indicted for murder, Judge Somerville delivered an elaborate historical statement in the Supreme Court of Last Resort in Alabama, and departed from the beaten track of the lawyers by questioning whether there may not be an insane person who, while capable of perceiving the difference between right and wrong, is, as a matter of fact, so far under the duress of a diseased brain that the power to choose between right and wrong is destroyed. The judge expressed the opinion that such a one, although he perceived such difference, was not criminally responsible for an act done under the influence of such controlling disease. The judge quoted with approval a passage from Bucknill and Tuke's "Manual of Psychological Medicine," in which it is stated that the true test is "whether, in consequence of congenital defect or acquired disease, the power of self-control is absent altogether, or is so far wanting as to render the individual irresponsible. As has again and again been shown, the unconsciousness of right and wrong is one thing, and the powerlessness, through cerebral defect or disease, to do right is another thing. To confound them in an asylum would have the effect of transferring a considerable number of the inmates thence to the treadmill or the gallows." The judgment of Judge Somerville was entirely in accordance with this principle. It should be stated that Chief Justice Stone dissented in part, and expressed his own views separately.

Mr Bell concludes his paper by observing that "these two cases, the former a decision of the highest Appellate Court in the State of Alabama, and the latter by one of the judges of the Supreme Court of the District of Columbia, at the national capital, indicate the change which is going on on this side of the Atlantic in the judicial mind. I trust it will in the near future be universal in the American States, and help to lead the way to such legislation in the English Parliament as that contained in the law, proposed there in March, 1884, the work of an eminent English jurist, with the approval of the late Chief Justice Cockburn, setting at rest in English-speaking countries a question so full of interest to every citizen, and so pregnant with the rights and destiny of the insane."

It is to be hoped that such will be the case. It is notorious that, in many instances, the English judges commence their charge to the jury by laying down the law as to the test of moral responsibility in accordance with the dicta of the judges of 1843, while they are in the end compelled by the nature of the case to fly, very much against their will, in the face of their own ruling. Thus, the dignity of the law is lowered. In spite of the dilemma in which the Bench finds itself placed from time to time, there continues to be an obstinate persistence in the same doctrine, without any general desire or attempt to have the law altered. The American judges, although the English maxim has been adopted in the States, do not appear to hold themselves bound to charge juries in the same way as in England, and so avoid self-contradiction in the judgments they deliver in the Courts, when, in cases of murder, the plea of insanity is set up by the defence.—*British Medical Journal*, Nov. 3, 1888.

Correspondence.

On the Use of Restraint in the Care of the Insane.

By Alex. Robertson, M.D., F.F.P.S.G., Physician to the Royal Infirmary and City Parochial Asylum, Glasgow.

To the Editors of "The Journal of Mental Science."

Gentlemen,—The Journal for January of the present year contains a report of an important discussion "On the Use of Restraint in the Care of the Insane" at the Edinburgh meeting of the Association in last November. As I was unable to be present, I ask you to be so good as to permit me to express my views through

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the medium of your columns on this very important subject. I learn from the report that it has been the occasion of a controversy in the "Times" between leading members of the profession in the south, but as I have not seen the articles on either side, my remarks can in no way be influenced by the opinions of any of the writers.

Many, like myself, will have learned with no small surprise that the use of mechanical personal restraint, to a somewhat considerable extent, is advocated by physicians in charge of leading asylums. Hitherto even intelligent laymen, when they have had occasion to refer to the evidences of progress in the nineteenth century, have in illustration pointed with pride to the non-restraint system of treatment in our asylums for the insane. Distinguished Continental and American physicians have studied it in operation in these institutions, and recorded their high appreciation of the results. Its beneficent influence has also extended to many of the asylums of other lands. While I write, the biennial report of the Alabama Insane Hospital has just been received. Dr. Bryce, the Physician-Superintendent, in referring to "the abolition of all mechanical restraint" some years ago, remarks: "Every year's experience since that notable event has impressed me more and more forcibly of its supreme wisdom and efficacy; our wards are as quiet under this system as those of any well-ordered private family." After many more remarks of a similar kind, he closes with a note of warning, "Let us see to it that we take no step backward."

Many of us can still recall the gratification felt on the presentation of the bust of Conolly by the late Baron Mundy, M.D., to the Association, and afterwards through its representatives to the Royal College of Physicians of London. That eminent physician, in his eulogy of Conolly on the occasion of its formal acceptance by the College, said, addressing the chair, "You have been enjoying for almost a quarter of a century the work of the great man who is no more, and still your neighbours, close to your shores, have yet, at the moment I address you, two thousand unfortunate beings tied in strait jackets . . . and the total number of the insane on the Continent confined in cells, fastened in beds, and strapped up in strait jackets amounted in 1867 to fifty thousand. It is for me as a foreigner a humiliation, and perhaps at the same time a proof of my professional courage that I denounce these facts before so high an authority as yourself, and on so solemn an occasion as this of to-day." The President of the College, the late Sir Thomas Watson, in the course of his reply, remarked: "His (Conolly's) name will go down to a remote posterity, and be reckoned among those of the greatest and most noble benefactors to a very suffering portion of the human race that our profession and our country have ever produced." Little did either of these eminent men then think that within twenty years of the time they spoke, physicians of eminence at the head of some of

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our chief asylums would have advocated a return to the use of measures of restraint whose all but total abolition was the especial glory of Tuke at York and Conolly at Hanwell, and reflected honour on the land of their birth.

The report of the Edinburgh meeting certainly conveys the impression that the majority of the speakers approve of the use of restraint. But the practice of some of them scarcely bears out this theoretical expression of opinion. Thus Dr. Clouston applies restraint in surgical cases only, and where the suicidal disposition is exceptionally pronounced. Dr. Turnbull's practice is the same, but he distinctly states that he restricts the appliance in the suicidal cases to night. The form I infer to be always "locked gloves." Dr. Rorie only uses the "gloves" in "extreme cases," but he does not specify what these are. Now I have always understood that even Conolly fully allowed the use of mechanical restraint in surgical cases. I am inclined to think, too, that even though a medical superintendent orders a pair of locked gloves to the hands of a highly suicidal patient at night, the hands being otherwise free, in rare and extreme cases, *but only in such cases*, he may still be claimed among the supporters of non-restraint.* But whatever opinion is entertained on this point, there can be no doubt that the position of at least Drs. Yellowlees, Urquhart, and Johnston is very different. As the views expressed by Dr. Yellowlees were fully endorsed by the two other gentlemen, we turn to him for an exposition of his opinions. These were put very definitely before the meeting. He thinks that the use of mechanical restraint is required in four classes of cases. I quote his words:—"(1). *In cases where the suicidal impulse is intensely strong.* I have no hesitation whatever in putting gloves on these patients for their own safety and the protection of the attendants in charge of them. (2). In cases of extreme and exceptional violence. I think the use of gloves often wise in such cases. Once or twice I have used side-arm dresses, although not for many years. (3). In extremely destructive cases. (4). The helpless and incessantly restless patients, who day and night roll about the room," etc. For the last class he recommends the "protection bed." This, as I saw it many years since in an American asylum, is a deep and narrow box-bed, with a sparred lid or cover. The patient lies on a mattress in the bottom of it, and the lid, which is locked, prevents him from rising into the erect posture.

It seems to me that a question of this kind can only be determined by results. Comparison should be made between asylums

* That Dr. Robertson would not have been regarded as orthodox by Conolly is clear from the following:—"Even the stuffed gloves were found to possess so many of the disadvantages of restraint, that they were discontinued after a short trial. They were chiefly employed on the female side of the house; and the report of the nurses concerning the patients to whom they were applied, is that they are less combative and dangerous than they were before." See Dr. Conolly's "Treatment of the Insane without Mechanical Restraint."—[EDS.].

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in which restraint is used to the extent advocated by Dr. Yellowlees and those where Conolly's principles are still in force—where there is a minimum of restraint. This can be best done by a candid statement of experience based on a long series of years. I shall do so myself, and at the same time invite Dr. Yellowlees or any other gentleman who may concur in his views to put his experience also on record. In order that the comparison may be as complete as possible, it seems advisable that the facts should be elicited by answers to a series of questions, as follows:—

Q.—What is the length of your experience?

A.—Three years as assistant, upwards of thirty years as physician-superintendent.

Q.—How many patients are in your asylum?

A.—On an average for the first 25 years, 203; for the last five years asylum only licensed for 125; always full, often two or three beyond the complement.

Q.—What is the average number of admissions?

A.—For 21 years, between 1863 and 1883, the average number of admissions annually was 79; from 1884 to 1888 inclusive, 46. Besides, during each of the last twelve years 34 patients were on an average admitted on what are known as "certificates of emergency," and accommodated for a period not exceeding three days, when they were removed to other asylums, the parochial asylum being full. These cases being usually in the acute stage of their illness, add greatly to the responsibilities of the management.

Q.—What has been the average proportion of recoveries calculated on the admissions, say for the last ten years?

A.—47·3 per cent.*

Q.—Is every kind of case admitted?

A.—Yes; there is no selection.

Q.—What was the weekly cost of maintenance in your asylum during the last financial year?

A.—8s. ⅜d. This includes repairs and charge for rent.

Q.—What is the proportion of day-attendants to patients in your asylum?

A.—One to 15·8 patients.

Q.—What is your practice in the use of mechanical personal restraint?

A.—No strait jacket, or "side dresses," or anything of that kind has ever been used in my whole experience. Two patients suffering from surgical diseases, one 29 and the other 4 years since, were fixed to their beds by sheets and bandages till these ailments were cured. In a surgical case at present one glove is in

* This does not correspond with the annual reports of the Board of Lunacy. The proportion stated in them is based on the admissions, *plus the emergency cases*; my statement excludes them. These cases are only accommodated for convenience for, as mentioned, less than three days, and are not admissions in the ordinary sense of the word.

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use. In a small number of highly suicidal cases I have ordered locked canvas gloves at night, the hands being otherwise free. How rarely they are prescribed will be seen from the following list for the three years ending 31st December, 1888, which has been prepared from the statements of the attendants, corroborated by my own recollection, as no record was made:—April, 1886, gloves one night; May, 1887, gloves one night; May, 1888, gloves two nights. Two were cases of attempted suicide, the third was strongly disposed to suicide.

Q.—What is your practice in respect of seclusion?

A.—It is seldom used. Five patients were secluded during 1888, the sum of all their seclusions being 31 hours. No one was secluded in 1887.

Q.—Do you use guards of any kind for the windows or fires?

A.—The only guards in use are two nursery ones, quite open at the top, and simply hooked on at the sides. One is over the fire in a parlour where there are many epileptics, the other in the parlour for the most violent cases. There is no guard of any kind over any of the windows. The windows are, of course, so fixed on the upper floors that they cannot be opened at the top or bottom above four inches.

Q.—How many, if any, homicides have occurred in your experience?

A.—None.

Q.—How many, if any, suicides have occurred in your experience?

A.—None.

Q.—How many important injuries to patients have occurred in the course of your experience, in struggles either with attendants or fellow-patients?

A.—In ten cases bones were broken, but all were simple fractures. No patient is known to have suffered permanent injury.

Q.—How many, if any, attendants have been injured in your experience?

A.—Two attendants have each had his shoulder dislocated, but it was easily reduced. These, and one or two temporarily stunning blows on the head, were by far the most serious occurrences. No one was ever permanently injured.

Q.—What was the value of the clothing of all kinds destroyed in your asylum last year?

A.—7s. 6d.

Q.—What was the value of the glass destroyed in your asylum last year?

A.—Not more than 1s.

Q.—What have been the usual entries of the Commissioners in their reports respecting the order and quietude of your asylum?

A.—Both have been stated to be satisfactory. There is, of course, occasionally some noise and excitement in the department for the acute cases.

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These details have been obtained by careful examination of the books of the establishment in the hands of Mr. Laing, the Governor of the Asylum and Poorhouse, to whom I am indebted for the trouble he has taken in this inquiry, as well as for his co-operation in the management, especially during late years. The results I believe to be creditable to the principle of non-restraint. I was trained in its practice by my late respected master and friend, Dr. Alex. Mackintosh, of Gartnavel Asylum, and I have not yet seen any reason to modify my high appreciation of its wisdom and value. However, we must wait till those who favour the more extended use of restraint tell us their results before determining the question. Meanwhile, any who are in doubt may refrain from arriving at a conclusion.

I may be asked, What are your methods of treatment? I answer, nothing special, simply careful individualization—studying and applying the indications of management and treatment in each case—work, outdoor exercise, careful dieting, amusements, and medicinal treatment. In reference to the last of these, I refuse to admit that when a patient is soothed by medicines fitted to allay the irritability of a brain in a state of disease, I am employing "chemical restraint," at least in the offensive sense attached to the expression by some, and especially by those who favour mechanical restraint.

I have only further to express my regret that in this communication I have been obliged to name gentlemen whom I count among my personal friends. But all personal considerations must be sunk in view of the importance of the question under consideration. Especially do I regret that I have been constrained to refer particularly to Dr. Yellowlees. It is simply because he initiated and took by far the most important part in the discussion at Edinburgh, and is at present the leader in Scotland of what I believe to be a distinctly retrograde movement. He would do well to remember when advocating the cause of restraint or about to order the application of the "side-arm dresses" or the use of the "protection bed," that there is a plate on the foundation-stone of Gartnavel Asylum bearing an inscription which declares that the asylum is erected on the principle of "EMPLOYING NO MECHANICAL PERSONAL RESTRAINT IN THE TREATMENT OF THE PATIENTS."

LAY REVOLT AGAINST MEDIÆVAL ALIENISM.

To the Editors of "THE JOURNAL OF MENTAL SCIENCE."

SIRS,—In the history of the remarkable movement in which the alienism of the middle ages was swept away, graceful and well-deserved tributes of praise have been bestowed on the labours of Tuke, Pinel, and Esquirol, whose enlightened policy is contrasted—not always with a nice regard to chronology—with the fanaticism of theologians like De Lépine, and the bigotry of the judicial savage who wished that all the witches of Burgundy might be gathered into one place and destroyed.

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