the erect posture, and that racial and climatic influences are not potent. Coast fishermen and labourers standing barefooted in water or mud are usual victims. Their posture, liability to skin inflammation from changes of temperature and checked secretions, and spanemic state from lowly nitrogenised food and malaria, afford all the conditions favourable to lymph production, stasis, and blockage. Elephantiasis is more frequent in Ireland than in England, and with us factors like those just named exist. The evidence seems complete that this hypertrophy of every tissue arises from over-supply of lymph, over-produced or stayed in its flow. Pathological changes in some other lymph-abounding parts are somewhat analogous—for example, recurrent tonsillitis leaving much enlargement and macro-glossia. Phlegmasia dolens again presents some likeness, differing however in its acuteness, non-recurrency, and the entire resorption of the effused lymph.

If posture has, as contended, much to do with the production of elephantiasis, elevation, friction upwards, and compression with elastic bandages, should be hopeful measures during the stage of inflammatory oedema.

Since the above was written, Mr. Hutchinson's last fasciculus has been published. That profound pathologist states: "As favouring the production of elephantoid conditions, it is almost essential that the part affected should be pendulous, or, as in the case of the lower extremity, at a hydrostatic disadvantage in reference to its circulation."

OPERATIONS UPON THE FOOT VIEWED FROM A MECHANICAL STANDPOINT.

By BRIGADE-SURGEON C. H. Y. GODWIN,
Assistant Professor of Military Surgery, Army Medical School.

ONE of the advances of modern surgery is illustrated by the manner in which useful portions of the foot may be saved both after injuries and in disease; and so much attention has been given to this conservative treatment of the foot, that the operations performed by surgeons have come to be various in their nature, but all dominated by one thought—namely, "the least possible sacrifice of parts," or, in the language of Mr. Bryant, "that no more of the body should be removed than the necessities of the individual case require." With such principles to guide us, I was somewhat startled by reading in a work called "*Artificial Limbs and Amputations*," the following statements.

"It is better to remove the entire foot than to perform any such operation as Hey's, Lisfranc's, or Chopart's, for in all these the heel is left, but in front of the heel remains a portion of the foot of greater or less length which is absolutely useless, and is very much in the way of any mechanism which may be devised with the purpose of restoring artificially the tread that is so necessary for natural walking. These operations through different parts of the foot should, therefore, become obsolete from a mechanical standpoint."

"The foot is," the author says, "a lever with its trio of essentials, of which the ankle-joint is the fulcrum, the tendo Achillis is the representative of power, and the tread the recipient of the weight. If the tread is lost or incapable of action, then the trio is dissolved, and the lever no longer exists; the foot ceases to be of further service, is an impediment, and is best removed."

"The tread of the foot depends upon the great toe as a whole, not only on the ball of the great toe, but also on its continued phalanges. As a rule, therefore, removal of the great toe, whether with or without its metatarsal bone, ruins the tread of the foot. If all the toes are removed, the tread of the foot is lost, and experience has shown that it is better therefore to remove the whole foot."

"Whenever the natural foot cannot be preserved in such intactness as to act perfectly as a lever of which the tread, ankle-joint, and tendo Achillis are respectively representatives of weight, fulcrum, and power, it is better to excise it, and replace it by an artificial lever, with correct representations of these parts."

"The best stumps for the application of an artificial limb are afforded by Syme's or Pirogoff's method."

The principle involved in these remarks is that in the case of injuries and of disease of parts of the foot, instead of merely removing the injured or diseased part, the surgeon should remove the whole foot if it is a case where the natural tread would be spoilt, cases involving the fourth and fifth toes with their metatarsal bones not being here considered.

This seems to be an extreme measure, involving a practice and a principle difficult for surgeons to accept; it is one,

also, in which I should think the patient should be consulted. For example, in crushes of the fore part of the foot, including, perhaps, all five toes; or, again, in cases of disease necessitating, for instance, the excision of the first metatarsal bone, could it be right to remove the whole foot because no complete mechanical appliance can be fitted to the remaining stump? In a case that occurred last year, I removed the great toe for necrosis, and afterwards the metatarsal and internal cuneiform bones of the same foot for caries, the patient recovered, the foot was not greatly deformed, yet he had lost the natural spring of the proper tread of the foot, though he could get about with facility. Now this man was content, I think, with his deformed foot, as he could walk upon it without any expense attending any artificial contrivance. But supposing his social status to have been different, and his private means ample, would the removal of his foot have been in any sense proper without his own concurrence?

It would seem that operations done to suit mechanical apparatus and not surgical necessity must always be operations more or less of convenience, and the case would then formulate itself something in this way. An operation is necessary; it can be done by removing a part only of the foot, but it will leave the patient with an odd-shaped and deformed extremity, upon which he will, doubtless, be able to walk, but to which no perfect artificial aid can be fitted; on the other hand, if he have the whole foot removed, a more or less perfect substitute can be fitted which will, both in progression and in appearance, be like a natural foot. A difficulty here at once presents itself in cases of severe injury. Say, for example, that of an officer shot through the foot. A calm review of the case by the patient is impossible, and he gives himself up to the surgeon in all confidence that the best will be done for him. A Hey's or a Chopart's operation would meet the case, but the surgeon knows that if this is done the mechanician will subsequently tell the officer that he cannot give him an artificial foot, but that if the surgeon had only performed a Pirogoff or a Syme, then he could give him a more or less perfect substitute; yet I apprehend if such operation had been done, it might have been considered a very extreme method, and certainly would have been a course directly opposed to the axiom of "the least possible sacrifice of parts."

In the poorer classes of society, to remove the whole foot by performing a Pirogoff or Syme when a Hey or a Chopart would suffice would, I think, be culpable on the part of the surgeon, as all artificial mechanical apparatus is expensive to buy in the first instance, and expensive to both repair and replace, and patients can usually get about very fairly upon the stumps formed after partial operations upon the foot. For the more perfect apparatus the more extensive operation may be necessary, but I would submit that it should not be done, even in the case of the wealthy, without the full consent of the patient, given after a proper explanation.

NOTES ON STROPHANTHUS.

By K. N. BAHADHURJI, M.B., B.S. LOND.
[From the Pharmacological Institute, Berlin.]

SINCE Professor Fraser introduced strophanthus as a valuable cardiac remedy, it has been much taken up by clinical observers, and various results have been from time to time recorded. In connection with clinical observations, notes of experimental work may prove interesting and useful. The following is a summary of the chief results of a series of experiments carried out by me at the Berlin Pharmacological Institute, with Dr. Langgaard's co-operation. A full account, with interpretations of the results, will be given later on. For simplicity, the drug's action may be considered in relation with the various systems separately, beginning with the heart and circulation.

In frogs, large doses send the heart into a tetanic spasm, preceded by an initial vigorous action. Smaller but toxic doses strengthen the contractions at first, and produce an irregularity in rhythm before the beats are reduced in number by one-sixth. The ventricle contracts firmly at each systole, and has an increasing tendency to disallow a full relaxation, so that the heart fills less and less at each diastole. In cardiac tracings one sees a steady rise of the foot of the curve from the base line. The sinus presents an increasingly gorged appearance. There is no gradual slowing of the pulse, but soon the ventricle shows a peristalsis, as if a cramp was passing over the cardiac muscle, and the moving of blood in the ventricle seems very much like the writhing of worms. At last the ventricle stops in systole, and is quite small beside the gorged sinus. Once the spasm of the ventricle begins, there is complete closure of the apex, and this firm contraction travels

upwards, so that the blood has to traverse decreasing portions of the base of the ventricle. Physiological dose reduces the number of beats to one-half, and makes them more forcible—the heart fills well and empties well. There are no irregular and peristaltic movements observed, and the pulse soon resumes its normal frequency and force.

With an isolated heart the effects are exactly the same, only the first irregularity in rhythm is not observed, and the whole series of changes are delayed.

On cutting the vagi as soon as the first slight slowing with irregular rhythm sets in, the heart beats rise in frequency and lose their irregularity; but after a time the late phenomena of cramp and final stoppage in systole are obtained as before. It is worthy of mention that when removed from the vagus influence the heart takes long to be affected, and is able to bear larger doses than otherwise, and each physiological dose requires to be made stronger at every repetition.

Injection of atropine after toxic doses of strophanthus causes only a few passing blushes in the shrivelled up white ventricle. Reversing the experiment and giving strophanthus when the heart is brought into a dilated condition by atropine, the systole gets more vigorous, the dilated appearance vanishes, and later the cramp and systolic stoppage follow. Here also the initial slight slowing with irregular rhythm is not observed.

In rabbits very much the same thing is observed. With the initial slight slowing is always associated an irregular rhythm. Then follows an excessively irregular pulse—a few quick beats followed by slow and scattered ones—and then comes a pause before the heart flutters again. The pause is at times for half a minute. The heart finally stops in systole, the animal in some cases lying utterly prostrate, in others convulsed before death. The respirations stop later on.

Cutting the vagi removes the irregular rhythm and raises the beats to normal, enables the heart to bear large doses of the drug before it stops in systole; there is no slowing of the pulse, but the heart has many pauses before it makes a sudden stop in systole.

The heart tracings are different from those taken with digitalis, and from the latter strophanthus differs also in having a marked central effect on the vagus.

On the vessels the effect is not constant. So far they seem to be contracted under its influence, but further experiments are being made to arrive at definite results.

Blood-pressure tracings show no appreciable rise. Just before the death of the animal there are sudden rises after a fall below the abscissa.

Respirations are at first increased in frequency, but later are less frequent, and become deeper and markedly dyspnoic; the abdominal respirations gradually sink to *nil*, and the thoracic rise concurrently till a purely thoracic breathing is established.

Diuresis is not very marked in healthy animals. Experiments with insertion of cannula into the ureter after induction of complete anæsthesia and vaso-motor paralysis, by chloral hydrate, show at most a doubling of the number of drops in a given time. It is peculiar that when the nervous symptoms are most marked the diuresis is much freer. Further investigations with artificial renal circulation are being made, and the results will be given in due course.

The nervous system is markedly affected by strophanthus. At the outset the question of a secondary influence only through the heart and circulation may be set aside from the fact that in small doses, before the heart is appreciably affected, nervous symptoms are to be observed. In other cases the heart is not at all affected.

The rabbits remain quiet, and invariably drop their head, with eyes shut and resting mostly on one side on the outstretched forelimbs. They get hyperæsthetic in the hind-quarters and trunk, and show a weakness in the fore-limbs, which passes into complete paralysis. When touched, the head is thrown back, and from time to time it is maintained in that position; the hyperæsthesia gradually vanishes, and the hind legs get weak and at first lose power of flexion, and later that of extension, and remain completely paralysed. The symptoms persist for hours together, and if the dose be not a lethal one for the heart, the animal gradually regains sensation and motion. In one most curious case the paralysis was followed by tetanus, in which the animal remained for three days, the heart being not the least affected.

In the frog, the symptoms are the same, whatever the dose, only they differ in the time they take to develop. At first the frog is frisky and restless. There is hyperæsthesia, so that a prick of one foot excites twitchings in the back muscles and jerking of the opposite leg. Later, it remains quiet, as if hypnotised; it shows a general weakness; it has lost its natural leap, and falls flat on its abdomen; its movements are slow and sluggish; it has to stretch its limbs about as it moves, and looks like a crawling crab; it has a tendency to move

on one side; the leg is moved a few seconds after a prick (delayed sensation!); then supervenes loss of flexion in the limb and abolition of reflexes; the latter is well seen by means of Turke's experiments. Later, extension is also lost, and complete paralysis ensues. It always gets blown out, and on squeezing out the air it gets blown out again, and remains so till death. With a dose that does not affect the heart, the frog shows, after four hours, a waddling gait, with delayed sensation, and, later, a passing paralysis.

Electrical tests give the following results:

1. Stimulation of peripheral end of the sciatic gives only a slight flickering of the muscle with very strong currents.
2. Stimulation of the muscles themselves shows strong contractions with moderate currents, but weak currents are ineffectual.
3. Stimulation of the central end of the sciatic causes no contraction in the opposite leg with the strongest currents, and that is also the case when the artery is tied in the opposite leg.
4. Stimulation of the peripheral end of the sciatic on the ligatured side produces a better marked contraction than the flickering without ligaturing the artery, as in 1; and with strong currents the leg is distinctly moved.
5. The muscles also respond better on the ligatured side.

The striped muscle, when placed in a watery solution of the residue of alcoholic tincture, gets contracted and pale, and is increased in consistence. Experiments on intestinal peristalsis are not yet complete enough for definite statements.

SECTION OF PSYCHOLOGY.

[Continued from page 508.]

Our Laws and Our Staffs.—Dr. OSCAR WOODS read a paper on the above subjects. Having referred to the fact that thirteen of the Irish asylums had no assistant medical officer, he drew attention to the forms of admission; the ordinary form in 1865 was only used in 862 cases, while the criminal warrant was used as a mode of committal in 1846. The objections to handing nervous and diseased patients over to the care of the police was very great; it frequently originated or increased delusions. This Act of 1867 was drawn up on the line of the Act of 1837 (1 and 2 Vict. c. 14), and while only one patient was committed in England in 1885 on this Act, 1,846 were sent to asylums on the Irish Act. No one was made responsible for inquiry as to the state of a supposed lunatic, unless an overt act had been committed, and as a consequence dangerous lunatics were allowed to remain at large, a source of danger to themselves and to the public; last year a man was allowed to murder his wife, although manifestly insane for some time, and a few days before the meeting a sad instance of the defect in the law occurred, when a lunatic murdered four people in the north of Ireland. On the other hand, feeble old women and harmless idiots were daily sent into asylums from the workhouses, the other inmates being only too ready to swear an information, in order to rid themselves of some slight responsibility. In addition to the injury to the patients, the superintendent was exposed to unfair risks when warrants were imperfectly filled; also, as the information given was the smallest possible, the statistical returns were not as valuable as they otherwise would be. With regard to the staff, much stress was laid on the responsibility of the appointments being taken out of the hands of the superintendent, and quotations were made from Kirkbride, on *Hospitals for the Insane*, to show the absolute necessity for leaving all appointments to be dealt with by the superintendent: the appointment of better educated attendants was advocated, and a hope expressed that ladies would before long be found in the wards of asylums, to undertake the moral care of the patients.—Dr. RINGROSE ATKINS said: I have listened with much interest, as I am sure all present have, to Dr. Woods's paper. We here, in Ireland, are of course more directly concerned with the subjects introduced than are our brethren in England and Scotland; but still, points have been raised which must be of interest to all. In the first place, Dr. Wood has touched lightly on the question of assistant medical officers. We are all agreed, I doubt not, on the necessity which exists for such, but while the office of visiting physician exists in the Irish asylums, we cannot, I think, hope to see such officers appointed in the smaller asylums, and at the present time the visiting physician is regarded by many as a kind of connecting link between the public outside and the patients within the walls of the asylum. As regards the Irish Lunacy Laws, I, in common with Dr. Woods, entirely disapprove of the provisions of the 30 and 31 Vic. cap. 118, as I do not consider it just or right that any patient who may become afflicted with mental disease should be regarded as a criminal, and treated as such, and that the asylum physician should be constituted his gaoler. As regards the use of these Acts, I would point out that the practice differs widely in different districts; in

some, as in the district with which I am connected, facilities are afforded for the admission of patients on the ordinary or "house form," and the Act referred to is not very frequently had recourse to; it is a matter for deep regret that such little or such incorrect information is supplied to the asylum officers by the medical men certifying, or by the friends of the patient; this is, I believe, due to the want of knowledge of mental diseases on the part of general practitioners, in consequence of the little attention hitherto paid to the subject by our universities and medical corporations, and to the reticence on the part of the friends in disclosing the possible hereditary tendency to the disease, or certain other conditions which may be operative in its production. I consider that if further information was supplied on the ordinary form, and facilities afforded for its wider adoption, that this method of admission ought to work satisfactorily. In reference to our staffs, I think Dr. Woods has rightly called attention to the very meagre wages paid to the attendants, and to the mode of their selection. In these points also the practice is different in different districts. In some districts the staff is much better paid than in others; while some boards of governors rigidly exercise the function of appointing the attendants, others delegate this in whole or in part to the medical superintendents. I am strongly of opinion that the attendants should receive a much higher scale of pay, and then men and women could be procured drawn from a higher class than that of the patients whom they are to supervise, and thus a greater moral influence would be brought into play. As matters stand, however, I consider it best to try and engage the services of local persons as attendants, as they may, from family or other considerations, strive to retain their places by good conduct, with greater zeal than if they were chance comers. Dr. Woods's paper is one of much practical interest, and I think he deserves the thanks of the Section for bringing it before us.—Dr. ASHÉ corroborated the views of Dr. Woods as to the disastrous results arising from the difficulties of obtaining admission of dangerous patients to asylums. He had known many cases in which life had been lost in consequence of delay. There was also grave danger due to the fact that patients, though not recovered, could be reclaimed by their friends, on simply giving a bond for £10 for their safe-keeping. Such a bond was perfectly valueless; and he had known suicide committed by such a patient within a month of his discharge. He suggested that discharges should be quarterly only, and that the judgment of the superintendent should be corroborated by that of an inspector, qualified by practical administration of an asylum as superintendent thereof to form a sound judgment on individual cases. He fully agreed that the superintendent should have the power of discharge of attendants, as no real control over the staff could otherwise be obtained, nor sound discipline maintained. He instanced some grave cases of dereliction on the part of attendants, in which the superintendent had failed to obtain the discharge of the offender.—Dr. CONOLLY NORMAN spoke very strongly of the anomalous position of medical superintendents in Ireland. The absence of any real interest in lunacy or asylum matters which existed in Ireland was at the root of all their difficulties. With regard to attendants, it appeared to Dr. Norman that it was of no use to give the superintendents further power in appointment of attendants unless it were accompanied by an increased power of dismissal. He mentioned some remarkable cases of refusal by boards of governors to dismiss unworthy attendants. In reference to the law of bail, he quoted a remarkable case in which an uncured patient who had been removed on bail proposed to go bail for another patient, and, although he was prevented from doing so, yet there was absolutely nothing in the law that rendered it impossible for one uncured lunatic out on bail to enter into recognisances for another who was still in the asylum.—Dr. URQUHART suggested that a committee should be appointed to consider whether a resolution should be brought before the Section, expressing dissatisfaction with the state of affairs affecting the resident medical officers of the Irish asylums, and of those under their care. He named as a committee Dr. Tuke, Dr. Yellowlees, and Dr. Woods, and moved accordingly. This was seconded by Dr. Drapes, and carried *nem. con.*—Dr. LYLE spoke of the great want in Irish asylums of assistant medical officers, and expressed an opinion that it would be a great improvement if the salary paid to the visiting physician could be appropriated for the payment of assistant medical officers. The appointment of the officers and staff should be entirely in the hands of the medical superintendent. Want of interest was at the root of the unsatisfactory manner in which the Irish asylums were managed. He suggested that Irish superintendents might invite their respective committees to visit English and Scotch asylums. He felt sure that such a visit would be attended by good results. He thought it rather doubtful whether the introduction of lady and gentlemen nurses to visit and

read to patients in asylums would be attended by any good. In his opinion better nurses and attendants could be drawn from the middle class and from agricultural districts. The information furnished by the relieving officers in England, when they brought patients, was almost as imperfect as that described by Irish superintendents; the information thus supplied must be taken with reserve.—Dr. WOODS, in reply, said: I have to thank all for the kind manner in which my paper has been received, and for the remarks made thereon. I do not consider house form "E" can be used more generally, as people living fifty or sixty miles from the asylum can scarcely be expected to delay the sending of an acute case by writing to the asylum for a form, and afterwards returning it before the patients can be transmitted; besides, this form, is, as a rule, imperfectly filled, and there is no authority to have it corrected. I do not agree with Dr. ASHÉ that a dangerous lunatic must be allowed home if friends give £10 bail; magistrates are bound to inquire into each case, and to give a patient up to the care of his friends, unless there is a reasonable prospect of his being properly looked after, without undue risk to himself and his neighbours, and should, in all cases, be a substantial bail. I feel strongly that frequent visits of ladies in asylum wards would be of much benefit, not as nurses, but as consolers and comforters to the mind diseased.

Private Treatment versus Asylum Treatment.—Dr. YELLOWLEES opened a discussion on this subject. In his opinion the question of whether any patient should be treated at home or in an asylum was not one of principle but of convenience, of medical judgment, or expediency. He pointed out in detail the various indications for asylum treatment and the various features of a case which might render treatment at home possible, prudent, or even desirable. Much valuable time was no doubt often lost through obedience to a silly prejudice against asylum treatment in cases where nothing else could be of any avail, but at the same time some consideration was no doubt due to the possible effects upon the patient's future, which would accrue from his having been confined in an asylum. In many cases nothing would effect a cure unless there were total separation from social and moral surroundings, either in themselves injurious, or acting injuriously on the individual patients. Dr. Yellowlees considered at some length the Scotch system of boarding out lunatics which may be regarded as an approach to home treatment, but free from many of the disadvantages of the latter. The success of the Scotch system Dr. Yellowlees attributed very largely to the constant care and unwearied exertions of the Scotch Commissioners and Assistant Commissioners. Where such laborious care could not be bestowed, such a system would probably fail to work satisfactorily.—Dr. TUKE could not agree with Dr. Yellowlees that asylums had an advantage over private care in the matter of trained attendants, as these might be obtained in the latter; nor as regards supervision was the advantage always in favour of the asylum, for in a medical man's house there might be ample supervision. He attached great importance to what Dr. Yellowlees had said as to the impersonal character of the authorities in asylums. The effect of this was sometimes most remarkable where private care had failed. He could distinguish more than Dr. Yellowlees had done both the forms of private care. The treatment of a patient at home was one thing, that in lodgings another; and again, that in a medical man's house quite another thing. He agreed with Dr. Yellowlees that each case must be judged on its own merits. Suicide cases, as a rule, he should prefer seeing in an asylum.—Dr. SAVAGE thought public asylums better than private asylums, from the impersonal character of the headship. The responsibility was more diffused and less interested. The superintendent could run risks for the good of the patient which a private man could not. A suicide was a worry to public officers, but might be the cause of ruin to the other, and, in consequence, suicidal patients were harassed by supervision. He thought patients were often sent out too soon from private care, for fear of being accused of acting from interested motives. Small private asylums were very useful.—Dr. OSCAR WOODS: We, in Ireland, can scarcely look on the question from the same standpoint as our English and Scotch brethren. I have no doubt whatever that in our country home treatment in all classes is most injurious to the patients; with better class patients frequent instances of most injudicious treatment have come under my observation, and amongst the pauper classes their treatment is ludicrous; their recovery is, in my district at all events, very hopeless when left at home more than a month. Patients, as a rule, are too soon discharged; relapses, I believe, seldom occur, if there is no hereditary predisposition, if the patient is detained a sufficient length of time after "apparent recovery." I believe in almost all cases progress goes on much longer than most of us imagine; delusion lies dormant, but completely absent for a considerable time.

Are Airing Courts, Locked Rooms, and Restraint necessary in Asylum Practice? By JOHN KEAY, M.B.—Fifty years have elapsed since what Conolly called the “non-restraint” system was adopted at the Lincoln Asylum. Mechanical restraint was abolished by Conolly himself in Hanwell Asylum two years afterwards. His example was followed by the superintendents of the English public asylums, and later by those of the Scotch Royal asylums. Little improvement in the treatment of the insane during the following fifteen years, either in England or Scotland. Scottish Lunacy Commission appointed in 1855. Condition of the insane in the Scotch asylums at that time. Nature of the accommodation provided, and methods of treatment employed. Great progress made during the fifteen years following. The experiment at the Argyll District Asylum. The airing courts abolished, and the patients employed on the asylum farm. Marked success of the experiment. Seclusion and restraint rendered unnecessary. The example of the Argyll Asylum followed by others in Scotland. Another step in advance made in 1875. The Barony Parochial Asylum at Woodilee opened, having neither airing court nor padded room, and conducted with open doors. System of treatment followed at Woodilee and the results. Restraint and seclusion unused. Freedom from excitement. Breakages and destruction to property correspondingly diminished. Low death-rate. High recovery rate. Alcoholic stimulants and sleeping draughts seldom required. Escapes and suicides uncommon. These results are obtained by open doors, freedom from all restraint, and regular employment. The existence of such asylums as Woodilee is the strongest possible argument against the use of airing courts, locked doors, and restraint. Why has not this “open-door” system become the universal mode of treatment? The difficulties in the way, a greater amount of land required, and a better class of attendants, than under the old system of treatment. The attendants must work with the patients, and not stand by like prison warders. Patients in pauper asylums are easily induced to work on the farm, even those drawn from large towns who have never done such work before. More difficulty in inducing private patients of the upper classes to similarly occupy themselves. How it has been accomplished in some asylums with great benefit to the patients. The necessity for further development of this feature of modern asylum treatment. Useful employment is of much greater value than amusements in the treatment of the insane. The arguments used in defence of airing courts, seclusion, and strong clothing are practically the same as were used half a century ago in defence of strait waistcoats, handcuffs, and leg-locks.—Dr. GASQUET: The uncompromising defence of open doors and total absence of all restraint is particularly interesting just now, when there is a certain amount of reaction against restraint. I should desire to know the numerical proportion of attendants in open-door asylums; and other details of the method.—Dr. SAVAGE: If the principle is true, asylums are of no use. Removal to asylums is restraint. For acute cases we must be willing to try anything that is best. Dr. Keay is at present in the young and prophetic stage; he will get over this. The principle of non-restraint is good, just as the young man with the banner with the strange device, “Excelsior!” ended disastrously, but his motto has aided other young men to useful effort. So with the non-restraint motto. I think we want a definition of the term non-restraint. As to locked doors, surely a man at the door is as much control as is a key. I believe honest effort to give treatment is what is needed. Surely some insane patients are ill, and require treatment, just as typhoid cases. I prefer to see the patients to knowing that they are quiet, respectable; but in seclusion, and without airing courts and strong clothing I could not do this.—Dr. OSCAR WOODS regretted that Dr. Keay’s paper was not read earlier, when more members were present. He could not at all agree with the open-door system, and believed that in every asylum where it was adopted accidents must occur. He had heard a superintendent say, “Better have accidents occasionally if open doors are of benefit to the many.” He was almost inclined to say the system was dishonest. It was impossible to carry it out. Of course he took it they all agreed that as little restraint should be used and as much liberty given as possible. But it was all a question of staff; and the more competent and kinder the staff was, the less restraint would be necessary.—Dr. DRAPES said that this question of restraint was altogether a question of degree, there being every shade and gradation of restraint, from that of extreme coercive measures to absolute liberty. But, undoubtedly, let as full liberty as was consistent with safety be given to the majority of patients, there would still be a residuum to whom it would not be wise and sometimes impossible to grant the same indulgence, such as violent patients and those of destructive and dirty habits. The agitation on this matter was an illustration of that action and reaction to which medical treatment was especially prone. The pendulum might swing too far in either direction, and probably

the men of largest experience had come to the conclusion that until lunacy changed its character it was hopeless to look for the total abolition of restraint.—Dr. CONOLLY NORMAN said that in a general way he fully agreed with the remarks of Drs. Savage and Yellowlees. He would have no hesitation whatever in applying restraint in acute delirious mania if he saw any medical indication for it. That affection was rare in Ireland. During a number of years he had never had to apply mechanical restraint. He did so, however, for a short time recently in a surgical case.—Dr. LYLE said that much freedom was given to the asylums in England, and that seclusion or restraint should be applied when necessary. Each individual patient should be treated on his or her merits. Occupation in the open air was most useful to prevent excitement; hence seclusion was not so necessary. There was no doubt as to the value of a large farm attached to each asylum. If locks were done away with, there would require to be an increase in the staff. It was not so easy to find occupation for patients drafted from towns. The class of patients differed in the various districts they were drawn from. Some, more excited than others, found airing courts a blessing for feeble epileptics.—Dr. TURK was much interested in this discussion, as he had been educated in the principles of the York Retreat, where it was held that as much freedom should be given to a violent patient as was consistent with his safety. These principles were simply the application of humanity to the treatment of the insane. When Dr. Conolly came forward with absolute non-restraint, his movement was recognised as highly beneficial; but the managers of the Retreat refused to be bound by a dogma, preferring to be guided by the necessities of each case. He hoped, however, that Dr. Keay would not have his enthusiasm in any way damped by the opposition raised to his paper.

Resolution with regard to the Irish Lunacy Laws.—The following resolution was moved by Dr. YELLOWLEES, and seconded by Dr. SAVAGE:

“That this Section of the British Medical Association having had under consideration, during the meeting in Dublin, the Irish lunacy laws and their practical working, and having strongly felt their grave defects when compared with those of England and Scotland, conclude to bring this subject under the consideration of the Council, in the hope that they will take such steps as to bring under the attention of the Government the urgent need of better regulations and further legislation in regard to this matter. The chief defects are the following:

- “1. The modes of admission of patients into asylums, which often involve injustice and injury to the patient and great danger to the public.
- “2. The defective powers possessed by the medical superintendent for the proper and efficient management of the asylum; for example, his having no power to engage or to dismiss the attendants, on whose loyal discharge of duty the welfare of the patients so greatly depends.
- “3. The want in the majority of asylums of assistant medical officers, so that the medical superintendent is unable to give the necessary time to his strictly medical duties, and large asylums containing some hundreds of lunatics may be left entirely without resident medical supervision when the superintendent is absent.”

OPHTHALMOLOGICAL MEMORANDA.

MINERS’ NYSTAGMUS.

I SAW an interesting and somewhat instructive case of this affection last week. Thomas K., aged 30, height about 5 ft. 6 in., has been a coal miner for nine years, working on the “longwall” system, in which there is no constraint of body; in fact, he can stand upright in the pit. He has hardly ever worked as a “holer,” that is, in a constrained position. So little of this has he done, that I had repeatedly put the question to him before I could get him to admit that he had ever worked in that position at all.

For the last three years he has had slight attacks of nystagmus, lasting from a day or two to a week, but, in the intervals, he got quite well. He himself thinks they were due entirely to the bad light in the pit.

The present attack came on thus: he was in the pit for the last time eight days before I saw him, being laid up next day with a “heavy cold” in his head, and knife-like pains in the right side of the chest, but nothing wrong with his eyes. Five days later he noticed the onset of the present attack when the street lamps were being lighted in the evening, and this had continued for three days, varying, however, very