are confirmed by this independent and unbiased testimony, the opposition of all reasonable persons is silenced. No layman, no judge, no committee, not even the General Board of Control itself, can act independently of the opinions of these two independent medical men, who form the supreme and, for the time being, the final court of appeal. We thus have in Scotland a purely medical system that affords complete protection, that has stood the test of time, and that satisfies public opinion. The personal intervention of a justice is therefore not necessary as a safeguard against improper detention if this tribunal exists. An appeal is not made often, and obviously frivolous appeals are discouraged by the authorities. In Scotland a sum of £30 a year apparently suffices for the payment of those cases in which no other funds are available.

In the second place, it is stated that it is a principle of English law that the liberty of the subject may not be infringed without the intervention of some judicial authority.

The Judicial Authority.

The object of the lunacy law is to authorize violations of personal freedom for the benefit of the patient and others under certain circumstances and formalities. Between 1845 and 1890 we were informed, on the authority of Dr. J. C. Bucknill, Lord Chancellor's Visitor, that

"any one of the Queen's subjects may be deprived of his liberty, captured, confined, and detained by the proprietor of a licensed house or his servants, upon the order of any person whatsoever, either a British subject or an alien, either an adult or an infant, either a relative or a stranger, either an equal in social rank or a menial substitute; the only condition being that he has seen the alleged lunatic within one month of making the Order, and is supported by the certificates of two men qualified to practise and practising the medical profession."*

In spite of this absence of any judicial authority the Select Committee appointed in 1877 to inquire into the subject of improper detention under the law of 1845, reports: "Assuming that the strongest cases against the present system were brought before them, allegations of *mala fides* or of serious abuses were not substantiated." It would therefore seem that the infringement of the liberty of the subject without the intervention of a judicial authority is not without ample and striking precedent in the domain of mental disease, and that it was freely practised in England for forty-five years without the occurrence of serious abuses. It is still practised in Ireland without abuses arising.

Judicial intervention is not desired by the sick patient nor by his distressed relatives. It is quite alien to medical feeling. It creates difficulties, it adds complications, and it causes delay at a time of great trouble and unhappiness. If there must be some form of judicial intervention, then the Scottish procedure has much to recommend it. It preserves the integrity of the medical ideal, it respects the sanctity of the home, and it introduces the judicial element in a purely legal capacity. The sheriff, who signs the reception order, is an experienced barrister and a salaried judge. He never sees the patient; he does not make any quasi-medical examination. The application and medical certificates are presented to him, and if these be in order, and if the facts observed by the doctors indicating insanity

satisfy him, he invariably signs the order. No one could discharge these duties better than this highly trained official, no legal intervention could be less objectionable than the one he follows, yet the question arises, Is judicial intervention necessary?

Judicial intervention in Scotland is quite superfluous. The inspection of the application to see that everything is in order and the examination of the medical certificates to discover if they truly indicate insanity, which is all that the sheriff does, are in every case as carefully performed by the General Board of Control as by the sheriff. If an order must be signed by a fourth party, there is no reason why it should not be signed by the General Board of Control, and the sheriff allowed to drop out altogether. The sheriff is only a fifth wheel to the coach. It is more appropriate that a permanent body that has medical as well as legal members on its staff, that is competent to examine patients as well as to scrutinize legal documents and weigh written evidence, should perform the duty of signing the order. This was the view held at one time by the General Board of Lunacy of Scotland, and the Royal Commission contemplates that ultimately it may be that "the participation of a magistrate will no longer be considered necessary."

Let us now dramatize the procedure which has been recommended by the Royal Commission before a sick man can obtain medical treatment for his illness. The proceedings are not medical, for a layman is the presiding authority. The stage on which they are enacted is a distracted household, for nothing upsets a family so much, not even excepting death, as the occurrence of insanity in one of its members. Their only consolation is the comforting and encouraging words of the family doctor. The application is signed, not without perturbation, the recommendation filled in, and now word is hurriedly sent to the justice. Within seven days this strange official, who is not a doctor, comes to interview the sick patient. He is recommended to visit the patient in the patient's own home, and this, in the country, involves an expedition. His medical examination is to be no perfunctory performance, as was so often the case in the past. As those justices who have a natural or acquired gift for this delicate duty are to be selected, it may be assumed without offence that all do not possess the necessary accomplishments. Then the relatives are to be interviewed, and, if this be judicially done, both those "for" and those "against." The kinsmen of patients are often trying, and some are to be met who refuse ever to see any signs of insanity, because they say there has never been any in their family. If the justice be in doubt, he is to confer with the doctor, so he as well as the relatives have to put their time at the disposal of the justice, however inconvenient this may be to all of them. More than one visit may be considered necessary.

The justice is now to exercise what has been described as "a directed discretion." For example, if delusions have been alleged he may deem it necessary to investigate these further, and how much further afield these may take him no one can tell. All sorts of inquiries may have to be set afoot and many witnesses interviewed. Then he has to decide whether the patient is to be informed of these allegations. To experts this is, perhaps, not a difficult decision to make—but how often has one been asked by a perplexed layman: "Doctor, should I agree with everything he says, and if I contradict him will he get excited?" This layman has, in addition, two medical problems placed upon him which he must solve by a personal examination and by his own discretion. He has to decide, first, "Is the patient insane or not?" And secondly, "If insane, is he going to recover within six months or not?" How a layman without any medical training or experience can answer the latter question it is impossible to conceive. If he has to rely on the doctor's opinions, and is guided by him, why bring him on to the stage at all? We will here drop the curtain on the first act of this drama.

The second act opens, after an interval of six months. The patient has not recovered, and the question of placing him under a reception order has to be considered. Two doctors are now called in to assist and give certificates of insanity. The justice may now have the assistance of the

* *The Care of the Insane and Their Legal Control*, p. xxx.

clerk to the justices. The patient may now appoint someone to represent his interests, and there is nothing to prevent him employing a solicitor whom he has found amenable to his instructions. The court is thus carefully and fully prepared for a formal hearing of the case, but the adoption of a forensic procedure is deprecated by the Commission. Apparently those who conduct these medico-legal proceedings are advised to drop, so far as they possibly can, judicial ceremonial ways and adopt the less alarming methods of the medical man in their place. The justice requires to see and examine the patient again, but no instructions are given as to whether the patient is to be present at this "trial" or not. If the solicitor, to earn his fee honourably, defends his client the patient can hardly with justice be excluded from the proceedings during all the time. Nor can the solicitor be denied such access and such facilities of getting up his client's case as he considers necessary, and this almost certainly would involve the evidence of other patients. Lively scenes, it may be surmised, will sometimes occur. Irresponsible allegations will at times be flung about, and the Commissioners have very wisely recommended that all parties must be sworn to secrecy. But there is one tongue over which they have no control, and possibly not even its owner can curb it—the tongue of the patient. We know how fond manic patients are of revelling in scurrilous and intimate disclosures, and how they love to pose before an audience.

It may be said that the picture here presented is over-drawn, but the more nearly judicial intervention is judicial in character the truer will the picture be to what will occur. The perfunctory way in which these duties were sometimes performed in the past, as by one-minute interviews in taxi-cabs, may possibly have been a saving grace. It is a pity that such disclosures did not lead logically to the abolition of judicial intervention, instead of to its reinforcement and rehabilitation.

Whether non-existent, as between 1845 and 1890, whether performed perfunctorily, as was so often the case in England, or whether performed in the purely legal way without seeing the patient, as in Scotland, judicial intervention or non-intervention seems to have made little difference one way or another, and neither Select Committee nor Royal Commission has found any person improperly detained in our mental hospitals. It is clear that adequate protection exists and is afforded by other means. To us in Scotland, who have never had any experience of the personal intervention of a layman, this form of amateur medicine seems a monstrous and intolerable invasion of the sphere of the physician, and nothing less than a caricature and a mockery of medical science and practice. The reason why the medical profession in England has acquiesced in it has been the hope that the personal intervention of the justice would relieve medical men of some responsibility and reduce or abolish the risk of legal actions. That hope has not been fulfilled, although, according to Mr. Justice McCardie, the medical certificate was no more than a mere opinion, devoid in itself of operative force, and the reception order was the effective authority.

Some Conclusions.

The provisional treatment order forms the most striking departure from precedent of all the recommendations contained in the Report of the Royal Commission. Voluntary treatment has existed for a long time, and no facilities are offered that are not already enjoyed in Scotland, where certifiable as well as rate-aided patients can be treated voluntarily. The emergency or urgency order has always existed, but it has been greatly improved by not requiring a statement to the effect that the patient is insane. The provisional treatment order is the offspring of Schedule G of Scotland, but it is a much greater concession, for Schedule G applies only to private patients. The Mental Treatment Bill associated together in one clause, somewhat incongruously, voluntary patients and patients without volition but non-resistant, and it was, of course, very desirable that special provisions should be made for the latter class. The provisional treatment order has done much more, for it has conferred the privileges it contains

not only on patients of the class referred to, but also on volitional but resistant patients, provided they are deemed recoverable in six months' time. In effect, these privileges will apply to practically all cases of recoverable insanity. A greater boon cannot be expected of the legislature, and for it we have reason to be grateful to the Royal Commission. Its benefits will be much diminished, however, by the conditions under which they are to be conferred, and as we desire to see these faults removed, the five following recommendations are made:

1. In the first place, we consider that two doctors should require to give recommendations instead of one only. If the safeguarding of the liberty of the subject be so important a matter, the employment of two doctors instead of one should be acceptable. The power conferred by the provisional treatment order, although of limited duration, is great, and we think it should not be put into the hands of one medical man, even though a justice also sees the patient.

2. Secondly, as a further safeguard to the liberty of the subject, we recommend the right of appeal to be examined by two independent doctors. We believe this privilege will render improper detention almost impossible, as it has done in Scotland.

3. Thirdly, the employment of a second medical man and the right of appeal to two independent doctors, we believe, make it unnecessary for the judicial authority to visit and see the patient. In support of this we point to the results of seventy years' experience of this procedure in Scotland and think it conclusive. The visitation by the justice perpetuates those legal formalities that have in the past delayed treatment, blighted attempts at prevention, and differentiated mental disorders from other illnesses—all grave faults to overcome which were among the chief aims of the Commission.

4. Fourthly, we recommend that the justice be replaced by the Board of Control. It is a strong medico-legal body accustomed to visit patients, familiar with the requirements of the law, and actually engaged already as a part of its duties, in scrutinizing applications and medical certificates. Its task would be analogous to that performed at present by the sheriff in Scotland, which has proved very satisfactory, although he never sees the patient.

5. Finally, as prognosis and forecasting the date of recovery is difficult and uncertain, the conditions required for coming under the provisional treatment order should be altered to those of Schedule G—namely, that the malady is not confirmed and that the treatment to be given is with a view to recovery. This change would make no difference to the patients who would benefit, but it would confer a grateful relief to the physician.

When the remedial stage of the treatment of an insane person passes into the custodial, and the liberty of the subject, as distinct from his curative treatment, becomes the main question, no medical man can object to the adoption of such legal procedures as are considered necessary. It is again affirmed, in conclusion, that the right of appeal to be examined by two independent medical men is a more logical and perfect protection against improper detention than any form of personal intervention by a layman. It has proved a medico-legal panacea in Scotland for all problems dealing with the liberty of the subject in the treatment of mental disease.

DISCUSSION.

Dr. E. MAPOTHER (Maudsley Hospital, London) considered that the Report of the Royal Commission was disappointing. It was to a large extent devoted to the prevention of non-existent abuses, and that in a rather inconsistent way. A great many of the recommendations were matters within the ordinary province of the Board of Control. He could not accept Professor Robertson's clear-cut distinction between the voluntary and involuntary case, and added that there was a third class of great importance, which included most of the recoverable cases. At the Maudsley Hospital, where voluntary cases were treated, it was assumed that if a patient had voluntarily placed himself under control and subsequently passed into a state in which he was not unwilling, but incapable of expressing his opinion, the consent to treatment which he gave

originally still held good; the Royal Commission, however, recommended that such a patient should be put under a provisional order. What was a provisional order under the new regulations except a certificate? Some method of dealing with the unwilling case other than by certification was needed—some method of treating such a case outside the asylum temporarily, and some order which was distinguishable from a certificate and did not involve the intervention of a magistrate. One of the many points of detail in which the provisional order or certificate seemed open to criticism was that a patient must be seen by a magistrate within seven days. A doctor might have to wait seven days before getting his patient seen by a magistrate, and that would tend to drive him in most cases to the use of the urgency order. The doctor's responsibility when he signed an urgency order was rather different from that involved in signing one of the certificates in support of a provisional order. He was in favour of having special certifying medical men for the giving of a certificate in connexion with a provisional order. In the Commissioners' report this was mentioned as an optional proposal; it was not made a definite recommendation. At the termination of validity of the provisional order, and when the order was to be followed by a definite reception order, the Commission stated that the patient should have the right to claim the attendance of any one person chosen by himself, and that the justice could be assisted by his clerk; elsewhere it was stated that the justice might call upon the medical man to justify his certificate. Dr. Mapother objected to the institution of a sort of trial before the patient was committed to a mental hospital; in this procedure the patient, but not the medical man, might be represented by counsel.

Dr. T. B. HYSLOP (London), whilst most heartily approving the Report of the Royal Commission and Professor Robertson's paper, doubted whether the new proposals would get to the bedrock of the troubles existing in England. The first duty of the medical man was towards his patient, the second towards the community, and the third to himself. To certify that a person was of unsound mind not only deprived him of his liberty and his social, economic, and civil rights, but branded him with a label which was borne by his relatives and descendants as well as by himself. The insanity might have been due to bodily causes, such as defects in the internal secretions, in metabolism, in excretions, or to toxins, and it behoved all medical men to consider whether they were to label their patients as coming within the mental or the physical category. Intervention of the judicial authority had not been entirely successful, either from the point of view of the liberty of the subject or the safety of the certifying practitioner. Both the patient and the medical man should be afforded a sporting chance of the former's recovery without deprivation of liberty. In his opinion the whole question was of such urgency and importance that he hoped there would not be unnecessary delay in bringing into effect the recommendations of the Royal Commission. In the meantime the community must suffer from the inadequate provisions for its welfare.

Dr. W. F. MENZIES (medical superintendent, Staffordshire Mental Hospital) deplored the decision of the Royal Commission to decline to recognize the non-volitional class of case. The suggested procedure involved three successive personal examinations of the patient by the judicial authority; this was impossible in practice. Justices could not give up one day a week to lunacy matters, certainly in any country district in England; nor could a dozen or more private medical practitioners leave their work and travel ten or twenty miles to the institution where the patient was placed, and wait about for a half-day until the case came on. Two medical certificates, one by the family doctor, the other by a medical officer of the institution, should be placed before the management committee at its monthly or weekly meeting, and it should be given, *ad hoc*, the powers of a judicial authority specially appointed under the Act. The vast bulk of the population were not apprehensive of improper detention; the whole agitation was fomented by a noisy minority, many of them unrecovered patients.

Dr. RISIEN RUSSELL (London) said that if England enjoyed the privileges available in Scotland for the treatment of mental disorder he would be content. The laws for England and Wales ought to be altered to allow of patients so affected being treated for at least a year without interference by the law, and certification ought to be the last resort. As the law now stood in England and Wales treatment was constantly hampered by the ever-present fear of conflict with the law, and the general practitioner was even more perplexed. Two distinct issues were engaging the attention of the profession and the public at the present time: (1) whether the doctor should have the whole "say" in the matter of certification of a person supposed to be of unsound mind, without legal intervention; (2) whether the doctor who certified a person as of unsound mind should be made immune against the possibility of a civil action for damages in a court of law for alleged wrongful certification. When the question was merely one relating to the treatment of a patient the profession was well within its rights in claiming to be the proper judges of what was required. When, however, it became a question of depriving an individual of his civil rights, the matter passed out of the sole province of medicine and became a legal one. The profession was fully justified in claiming protection against civil actions for damages in respect of alleged wrongful certification, but it could only reasonably hope to secure this protection if it was prepared to accept the interposition of a legal authority on whom the whole responsibility must fall. Moreover, if medical men were to expect the protection they claimed, it would seem to be reasonable that they must be prepared, in conformity with all other instances in which they were called upon to give evidence, to do so on oath. Even in so comparatively unimportant a matter as whether a man was drunk or sober, a doctor's certificate was not enough, but had to be supported in the witness-box. How much more should evidence on oath be required where the decision carried with it such grave consequences to the individual concerned and his family! A lasting damage was inflicted, which might have far-reaching consequences on other members of the family in respect to marriage, life insurance, and other matters. The suggestion that there should be the intervention of a representative of the law, who must in all instances personally see and examine the person supposed to be of unsound mind, did not carry with it the need for publicity, for the person in question need not appear in open court. It had been suggested that the legal representative should be a man trained both in medicine and law, and that there were, probably, a sufficient number of barristers with medical training to fill these posts. This seemed reasonable, but it might leave the matter too "medical," and the question should be viewed from different standpoints, hence the importance of having as justice a man with no medical training. The "welfare" of a patient might be a purely medical question, but his "safety," or that of the public, was also a matter for laymen. Important recommendations by the Royal Commission in regard to such inquiries were that the judicial authority should always see the patient, that the person whose case was being investigated should be at liberty to have a friend present, and that the justice should be called upon further to exercise what was termed a "directed discretion," which meant that he must consider and state his decision on the face of his order as to whether the allegations with regard to insanity were proved, whether he had seen the doctor, and whether the patient should be told of the allegations. The most important recommendation of the Commission in the interest of the patient was that which would allow of treatment without certification for at least a month, and possibly six months. How the urgency order was abused in many instances, and made use of as a convenience instead of being strictly reserved for cases of real urgency, had been so strongly brought out by evidence before the Commission that the provision for the interposition of a magistrate before the person was sent to an asylum was justified even in the case of an urgency order. The profession should welcome anything that would offer the public a sense of security in these matters, so long as what was suggested did not conflict with what was necessary for the good of

the patient. That one of the two medical certificates should be supplied by a doctor who possessed special knowledge of mental diseases was reasonable in the highest degree, if found practicable; he saw no objection to having doctors specially appointed under the Act to fulfil this function. In suggesting a way out of the present difficulties a threefold object should be kept in view—namely, to do what was best for the patient, what was acceptable to the public in conformity with the law, and what would give full protection to the doctor. The medical profession should try to find a reasonable solution that would fulfil these three objects. Dr. Russell, in conclusion, made a few suggestions as to how these three requirements would be best met: (1) that there should always be two doctors supplying the evidence, except in the very rare event of a case being of such urgency as to make this impracticable, and that one of these medical men should have special knowledge of mental diseases; (2) that the judicial authority should, in every case, see and examine the person supposed to be of unsound mind, and see also the doctors; (3) that in order to secure protection against civil actions, the doctors should give their evidence on oath, and be subjected to cross-examination like any other witness. What was of paramount importance was that medical men should be allowed to treat their patients who were mentally afflicted, without certification, away from asylums for six months at least, and, if possible, twelve.

Dr. DONALD ROSS (medical superintendent, Argyll and Bute Asylum) described the simple way in which some of the problems so pressing in this country were dealt with in the Canton du Valais, in Switzerland. In that canton there was a most admirable mental hospital, the Maison de Santé de Malévoz; Dr. Repond, the physician-superintendent, had said to him, "Thanks be to Heaven, we have no lunacy laws, no inspectors, no boards of control." This last was, of course, their loss, for in Scotland, at least, the General Board of Control was the ever-helpful comforter and friend of the profession. In Valais there was a very simple and workable code of rules for the guidance of the superintendent, drawn up by a former superintendent in collaboration with one of the members of the Cantonal Legislative Council. The admission and discharge of a patient was governed by the superintendent's opinion of the suitability of the case. If a patient, though not recovered, was sufficiently improved to go home, but the relatives were unwilling to take him out, the relatives were asked to pay a much higher rate of board, and this was usually quite effective. Dr. Risien Russell had spoken of the desirability of having specially trained physicians appointed as certifying physicians in lunacy. One of the speaker's recovered patients, from whom he had learnt much wisdom, always maintained that two medical certificates were desirable, and that while one should be, if possible, by the family physician—as all would agree—the second should be signed by a medical officer in a mental hospital, because, broadly speaking, he alone had the proper experience for the task.

Earl RUSSELL (a member of the Royal Commission) said that the Commission had the advantage of hearing evidence from Dr. Robertson, by which it was much impressed, and it had also much admired the system he was able to administer. The Section must not think he undervalued the medical point of view, but when dealing with legislation and amendments to the law it was useless to discuss the matter purely from that aspect. Account must be taken of the attitude of the public—a thing a little overlooked in Professor Robertson's paper, but the Royal Commission had to bear it in mind. There were members on the Commission who held to some extent what he must call the antimedical view, and whether it was still the effect of Charles Reade's book or not, there did exist in England, among the great mass of the population, a certain amount of suspicion of doctors, particularly of doctors in connexion with cases of insanity. The attitude of the House of Commons had to be remembered. That assembly represented, not only the intelligence, but the stupidity and the prejudices of the people. The duty of the Royal Commission, among other things, was not to consider merely the

procedure for certification, important as that was, but also the happiness and well-being of that large body of patients who spent years under institutional treatment; regard had to be paid both to their comfort and their feelings—for example, in such matters as the sending out of letters to their friends under conditions of comparative privacy. Certification, of course, was an extraordinarily difficult question. He thought that many of them (presumably he was speaking of members of the Commission) would have been perfectly satisfied with the opinion, certainly of two medical men, if not in many cases of one medical man, but they had to consider the prejudices of the public, and the public's point of view was that the medical man was a person who was only too ready to certify, and without reason. The fact that the one object of the doctor was the treatment and benefit of his patient was not recognized in that simple form by the general public, which desired the intervention of a magistrate or some other judicial authority, who represented what they called the liberty of the subject. If the judicial authority could be dispensed with things would, no doubt, go on perfectly well; the real safeguard for patients in England was the Board of Control, which consisted of well informed people with ample powers and opportunities of inspection and control, who could perfectly well put an end to any improper detention. They were really of very much more use than any judicial authority. He regarded the suggestion made by Dr. Menzies that members of the mental hospital committee should be appointed the judicial authority as absolutely fatal. It would add to the suspicion already entertained that they were "all in the same gang." What was wanted was to satisfy someone from outside who was independent. He thought it undesirable also that the justice should be a person with medical knowledge. It was not the business of the justice to form a medical opinion, and it ought not to be his business. He had to consider the medical opinions which had been formed by competent people, and it was not for the justice to say from an entirely imperfect and incompetent medical diagnosis of his own whether a patient was sane or not. All he had to ensure was that care had been taken and the thing was in order. When the Commission referred to the "directed discretion" of the justice it rather meant that there were certain matters to which the justice ought to direct his attention as a matter of course in every examination he made and every certificate he gave—that is to say, he should not be left at large to perform his duties in a slovenly manner. The objections to anything like a public trial had been pointed out. There were the gravest objections to a public or a private trial in the ordinary forensic sense of the word. But the Commission received the strongest representations from those who claimed to speak on behalf of patients and ex-patients that they did desire, at some stage or other, to state their case. It was well known, of course, that the paranoiac would state his case with great volubility, and it would not further matters; but it was felt that the less the proceedings took the form of anything like a forensic contest the better. It had been suggested that the voluntary patient should continue to be treated as a man who had no volition at all. That might be a lawyer's point of view, but when it was said that a man was doing a thing voluntarily it carried a certain obvious meaning, and a man was not doing a thing voluntarily if he did not know that he was doing it. If voluntary treatment was to be made really successful the public must not be frightened into it. It was true that a voluntary patient would have moments of rebellion, in which he would say he was not going to stand it any longer; and it was to meet those moments that a delay of seventy-two hours was suggested. If voluntary patients were to continue to be treated as such when they became non-voluntary the advantages of the voluntary system would be destroyed. He would be very glad if public opinion in England would allow much greater freedom in the treatment of the insane; certainly that would be to the advantage of the insane, but the prejudice of which he had spoken had to be remembered. If any contribution were to be made to legislation, when it came—and he agreed that there was no chance of it this year, and he feared no chance of it next year—this

prejudice would have to be reckoned with and improvements would have to be sought in a way which would not leave the medical man with complete control. With regard to the urgency order, it had been suggested that justices should always intervene before the patient was removed to an asylum. It was obvious that it was not always possible to wait for the justice to intervene before the patient was restrained. The patient in some cases had to be restrained instantly. The liberty of the subject was maintained by the provision that a doctor or justice must see the patient within three days, but instant restraint might have to be applied. He was rather of opinion that the urgency order was employed where it often was not necessary, and it was very important that the urgency order should not be abused, otherwise it might not be available for cases where it was properly wanted.

Sir DAVID DRUMMOND (also a member of the Commission) said that Lord Russell had fully and admirably expressed his own views. It had been a great pleasure to him that the Report of the Royal Commission had been on the whole so well received by bodies of professional opinion, but he was sorry the Commission had found itself unable to safeguard the position of the medical practitioner more than it had done in that report.

Sir FREDRICK WILLIS (Chairman, Board of Control, England and Wales) said that some scepticism had been expressed as to whether legislation was really in view, but he happened to know that the Government was quite seriously considering the matter, and the Minister of Health was anxious, during his term of office, to pass a new lunacy law. In view of this, he particularly welcomed the present discussion, which would be of assistance in formulating proposals or a memorandum for the Ministry. Politicians were necessarily governed by public opinion in these matters, and a Minister might well hesitate to put forward what seemed to him and his advisers the best course if he knew that owing to the attitude of the public it would be rendered impracticable to carry out. The public were still very superstitious, and to some extent had not got away from the view of lunacy which was held a hundred years ago. He was anxious to avoid all formalities in the treatment of the insane so far as this could be done, but though these legal formalities deterred people from getting treatment, this was not the whole deterrent. They were deterred also by the fear lest, should they once consult someone for mental illness, they might be locked up for the rest of their lives. The Royal Commission divided patients into two classes—the voluntary and involuntary. As to the voluntary there was nothing to be said. The Commission had recommended what a good many had urged for years—complete freedom. The Board of Control felt that patients ought to be divided into three classes—the voluntary, the involuntary, and the unwilling. The ground for this was the well known fact that people did not come sufficiently early for treatment. Indeed, under the lunacy law, the rate-aided case could not get treatment at all at the public expense until after certification. One of the proposals in the new Lunacy Bill would be to give lunacy authorities perfect liberty to arrange for early treatment, and, if the case was voluntary, without any justice coming in at all. He thought the Royal Commission might have gone even further in this direction, and so have done much to educate public opinion in regard to the early case. In his view adequate safeguards were forthcoming without the justice; the only reason for bringing in the justice was because the public believed that it was a measure of protection. The Board of Control recommended that involuntary patients in need of early treatment should be received into institutions or homes which the Board had previously approved as suitable places for giving such treatment, and that the Board should be immediately informed of the reception of such cases, and should have a right to visit the institution from time to time whenever it was thought necessary. Such safeguards, he thought, would be quite adequate. Under the present arrangement—he spoke as one who had seen a good deal of the work of the justices in connexion with this matter—

he could not help thinking that there were no safeguards at all in a very large number of cases. If the safeguards were adequate to the treatment of these cases he did not see why the treatment need necessarily be limited to six months as the Royal Commission recommended. Many of these cases ran for eighteen months or two years. Why, if they were under proper treatment, with proper safeguards, should they not be allowed to remain on for that period? He did not quite see why any limit of time was needed. Another point which was exercising the minds of the Board was, What further protection should be given to the doctors? He had been very much distressed over some of the cases that had come recently into the courts. He could not help thinking that the jury, in England at least, was an absolutely unsuitable tribunal to test cases of this character. There was a notorious case in which, after a lapse of about twelve years, a trial took place lasting three weeks. Right through the trial it was obvious that the jury were in great sympathy with the patient—they were always against the doctor—and they decided that, twelve years ago, when the patient was certified, he was not insane. It seemed to the speaker rather absurd, and he hoped that some really constructive suggestions might be forthcoming with regard to that. His own feeling was that that sort of question should be taken out of the province of juries. If it were left to the judges of the High Court much greater justice would be done. In these cases it was usual for "experts" to come in, and it had been rather distressing to see the sort of evidence given by one doctor against another doctor. He wished the British Medical Association or the Royal Medico-Psychological Association would make some suggestions on this matter. On the question whether there should be two certificates or one, there was a financial consideration—namely, that in England it would cost £20,000 a year more to have two certificates for the rate-aided cases instead of one certificate. This was not an indifferent sum; it would be another matter if the safeguard was proved to be necessary, but no case was brought before the Royal Commission in which wrongful detention was established. The only purpose of the two certificates was to satisfy public sentiment. In conclusion, he felt that it was extremely important that all should do what they could to break down the superstition which existed in regard to mental illness. That was the rock on which the ship foundered every time.

Sir ARTHUR ROSE (Chairman, Board of Control, Scotland) confessed himself a whole-hearted admirer of the findings of the Royal Commission. He looked upon the report as a very valuable strategical contribution to this great subject. When he and Dr. Marr gave evidence before the Commission he gathered, from the questions asked, that there might easily be a very marked divergence of opinion among the Commissioners, and he was immensely relieved and somewhat surprised to find that the report of the Commission was unanimous. The reason for that unanimity was probably that the Commission went only so far as it was believed the public was likely to accept. If a more progressive view had been advanced there would have been a risk of a minority report, and possibly a somewhat strong report, which would have done much to retard any progressive legislation. He urged that any legislation which was proposed should be considered sympathetically by medical bodies, and he did so to a certain extent with a selfish object in view. In Scotland certain amending legislation was required, and while he saw no possible chance of Scotland going forward with an amending Act of its own, he was very hopeful that if a reasonably progressive measure were passed in England Scotland would be able to follow, not necessarily adopting the same measure, but perhaps going a stage further than England would have gone.

Dr. C. O. HAWTHORNE said that he had no title to speak on this matter as an expert in lunacy administration, but he happened to have been a member of the committee appointed by the British Medical Association to prepare the Memorandum of Evidence submitted to the Royal Commission, and subsequently to examine the Commission's report. What he had to say was without prejudice, he

hoped, as well as without intimate personal experience of the carrying out in actual practice of the provisions of the lunacy law. It was therefore with considerable sympathy as well as pleasure that he had heard the speech of Earl Russell, who had brought the discussion down from a somewhat academic level to the actual and practical situation. He had learned, in studying this subject under such conditions as he had defined, that certain broad views had to be considered in dealing with the situation. The first which impressed itself upon him was the severe interpretation attached in the public mind to the certification of a patient. This was an aspect of the subject which had to be most carefully considered. It had been suggested that the Board of Control was sufficient; but that Board arrived upon the scene too late. The stigma had already been inflicted by the certificate, even though the certificate was reported in a few days to have been unnecessary. Even looking at it from that narrow and practical point of view, the very serious nature of the step taken in granting a certificate could not but be admitted. A second impression made upon his mind by the studies and inquiries which were incumbent upon him as a member of the Association's committee was the great importance which was attached, at least in England, to the protection of the liberty of the subject. The propositions put by Lord Russell commanded the whole situation so far as legislation was concerned. The third consideration which he had to bear prominently in his mind was the position of doctors throughout the length and breadth of the land in respect to lunacy certification. There was a reluctance to sign certificates; even, in a considerable number of cases, a determination not to sign them. Deeds of partnership between doctors were being drafted one of the conditions in which was that neither partner should sign a lunacy certificate. It might be that this was a stupid view, but when it was said that sentiments widely spread must be respected in practical legislation he claimed that here was a body of sentiment which must be so respected. There were two positions, and only two, which could be logically defended when considering lunacy from the point of view of the doctor's relation thereto on the one hand, and on the other from that of legislation. It was quite a defensible position for doctors to make the claim that mental disorder, like physical disorder, was a medical matter, and that doctors alone were competent judges. That was a position which could be argued, but it involved a process of education of the public which, as had been generally admitted during the discussion, was very far from accomplished. The other position, which was a sound one, was that the State came in and said, "This is a form of medical diagnosis and treatment which invades the liberty of the subject, and we will not allow medical treatment of that kind to be imposed until we are satisfied that such treatment is necessary." When the State had once said that, it was for the State to say what was the legal machinery by which the State itself could be satisfied that this treatment was essential. The State might ask the advice of the profession, but it was for the State to accept the responsibility necessarily imposed upon it when it declared that this was a matter in which medical treatment should not take its normal course until the State was satisfied that it was necessary. His claim was that when the State had once stepped in and assumed authority, the State must at the same time recognize that it assumed responsibility. The doctors might be asked for advice, for their opinion upon the whole situation, or upon the particular case, but that was simply a contribution in the shape of evidence towards the solution of what had now been made a legal issue. If that was the true position, then manifestly the doctor ought to have in this issue the immunities which were enjoyed by other witnesses. Dr. Risien Russell had urged that the doctor ought to give not merely a certificate, but an opinion under the sanction of an oath. But why did he not do so now? Simply because the representative of the law did not call upon him to do so. Under the existing lunacy law it was competent for the justices to require that everything should be on oath. There was a choice, then, between these two alternatives: Was the medical profession to go to the public with the high academic doctrine that this whole matter was a matter for doctors, or was it going to say,

"No, we recognize the intervention of the State for determining whether this treatment ought or ought not to be applied, but the State must accept the responsibility, and must not allow that responsibility, which carries penal consequences, to be imposed upon the shoulders of the medical practitioners who have given you an opinion in the case?"

Dr. C. HUBERT BOND (Commissioner, Board of Control, England and Wales), after remarking how pleasant it was to find that all his colleague Sir Frederick Willis had said appeared to commend itself to the meeting, said that in 1884 the Earl of Shaftesbury was still chairman of the Lunacy Commission in England. Mentally he was as alert as ever, and devoting nearly the whole of his energies to the welfare of the insane, but he was in failing bodily health and feeling the weight of fourscore and five years. At that time a section of the public was suffering from what might be called an anxiety neurosis in mass form, manifested by a fear of wrongful detention for alleged mental disorder, just in the same way as when the recent Royal Commission was appointed. As a result of the feeling which was so much in evidence a motion was carried in the House of Lords for the institution of a committee of inquiry into the administration of the Lunacy Acts. It was not intended as an attack on the Lunacy Commissioners any more than was the institution of the recent Royal Commission, but the great-hearted Earl was hurt to the quick. He knew and felt the complete integrity of his own department, and he felt also that, to use his own words, "God had manifestly blessed the efforts of the Commission." He wrote also that he had "everything on his side except self-confidence in his own power to meet" what he felt to be a charge, and that "the defence would be perfect in any other hands." He saw in the drift of such an inquiry and in the legislation proposed to follow it, especially in the proposed intervention of a justice (again to use his own words), "the labour, the toils, the anxieties, and the prayers of more than fifty years being in one moment brought to naught." So far as Dr. Bond knew the history of those days, Lord Shaftesbury had the support of each of his colleague Commissioners, legal as well as medical, and of all the leading medical men practising psychological medicine. The depth to which Lord Shaftesbury's emotions were stirred had its echo in the prayer he was not ashamed to record in his diary: "Cast me not off in the time of old age; forsake me not, O Lord, when my strength faileth." No one could read or listen to the recital of that prayer without reverence and respect. To Shaftesbury, though a layman, the proposals, especially the intervention of the justice, were anathema, and he took the strong step of resigning the chairmanship of the Board of Commissioners. This was in May, 1884; but in June, upon a hitch arising in the setting up of the committee of inquiry, he was induced to withdraw his resignation. Death, however, withdrew him from the fight shortly afterwards. It was at least permissible to speculate whether, had he been spared, and with sufficient bodily powers to play his part in the fight when it did come, the intervention of the justice would ever have been carried. At any rate, inured to the justice, as in a sense were those who worked in England, they could not listen to Professor Robertson's magnificent and virile appeal to their medical instincts without desiring to pause and ask whether it was yet too late to relieve the justice of a task for which the majority of justices had no love or even taste. It might be that if the uninformed part of the electorate, whose importance Lord Russell had emphasized, really knew these and other cognate historic facts, knew of the absence, as found by the Royal Commission and other inquiries, of any cases of improper detention, and could hear or would read Professor Robertson's presentation of the medical needs and the medico-legal aspects, they themselves would give a swing to the pendulum in the direction of *Res floreat medicinae*.

Dr. VERNON BRIGGS (Boston, Mass.) said that his excuse for speaking in the discussion was that he had served in Massachusetts as a member of three different boards concerned with mental disease and under three

different political administrations. He was now on the advisory committee of the State Commission of Mental Diseases. He had followed the discussion of this subject in the medical journals of this country, and he was hoping that England would go far beyond what it had been possible to accomplish in the States. He thought that the experience in the States might offer some suggestions towards the solution of the problem here. In the States the medical societies set themselves to educate the public, and had invited the magistrates to give addresses which were followed by discussion in which the medical men represented their side of the question. This had been of great value to the magistrates and indirectly to the public. Another point in the education of the public had been to endeavour to set in its proper and less alarming perspective the hereditary factor in insanity, with the consequence that the people were not so much alarmed or depressed by the notion of hereditary taint as was the case ten years ago. An investigation had been made of 28,000 certified cases in mental hospitals extending over forty-two years, and the hospital records of these cases showed that in only 54 per cent. was there an hereditary factor. In other words, a man who had mental disorder was as likely not to have had a tainted ancestry as to have had it. These were facts beyond dispute, and the education of the public along these lines helped to bring about a better state of feeling. With regard to certification, the plan was for two physicians to certify cases which were considered dangerous to the public or to themselves or to need medical treatment. There was such a thing as voluntary commitment, whereby the patient could go into hospital for any length of time, so long as he did not become irresponsible. A system of six months' parole, which could be renewed for a further period, was in force for patients who had recovered up to a certain point, and such patients could be, if necessary, returned to the hospital without any further legal procedures. The patients had not to be brought before a magistrate; it was true that the magistrates had a right to send for the patient, or to go and see the patient, but they hardly ever exercised it. Probably 95 per cent. of the patients committed were never seen by any magistrate. He could recall only one legal action by a patient against a physician—it was in New York—and though the jury awarded a certain amount of damages, the verdict was afterwards set aside on the ground that certain of the evidence was inadmissible in law. The opposed testimonies of medical men relating to the same case in criminal actions had caused some perplexity, and an effort had been made to eliminate such occurrences by discussions. One result had been that in the case of criminals who had been to gaol before and criminals arraigned on a capital charge there was, before trial, an examination by the State Commission of Mental Disease. A law to this effect had now been in force for five years in the State of Massachusetts. The clerk of the criminal court was bound to report the case to the Commissioners of Mental Disease, and the Commission appointed two alienists of standing to examine the alleged criminal. Their report was filed by the clerk of the court, and was open to both sides—the prosecution and the defence. In the five years during which this plan had been in operation there had been no case for trial before the courts in which medical men had appeared against each other in the witness-box; previously it was a constant occurrence. The result had been to raise the position of the profession. He hoped to learn something from this country as to the treatment of the early case. In his own State a sum of £20,000 a year was now being appropriated for clinics to which early cases could be sent. The Legislature felt that the money was well spent, because cases might so be prevented from becoming a burden for many years upon the State.

The CHAIRMAN (Dr. Marr) said that owing to the lateness of the hour he was now compelled to close the discussion although there were several others who had intimated their desire to speak. Dr. MORTLOCK-BROWN protested against the closing of the discussion, to which, she thought, a whole day might well have been allocated; the voice of the general practitioner had scarcely been heard; and the woman's point of view had not been put

forward. The CHAIRMAN said that he regretted very much having to close the discussion, but he pointed to the lateness of the hour and to the fact that the audience was rapidly thinning. He had selected the names of speakers in the order in which they had intimated their desire to speak, except that he had called upon two or three others who, because of their position or work, he thought everyone would wish to hear.

SECTION OF THE HISTORY OF MEDICINE.

JOHN D. COMRIE, B.Sc., M.D., F.R.C.P.Ed., President.

A VINDICATION OF THE SECTION.

THE PRESIDENT remarked that this was the first occasion on which a Section of the History of Medicine had been held at an Annual Meeting of the British Medical Association. He had had many letters from persons in this country, on the Continent, and in America, expressing their approval. At the present time no medical school in Great Britain required its students to learn the history of the subject, and there were only a few at which it was possible for the student who desired it to obtain such instruction. This was remarkable in view of the fact that a knowledge of ancient law was necessary for the training of a lawyer, while Church history was considered essential to the theologian. Even in practical sciences like chemistry, physics, and engineering, a knowledge of when and by whom the various laws and facts of their sciences had been discovered was regarded as a necessary part of the study of the chemist, the physicist, and the engineer. He would go so far as to say that in connexion with even so common a disease as pneumonia the doctor would be likely to treat his patients more successfully if he knew something about the history of this disease, and if he had some inkling as to why some measures of treatment had been abandoned while others had persisted. The office-bearers of the Section had decided at this first experimental meeting to regard the subject from a practical rather than from what might be called the antiquarian standpoint, and they had accordingly arranged for a discussion on "The historic evolution of disease."

CLINICAL VARIATIONS IN DISEASE FROM THE HISTORICAL POINT OF VIEW.

SIR HUMPHRY ROLLESTON, Bt., K.C.B., M.D. (Regius Professor of Physic in the University of Cambridge), opened a discussion on this subject by reading the following paper:

This is the first time that a section has been devoted to the History of Medicine, and the exertions of our President, who is Lecturer on the History of Medicine in the University, to bring this about in a city with such high traditions in medicine have most appropriately been crowned with success.

A discussion on "Clinical variations in disease from the historical point of view" is also singularly appropriate in the Northern Athens, where it was the subject of much high debate some seventy years ago. W. P. Alison and Robert Christian were convinced that a change in the clinical manifestations of disease had gradually taken place during the first thirty years of the nineteenth century, whereas John Hughes Bennett, who in 1848 succeeded to the Professorship of the Institute of Medicine, which Alison had held from 1822 to 1842, Allan Thomson intervening, was emphatic in the opposite direction. On January 21st, 1857, Hughes Bennett read a paper before the Medico-Chirurgical Society of Edinburgh on "Observations on the results of an advanced diagnosis and pathology applied to the management of internal inflammation, compared with the effects of a former antiphlogistic treatment, and especially of blood-letting," which aroused much adverse criticism from Alison, T. Watson, and W. T. Gairdner, to which Hughes Bennett promptly replied. He considered that the supposed change from a sthenic to an asthenia