Lunacy law for medical men / by Charles Mercier.

LUNACY LAW

FOR

MEDICAL MEN

BY

CHARLES MERCIER, M.B.

LECTURER ON NEUROLOGY AND INSANITY, WESTMINSTER HOSPITAL MEDICAL SCHOOL AND THE MEDICAL SCHOOL FOR WOMEN.
AUTHOR OF 'THE NERVOUS SYSTEM AND THE MIND;' 'SANITY AND INSANITY;' 'LUNATIC ASYLUMS, THEIR ORGANIZATION AND MANAGEMENT;' 'THE ATTENDANT'S COMPANION,' ETC., ETC

LONDON
J. & A. CHURCHILL
11, NEW BURLINGTON STREET
1894

PREFACE

Ne sutor ultra crepidam is the criticism that will rise to the lips of every lawyer who sees this book. The answer to this criticism is contained in a cognate proverb, viz. that no one knows where the shoe pinches so well as he that wears it; and no one can know the difficulties that medical men find, in discovering and applying the lunacy law, so well as a medical man whose daily avocation it is to deal with it. The book is not so much an exposition of the law as an explanation of the duties that the law imposes upon medical men. To discover these duties in the ordinary legal text-books is a work of time and difficulty, since they are there thinly scattered through a vast deal of enactment and judicial decisions with which medical men are not concerned. From this state of dilution they have been concentrated and brought together in this small volume in a form which it is trusted will be found convenient and easy of reference. Technical legal terms have been entirely avoided, and full explanation has been given of every doubtful and difficult point.

In addition to the knowledge required for the legal duties cast by the Legislature upon the medical practitioner who has to deal with persons who are or are alleged to be insane, it is very expedient that he should have a general knowledge of the proceedings which are prescribed by law with respect to dealing with insane persons, for it will very often happen that he will be asked by the friends of patients to advise them with respect to proceedings which are outside the functions of the medical practitioner himself, but with which he will be expected to have some familiarity.

Endeavour has been made to give in this book clear information on every point of lunacy law on which a practitioner of medicine is likely to be consulted, as well as upon every point that he will have to consider in his own dealings with insane persons.

LUNACY LAW FOR MEDICAL MEN

INTRODUCTION

THERE are three occasions on which a medical man may be brought into contact with the law in dealing, in the course of his profession, with persons who are, or are alleged to be, insane. The commonest occasion is the management of an insane patient; the next commonest occasion is when the question of testamentary, disposing or contracting capacity arises; the least common is when the question of the responsibility of a criminal has to be determined.

*** The references at the ends of the paragraphs in Part II are to the Lunacy Act, 1890, and to the Rules made under the Act by the Commissioners in Lunacy.

PART I

IDIOTS

Placing under Control.

The proceedings necessary for placing under control a person who has been from birth, or from an early age, idiot or imbecile, are much simpler than those for placing under control a person who has become insane during adult life, provided always that the idiot or imbecile is to be placed in an institution registered under the Idiots Act, 1886. If it is desired to place an imbecile or an idiot in an institution for lunatics, then the proceedings to be gone through are the same in all respects as in the case of a lunatic.

An idiot or imbecile from birth or from an early age may be placed under control, and detained in an institution registered under the Idiots Act, upon the certificate of one medical practitioner, accompanied by a statement made by the parent or guardian of the patient, or the person who undertakes or performs towards him the duty of a parent or guardian (Idiots Act, 1886, Section 4).

These documents are precisely the same whether the patient is of full age or under age at the time that he is placed under care. An idiot or imbecile who has, while under age, been received into an

institution for idiots, may, with the consent of the Commissioners in Lunacy, be retained therein after he is of full age (Idiots Act, 1886, Section 5).

It is essential, however, that his mental affection shall have dated from birth or from an early age. From how early an age the malady must date, the Act does not state, and it is obviously needless that it should do so.

The Act applies to idiots and imbeciles only,—that is to say, to those whose mental malady is of the nature of simple defect, and not of active insanity. A person who was subject to delusions could not be considered as an idiot or an imbecile, and could not be placed under control under the Idiots Act, even although his malady exhibited itself before he was of full age. Mere mischievous propensity would not, however, be considered active insanity.

Imbecility is a less degree of the defect which, when great, is styled idiocy.

The following is the form of the documents necessary for placing an idiot or imbecile under control.

Form of Medical Certificate.

I, the undersigned *A. B.*, a person registered under the Medical Act, 1858, and in the actual practice of the medical profession, certify that I have carefully examined *C. D.*, an infant [*or* of full age] now residing at , and that I am of opinion that the said *C. D.* is an idiot [*or* has been an imbecile from birth, *or* for years past, *or* from an early age], and is capable of receiving benefit from [the institution (describing it)] registered under the Idiots Act, 1886.

(Signed)

Dated . Full postal address.

Form of Statement.

[If any particulars in this statement be not known, the fact to be so stated.]

Name of patient, with Christian name at length.

Sex and age.

When and where previously under care and treatment.

In any asylum or institution.

Whether subject to epilepsy.

Whether dangerous to others.

I certify that to the best of my knowledge the above particulars are correctly stated.

(Signed)

Full postal address.

[To be signed by the parent or guardian of the idiot or imbecile, or the person undertaking and performing towards him the duty of the parent or guardian.]

It will be observed that in the case of an idiot or imbecile, not only is there no need for a judicial reception order, but no order of any kind is needed, the medical certificate alone being sufficient.

PART II

THE MANAGEMENT OF AN INSANE PATIENT

The management of an insane patient resolves itself into two separate departments: 1, the placing of an insane person under control; 2, the legal obligations of a medical practitioner who has the control of an insane person.

The duty of a medical practitioner with respect to placing a lunatic under control varies very much according to whether—

1. The lunatic is or is not a pauper;
2. If the lunatic be not a pauper, the case is or is not so urgent as to necessitate his being "forthwith" placed under control;
3. The lunatic is or is not under proper care and control, or is or is not cruelly treated and neglected;
4. The medical practitioner is or is not medical officer of a union;
5. The lunatic is or is not wandering at large.

Private Patients.

The procedure for placing under control an insane person who is *not* a pauper varies according as the patient (1) is with his family or friends under ordinary circumstances; or (2) is not under proper care or control; or (3) is cruelly treated or neglected by

any relative or other person having charge of him ; or (4) is wandering at large.

In the first case, in which a person becomes insane while with his family or friends, who can and will take steps to place him under control, there are three ways in which this end may be attained.

1. By a judicial order on petition.
2. By an urgency order.
3. By an inquisition in lunacy.

In the great majority of cases the first method, that of judicial order on petition, is followed.

In this method a *petition*, accompanied by a *statement of particulars*, and by *two medical certificates*, is presented to a judicial authority, who, if he sees fit, makes an order for the reception of the patient into an institution, or for placing him in private care.

The Petition.

This must be presented, if possible, by the husband or wife, or by some other relative of the patient. If presented by another person, the reason why the petition was not presented by the husband or wife or other relative must be stated in the petition, and the document must further set forth the connection of the petitioner with the patient, and the circumstances under which he presents the petition (Section 5). There are certain other conditions necessary to be complied with, but as these appear on the face of the form of petition given in the Act, it will be sufficient to recite the form here and append the necessary comments in passing.

Petition for an Order for Reception of a Private Patient.

In the matter of *A. B.*, a person alleged to be of unsound mind.

Give all the names in full of the patient.

To , a justice of the peace for [*or* To his honour the judge of the county court of , *or* To the stipendiary magistrate for].

The name of the judicial authority to whom the petition is to be presented will commonly be left until it can be ascertained. It will only rarely happen that the county court judge or the stipendiary magistrate will be appealed to. In almost every case the petition will be presented to a justice of the peace. It is important to note that not every justice of the peace is competent to make the order. He must, in order to obtain power to make an order, be "specially appointed" by his brother justices to act in these cases (Sections 9 and 10), but—and this is very important—if so appointed he may make an order for a patient in any district, whether his ordinary jurisdiction is in that district or no (amending Act, Section 24 [1]).

A justice who is not "specially appointed" may make a provisional order, and this order becomes permanent if it is, within fourteen days after its date, approved and signed by a judicial authority (amending Act, Section 24 [3]).

When occasion arises for the presentation of a petition, the preliminary difficulty usually presents itself of discovering to whom it should be presented—that is to say, who is the nearest justice of the peace who is "specially appointed" under the Act. The

name and address of this authority can be obtained from the clerk of the peace or from the magistrate's clerk, who, in his turn, may be discovered from the local directory, or by inquiry at the nearest police station, or from the clerk to the guardians.

A judicial authority who is a relative of the petitioner, or of the patient, or of the husband or wife of the patient, is incapable of making the order (Section 4).

The petition of *C. D.*, of , in the county of .

Here the petitioner inserts his full name, his full postal address, the administrative county in which he lives, and his rank, profession, or occupation.

1. I am years of age.

It does not appear that the petitioner need state his actual age. The Act requires that he shall be at least twenty-one, and if he, or rather she, states that she is more than twenty-one, the provisions of the Act will be complied with without entering into greater detail.

2. I desire to obtain an order for the admission of *A. B.* as a [lunatic, or idiot, or person of unsound mind] in the asylum [or hospital, or licensed house, or house] of , situate at .

Here the full names of the patient should again be stated.

As defined by tbe Act, a lunatic means an idiot or a person of unsound mind. It is therefore immaterial whether the first or the last of these terms is used.

The full and exact name and postal address of the asylum, hospital, licensed house, or private house to which the patient is to be sent should be here inserted.

What is commonly called a "private asylum" is known in law as a licensed house.

3. I last saw the said *A. B.* at on the day of .

The date on which the patient was last seen must be not more than fourteen days before the petition is *presented.*

4. I am the of the said *A. B.*

Here state the relationship of the petitioner to the patient. Or if the petitioner is not related to the patient, or connected with him by marriage, state as follows :

I am not related to or connected with the said *A. B.* The reasons why this petition is not presented by a relation or connection are as follows : [*State them.*]

The circumstances under which this petition is presented by me are as follows : [*State them.*]

The circumstances required in this paragraph to be stated are those which (1) render it advisable to place the patient under control, and (2) when the petitioner is not related to the patient, those which induce him to act in the absence, or unwillingness, or inability of the relatives and connections of the patient. For instance, the fact that he is a friend of many years' standing, or a guardian, &c., would be a "circumstance" within the meaning of the section.

5. I am not related to or connected with either of the persons signing the certificates which accompany this petition as (*where the petitioner is a man*) husband, father, father-in-law, son, son-in-law, brother, brother-in-law, partner or assistant (*or, where the petitioner is a woman*), wife, mother, mother-in-law, daughter, daughter-in-law, sister, sister-in-law, partner or assistant.

6. I undertake to visit the said *A. B.* personally or by some one specially appointed by me at least once in every six months while under care and treatment under the order to be made on this petition.

The obvious intention of the Legislature, in inserting this provision, is to secure that the patient shall have opportunities of interviewing periodically the person who is primarily responsible for his detention, and who has the power to remove or discharge him. If, therefore, the petitioner is unable himself to visit the patient, he should depute some responsible person to visit and report to him the condition in which the patient is, and any complaints that he may make. There is no form of "appointment" prescribed, and a verbal request will be sufficient; but in case it should happen that the substitute is refused admission by the authorities of the asylum, it is as well to provide him with a written authorisation.

7. A statement of particulars relating to the said *A. B.* accompanies this petition.

The statement of particulars need not be, although it usually is, made out and signed by the same person as the petition.

If it is a fact, add—

8. The said *A. B.* has been received in the asylum [or hospital, or licensed house, or home, as the case may be] under an urgency order dated the .

The petitioner therefore prays that an order may be made in accordance with the foregoing statement.

(Signed) (full Christian name and surname.)

Dated .

The date here inserted must be that on which the petition is *presented* (*see* p. 38).

The following words are not in the form given in

the schedule to the Act, but should nevertheless be here inserted (*see* p. 19).

The reason why neither of the medical certificates accompanying this petition is under the hand of the usual medical attendant of the said *A. B.* is [ ].*

* Strike out these words if one certificate is under the hand of the usual medical attendant.

The first document that must accompany the petition is the Statement of Particulars, which is in the form prescribed by the Act (Form 2, Schedule II), and given below. The only comment that is necessary with regard to it is a reminder that every particular in the statement must be filled in; and that if the particular is not known, the space must not be left blank, but the fact that it is unknown must be stated.

Statement of Particulars.

Statement of particulars referred to in the annexed petition [or in the above or annexed order].

The following is a statement of particulars relating to the said *A. B.*

Name of patient, with Christian names at length.

Sex and age.

† Married, single, or widowed.

† Rank, profession, or previous occupation (if any).

† Religious persuasion.

Residence at or immediately previous to the date hereof.

† Whether first attack.

Age on first attack.

When and where previously under care and treatment as a lunatic, idiot, or person of unsound mind.

† Duration of existing attack.

Supposed cause.

Whether subject to epilepsy.

Whether suicidal.

Whether dangerous to others, and in what way.

Whether any near relative has been afflicted with insanity.

Names, Christian names, and full postal addresses of one or more relatives of the patient.

Name of person to whom notice of death to be sent, and full postal address if not already given.

Name and full postal address of the usual medical attendant of the patient.

(Signed)

When the petitioner or person signing an urgency order is not the person who signs the statement, add the following particulars concerning the person who signs the statement.

Name, with Christian names at length, rank, profession or occupation (if any), how related to or otherwise connected with the patient.

The Medical Certificates.

Medical practitioners are aware, some of them are, perhaps, too vividly conscious, that signing certificates of lunacy is attended by a certain risk. Since the Act of 1890 the risk is not great, and it may be almost altogether avoided by the exercise of the most ordinary care and forethought. It is scarcely too much to say that if the rules and precautions recommended in this book are followed, the risk is altogether obviated.

Certain forms of insanity are accompanied by an extraordinary development of the litigious spirit. Persons thus affected will, after their liberation from detention as lunatics, bring actions against not only every person who has been concerned in their detention—the petitioner, the certifiers, the signator of the "statement," the judicial authority, the superintendent, assistant medical officers, and members of the committee of the asylum,—but even against persons who have expressed an opinion as to their

insanity. Such patients will bring actions well knowing that they have no chance of gaining them, and well knowing that, if they lose, they cannot pay the costs of the defendant. The actions are brought, in many cases, not in the hope of gaining them, but simply and solely as a means of annoyance, and to put the defendant to expense, worry, and loss of time. Patients with this peculiarity are fortunately not common, but the injury that they can inflict is very great, and the action of one or two of them has created such a terror in the minds of medical practitioners that there are a few doctors who refuse to certify any lunatic under any circumstances. Such an attitude on the part of a medical man is hardly more reasonable than that of a patient who refuses food for fear it may contain poison.

Most of the power of such patients to inflict harm is abolished by the protective clauses of the Lunacy Act of 1890, which run as follows:

"Section 330 (1). A person who before the passing of this Act has signed or carried out or done any act with a view to sign or carry out an order purporting to be a reception order, or a certificate that a person is of unsound mind, and a person who, after the passing of this Act, presents a petition for any such order, or signs or carries out or does any act with a view to sign or carry out an order purporting to be a reception order, or any report or certificate purporting to be a report or certificate under this Act, or does anything in pursuance of this Act, shall not be liable to any civil or criminal proceedings, whether on the ground of want

of jurisdiction or on any other ground, if such person has acted in good faith and with reasonable care."

This sub-section is very comprehensive, and is an absolute protection to any practitioner, who acts in good faith and with reasonable care, from *losing* an action brought against him for anything done in pursuance of the Act. It was recognised by the Legislature that this was not sufficient protection, for a vindictive and litigious patient could put a medical man to very great expense and annoyance by the mere bringing of an action, even though there was no chance whatever of the action succeeding. Another sub-section was therefore added to give still further protection. This sub-section runs as follows :

" If any proceedings are taken against any person for signing or carrying out or doing any act with a view to sign or carry out any such order, report, or certificate, or presenting any petition as in the preceding sub-section mentioned, or doing anything in pursuance of this Act, such proceedings may, upon summary application to the High Court, or a judge thereof, be stayed upon such terms as to costs and otherwise as the court or judge may think fit, if the court or judge is satisfied that there is no reasonable ground for alleging want of good faith or reasonable care."

Thus, under this sub-section, an action may be nipped in the bud before any considerable costs have been incurred, provided that the judge can be satisfied that there is no reasonable ground for alleging want of good faith or reasonable care. It will be seen that, in order to have an action thus

stayed, it is scarcely enough to show that as a matter of fact there *was* no want of good faith or of reasonable care. The defendant should show that the *bona fides* was so beyond dispute, and the care taken was so manifest, that there is no reasonable ground for alleging the contrary. It is quite possible, and it has actually occurred, that no want of good faith or of reasonable care could be proved in the action, and yet that the positive presence of both did not appear with sufficient plainness upon the face of the certificates to enable a judge to declare that there was no reasonable ground for alleging their absence. Hence the paramount importance of so framing the certificates, and attending to the circumstances connected with them, as explained and set forth hereinafter, that not merely cannot it be *proved* that there was no lack of good faith or reasonable care, but that it cannot even be *reasonably alleged* that there was any default in these respects.

In cases in which the judge has been satisfied that the allegation was not reasonable, actions have been stayed under this sub-section, and the defendants saved the expense and anxiety of the trial.

Not yet have we enumerated all the protections given to certifiers and others by the Act of 1890. Section 331 enacts as follows:

"1. Any action brought by any person who has been detained as a lunatic against any person for anything done under this Act shall be commenced within twelve months next after the release of the party bringing the action, and shall be laid or brought in the county or borough in which the cause of action arose, and not elsewhere."

"2. If the action is brought in any other county or borough, or is not commenced within the time limited for bringing the same, judgment shall be given for the defendant."

The design of this section is obvious, and were it observed by the judges would prove a very great protection to certifiers. It is remarkable, however, that although the words of the section are not permissive but mandatory, and positively require that under certain circumstances judgment *shall* be given for the defendant, yet, when those circumstances actually arise, judges will override the Act of Parliament, and refuse to give effect to its provision.

In Brown *v.* Carpenter and Dukes, tried at the Surrey summer assizes in July, 1891, the plaintiff was released in August, 1888, and no writ was taken out until November, 1889, yet the action was allowed to proceed. The cause of action arose and the writ was issued before the Act of 1890 was passed, but there was a similar provision in 8 and 9 Vict., c. 100, Section 105.

As already stated, if the certifying practitioner observes the rules and conditions laid down in the following portion of this book as proper to be observed in making a certificate, he may rest assured that he has nothing to fear from the vengeance of a litigious lunatic. Should he, however, be still nervous at finding that he is required to certify a patient who is likely to bring an action against him upon recovery and release from detention, he may require a guarantee of indemnity from the friends of the patient; and should he be successful in obtaining a guarantee, the following form is

recommended as efficient by the solicitors to the Medical Defence Union :

I [or we] hereby request you to sign a medical certificate that *A. B.* is a person of unsound mind in accordance with your verbal report to me [or us] to that effect. And I [or we jointly and severally] hereby undertake to indemnify you against all liabilities, costs, and expenses of what kind soever to which you may be rendered liable or which you may reasonably incur in consequence of any proceedings which may be threatened or instituted against you by reason of your having signed such a certificate, if in such proceedings it shall be admitted or proved that in so doing you acted in good faith and with reasonable care in accordance with the provisions of the Lunacy Act, 1890 (53 Vict., c. 5), or such proceedings shall be discontinued or not proceeded with.

Dated

(Signed)

C. D.

Witness to the signature of the said *C. D.*
Name.
Address.
Occupation.

The petition must, then, be accompanied by two medical certificates, which *must be written on separate sheets of paper* (Section 4).

One of these medical certificates must be made by the usual medical attendant of the patient, or, if that is not practicable, the reason why one of the certificates is not so signed must be stated in writing to the

judicial authority to whom the petition is presented, and such statement is deemed part of the petition (Section 31).

Although this provision is made in the Act for the insertion of this reason into the petition, it is curious that no form of words is introduced into the form of petition given in the schedule of the Act to carry out the intention of the section. At the foot of the petition the form of words given on p. 11 should therefore be inserted.

Certain medical practitioners are incompetent to sign certificates in certain cases (Section 32).

1. A practitioner who is *related to the petitioner* in any of the ways given on p. 9 may not make a certificate to accompany the petition.

2. A person under whose care the patient is to be placed, whether singly or in an institution, may not make a certificate for that patient.

3. A person who is interested in the payments on account of the patient may not certify the patient.

4. A regular medical attendant of an institution may not certify a patient who is to be placed in the institution.

5. No practitioner who is related to any of the persons in (2), (3), and (4) as husband or wife, father or father-in-law, mother or mother-in-law, son or son-in-law, daughter or daughter-in-law, brother or brother-in-law, sister or sister-in-law, or partner or assistant may certify the patient.

6. A practioner who is a member of the managing committee of a hospital may not make a certificate for a patient who is to be placed in the hospital.

7. A practitioner who is a commissioner or visitor may not sign any certificate for the reception of a patient into a hospital or licensed house unless he is directed to visit the patient by a judicial authority under the Act, or by the Lord Chancellor, or a Secretary of State, or a committee appointed by a judge in lunacy (Section 23).

The term *visitor* in this section of the Act clearly means the Lord Chancellor's visitors, and the visitors of licensed houses appointed by justices. It would also include members of the visiting committee of any asylum which had a contract with the hospital or licensed house.

The examination on which the certificate is based must be made within a period of seven clear days before the *presentation of the petition* (Section 29). Medical men are apt to suppose that if the date of signature of their certificate is within seven days of that of the petition, the requirement of the Act is complied with. This is not the case. The dates which must be not more than seven days asunder are those of *examining* the patient and *presenting* the petition.

It is not possible for a medical practitioner to be too careful in filling in and wording these certificates. It is the exception for a certificate to be passed by the Commissioners in Lunacy without being referred to the certifier for the correction of some formal error which might have been avoided by the exercise of ordinary care; and material errors are also very common. This is the less excusable since every statement in a medical certificate under the Lunacy Act has by statute the force of a statement made on

oath, and should therefore be drawn up with the same punctilious care as an affidavit.

It is, of course, in the statement of the "facts indicating insanity" that the greatest care is required; and the certifier should constantly bear in mind that his object in stating these facts should be to carry conviction of the insanity of the patient to any complete stranger to the patient who reads the certificate. The whole of the evidence necessary to establish the patient's insanity should therefore be embodied in the certificate, and the latter should not require to be supplemented by facts which may be in the knowledge of the certifier, but are not stated in the certificate. He should scrutinise every statement in his certificate, and draft it as carefully as if it were certain, instead of merely possible, that he would be cross-examined upon it by counsel in open court. The essentials of a good certificate are as follows:

1. It must be sufficient.
2. It must be definite.
3. It must be clearly expressed.

1. *The Certificate must be Sufficient.*—That is to say, the facts stated must be sufficient to carry conviction of the insanity of the patient to the mind of a complete stranger to him. A medical man in making certificates in lunacy is very apt to assume that all that is required is that *he* shall be satisfied of the insanity of the patient, and that, if he is confidently assured that the patient is insane, he can safely certify to that effect, without needing to state precisely the evidence upon which he has arrived at the conclusion. He has attended the patient for days or

weeks; has witnessed and borne a share of the terrible anxiety and harassing trouble that the friends have suffered before it was determined to place the patient under control; and when his certification is at last determined on, the leading idea in the mind of the family medical attendant in making out the certificate is that its sole function is to render possible the placing of the patient under control; that so long as he is satisfied of the patient's insanity, and records his conviction, that is enough. He will, therefore, state as a fact indicating insanity some belief entertained by the patient which the doctor himself knows to be a delusion, but whose insane character is not manifest to a person to whom the patient is unknown. For instance, certificates not infrequently contain as facts indicating insanity such statements as "she believes that her husband has deserted her, and taken her children from her." To the doctor who visits the house every day, and who is a daily witness of the care and solicitude of the husband for the patient, such a belief is manifestly a delusion, and needs to be stated only to carry conviction of its insanity with it. But the persons whom the certificate has to satisfy are, primarily, the judicial authority; secondly, the Commissioners in Lunacy; and thirdly, perhaps a judge and jury, none of whom have ever seen the patient or are acquainted with the circumstances of her household. The statement is not on the face of it evidence of insanity. There are women who soberly entertain such a belief upon grounds that are only too sure. In order to make it evidence of insanity it is necessary that it should be supple-

mented by a statement that it is incorrect; and not only that it is incorrect, but that the patient continues to entertain it in spite of plain evidence to the contrary. It should never be forgotten that it is not the erroneous nature of a belief that constitutes it a delusion. What constitutes a delusion is the inability to rectify the belief when the means of rectification are provided. Hence, before we can say that a belief is a delusion, we must show, first, that it is erroneous; and second, that the person who entertains it has had plain evidence of its falsity. For this reason debateable facts—that is to say, statements whose falsity cannot be positively proved—should never be introduced into certificates of lunacy. Such a statement as that "she believes," or "she entertains a delusion that her husband is unfaithful," should never be placed in a certificate. It may be an absolute delusion. We will suppose, for the purpose of argument, that it is an absolute delusion. But it is impossible to set forth in the certificate proof of its falsity, or to show that proof had been offered to the wife of such a convincing nature as to constitute the retention of the belief an insane delusion.

Summarily, it may be laid down that every fact stated as evidence of insanity should be accompanied by proof of its insanity, unless its insane character is apparent on the face of it. It is necessary to insist strongly upon this point because it is so frequently disregarded. Here are a few instances, taken from actual certificates given by medical men who themselves knew that the statements were false, but forgot that other people were not in the same position to judge of their falsity:

"She believes she has travelled all over Europe."

"Thinks she is engaged to be married."

"Says that she has spent two days in Russia."

"Says her intended husband will go round in his yacht from Poole Harbour to Harwich to see her father concerning her marriage."

"Says he is the Marquis de R——."

"Has written to Mr. Gladstone about the Darwinian theory."

"Says he is going into partnership with Mr. V—— in the gin trade."

Innumerable other instances might be adduced, but these will be enough to indicate to the reader, who is in the position of the third person with regard to these cases, how little indication of insanity there is in these statements taken by themselves, and how important it is that such statements should be completed by further evidence, first, of their falsity, and second, of the inability of the patient to recognise their falsity.

2. *The Certificate must be Definite.*—Want of precision in the statements embodied in them is a very frequent and a very serious defect in medical certificates. Many certifiers do not seem to recognise that what is wanted is the *evidence* upon which they have concluded that the patient is insane, and state instead the conclusion at which they have arrived. Thus it is no uncommon thing for a statement that the patient is "irrational," "is suffering from melancholia," "is in a state of dementia," "is imbecile," to be put forth as a fact indicating insanity. Such statements are, of course, statements that the patient is insane, but are not facts upon which the

certifier has formed his opinion that the patient is insane.

That a patient "suffers from delusions" is a fact indicating insanity, but it is not a sufficiently definite fact to introduce into a certificate. Upon so bald a statement no person should be deprived of liberty. For his own protection also, the certifier should be more specific in his statements. Suppose that several years afterwards he is examined in open court upon his certificate, he will be required to state the nature of the delusions, and it may then appear that they are of the character of those given in a previous page, or he may have forgotten all about them, and be placed before the public in a very unfavorable light. The precise character of the delusion should in every case be stated.

"Conversation that I have had with him" has been in at least one case stated as a fact indicating insanity, and a judge has decided that it was a sufficient statement; but it would be very unsafe to repeat this statement in the hope that another judge would be found to accept it.

Such statements as that a patient is "uncertain and wayward in his manner," that "his appearance is strange," that "he has a peculiar demeanour," and so forth, are inadmissible. If his appearance, manner, and demeanour are altered, and if this alteration is accepted as evidence of insanity, the character of the alteration should be stated.

That he is "rambling and incoherent in conversation" is a good and sufficiently definite statement for a certificate, and "incoherency," if present, may be stated, but is scarcely sufficient of itself.

"Absurdity of behaviour" is insufficient, for it is manifest that if a person's behaviour is absurd, the absurdity can be described.

The general rule which governs all these cases is this: *No statement should be made in a certificate in general terms if the facts admit of more specific terms being used.*

Want of precision frequently appears in certificates in the way in which the facts are stated. It cannot be too strongly impressed upon the certifier that he should confine himself to stating what he actually observes, and should avoid stating as facts the inferences that he draws from his observations.

No statements are commoner in certificates of lunacy than that the patient thinks, or believes, or imagines, or wishes, or is determined to, or has an idea that, or has a delusion that, or feels, or hopes, or desires, or is apprehensive, or does not understand, or has some other mental attitude. These are all matters of inference, not of observation, and should never be stated as facts. All that can be directly observed is that the patient STATES this or DOES that, and to his sayings and doings the certificate should be strictly limited. It is not even justifiable to state that a patient is depressed. All that can be observed is that he has an *appearance* of depression, and the signs which go to make up this appearance may be individually mentioned.

On the other hand, it is permissible to state that a patient is excited, for excitement is as truly applicable to conduct as to mind, and an excited demeanour is directly observable.

To say that a patient "has lost his memory" is

an unwarrantable statement. A total loss of memory can only exist with total unconsciousness, and therefore to say that a patient, who is conscious, though insane, has "lost" memory must always be erroneous. But apart from this, it is too much to say that a patient has a great defect of memory. What is actually observed is that the patient, when questioned as to past events, fails to give correct answers; and the usual statement that is made upon this observation is "he has forgotten," or "he cannot remember" so-and-so. For aught the certifier can tell, the patient may, however, remember the matter perfectly well, but may be unable or unwilling to say so. Occasionally, in an effort at greater accuracy, the certifier puts down, not that the patient is "unable to remember," but that he "cannot say" when a certain event took place, or as the case may be. But even this statement is beyond what the facts warrant. All that the certifier knows by observation is that the patient *does* not give a correct answer. Whether he *can* answer correctly is beyond the reach of observation, and beyond the competence of the certifier to state.

Generally it may be laid down that a certifier should never state that a patient is *unable* to do this or that. All that can be observed is that he *does* not do it. It is quite fair and accurate to say, if it is the fact, that the patient "appears to make an effort to do" the thing and yet fails to do it, but it should not be said that he *cannot* do it; whether he can or not is known to himself only. Occasionally a certificate will state that a patient "cannot concentrate his thoughts," or "cannot control himself." These are manifestly not observed facts.

Similarly, it must not be stated that a patient *will* not do a thing. Such a statement implies that the certifier has a knowledge of the patient's consciousness which is altogether beyond his ken. That "he will not speak for hours together," or "will not answer when addressed" are altogether unwarrantable assumptions. All that can be observed is that he *does* not answer and *does* not speak.

Lack of precision often appears in certificates in the form of exaggeration. The exaggeration is entirely unintentional on the part of the certifier, and arises merely from want of habitual close attention to the meaning of words used. Thus it is very common for certificates to state that the patient is "in constant apprehension," or "is continually talking" of this or that, when the fact observed was that he was apprehensive at the time of observation, and that he talked at frequent intervals on the subject stated. A certificate will sometimes set forth that the patient talked "incessantly" on one topic, and yet give remarks that he made on other topics.

Again, it will be said that a patient is "completely demented," when, perhaps, his dementia is not deep enough to prevent him from dressing and feeding himself; the fact being that he is only sufficiently demented to be incapable of answering questions intelligently; or his conversation is said to be "completely incoherent," when, as a matter of fact, it is the sentences only that do not cohere, the words being correctly related to each other.

3. *The Certificate must be clearly expressed.*—This is a matter in which certificates are often very imperfect,—indeed, some are almost unintelligible.

The certificate should be written in the indicative mood. Very commonly it reads thus:—"Wildness of manner," "Incoherence," "Her leaving the house at night," "Defective memory," "In a state of excitement," "Being under a delusion," "Found praying in the street," "Keeping obstinately silent," "Gesticulation," "Refusal of food."

The certificate should begin "He states" so-and-so, or "He does" so-and-so. It always is, or ought to be, founded on statements or acts of the patient, and these statements or acts should be plainly set forth in positive terms.

The most fertile source of confusion in certificates is, however, in the mismanagement of the pronouns. It is quite surprising what intricate and perplexing entanglements of he, him, and his a certificate will contain, and how incapable the medical mind appears to be in dealing with the *oratio obliqua*. These defects appear, of course, most conspicuously in the statements of the second class of facts—those communicated by others; though they are by no means absent in those of the first class, as the following specimen will show:—"The patient states that he knew Mr. M. in Australia, and that he has often visited him at his house there, and that on one occasion he went into his house and ate the dinner that had been prepared for him." Who was the visitor, whose was the house, and whose the dinner, are here left in uncertainty; and it is obvious that, on one reading of the statement, the fact that one man went into his own house and ate his own dinner is alleged as a reason why another man is to be considered insane.

In the statement of "facts communicated by others" this confusion of pronouns is rather the rule than the exception. The following examples will suffice :—"Mrs. B., sister to the patient, states that she has an idea that she can make their fortunes by electricity, has attempted suicide, religious mania, dirty habits, craving for drink, smashes all she can get." Here it appears that the patient is to be considered insane because her sister has an idea that fortunes are to be made by electricity, and has other peculiarities.

"Her mother, Mrs. R., tells me that she is unable to keep her in her room, and she threatens her with violence. She tells me she has been up and down stairs all night in a most excited condition, and she thinks she is a countess." To take one only, the last of these statements, it is evident that the phrase "she thinks she is a countess" is susceptible of four different interpretations; and even if the first "she" is understood to refer to the patient, there are yet two alternatives : it may be herself or it may be her mother whom she believes to be entitled to the rank.

The way to avoid these ambiguities is obvious. The pronouns should be used as little as possible, and the names of the persons indicated inserted in their stead. Or if the pronoun be used, the name of the person to whom it refers should be added immediately after it, either in or out of brackets, unless it is perfectly clear from the context to whom it refers. Thus the first sentence should read, "Mrs. B., sister to Miss F., states that Miss F. has an idea that she (Miss F.) can make their fortunes,"

&c. The second should read, "Mrs. R., mother of Miss R., tells me that she is unable to keep Miss R. in her room, and that Miss R. threatens her with violence. Mrs. R. states that Miss R. has been up and down stairs all night in a most excited condition, and that Miss R. thinks that she (Miss or Mrs. R., as the case may be) is a countess." So stated, the only ambiguity that remains is as to whether the room in which Miss R. could not be kept was her own or her mother's, and this could, if it were material, be elucidated by the same means.

Returning now to the form of the certificate, we find that it begins by reciting the name, address, and occupation of the patient. The purpose of this recital is the identification of the person to whom the certificate refers, and the particulars cannot therefore be too carefully or fully inserted. In the first blank must be inserted the full Christian names and surname; in the second blank the full postal address; in the third, the administrative county, that is to say, the county, county city, or county borough, in which his residence is situated. Lastly, it must not be forgotten, though it usually is forgotten, that the rank, profession, or occupation of the patient must also be inserted in the last blank. As certificates are usually printed, every temptation is held out to the certifying practitioner to omit this last particular, and to this temptation he usually succumbs. By the addition of a single letter to the statutory form, the omission would be made impossible except by gross negligence. In the statutory form the first line of the certificate runs—

In the matter of *A. B.* of [1] in the county [2] of [3] an alleged lunatic.

To which are appended the notes—

[1] Insert residence of patient. [2] City or borough, as the case may be. [3] Insert profession or occupation if any.

After the word "county" is inserted the word "city" or "borough," as the case may be, and after the final word "of" is inserted the name of the county. The certifier having reached the end of the line, and filled all the blanks, naturally considers that the [3] refers to a note instructing him to fill in the name of the county, and that this word being inserted, and the sentence complete, his task is at an end. So sure is he of the obvious nature of the reference [3] that in nine cases out of ten he does not refer to it; and consequently the occupation is omitted, and all the trouble is incurred of amending the certificate and sending it backwards and forwards between the Commissioners in Lunacy, the superintendent of the institution, the certifying practitioner, and the judicial authority.

All this trouble might have been averted if the first line in the certificate were printed and annotated thus:

In the matter of *A. B.* of [1] in the county [2] of [3] a [4] an alleged lunatic.

[1] Insert residence of patient. [2] City or borough as the case may be. [3] Insert name of county. [4] Insert rank, profession, or occupation.

In case the alleged lunatic is of no occupation the fact must be so stated.

The next clause in the certificate is—

I, the undersigned C. D., do hereby certify as follows.

Here the certifier should insert his full Christian names and surname.

1. I am a person registered under the Medical Act, 1858, and I am in the actual practice of the medical profession.

2. On the day of 18 , at [4] in the county [5] of [separately from any other practitioner] [6], I personally examined the said *A. B.*, and came to the conclusion that he is a [lunatic, an idiot, or a person of unsound mind], and a proper person to be taken charge of and detained under care and treatment.

[4] Insert the place of examination, giving the name of the street, with the number or name of the house, or should there be no number, the Christian and surname of the occupier.

[5] City or borough as the case may be.

[6] Omit these words where only one certificate is required.

It is important that the instructions in the annotations to the form should be exactly followed. The omission, for instance, of the name of the street or the number of the house will invalidate the certificate.

With respect to this paragraph of the certificate several cautions are required.

Where two certificates are required, the patient must be examined by each practitioner separately from any other. It is usual in lunacy cases for the family medical adviser, who signs one certificate, to call in a consultant, who signs the other; and the common custom, when consultations are held, is for the practitioners concerned to meet at the house of the patient. This practice is commonly followed in lunacy cases, and in order to comply with the provisions of the Act it is usual, after the consultation has been held, for first one and then the other practitioner to interview the patient for the second

time and alone, and for the certificate to be made upon the observations made at this second interview.

It is right, however, that medical practitioners should know that this common practice has been severely commented upon by an eminent judge during the trial of a notorious *cause célèbre*. For the two doctors to go together to the house of the patient, together to interview the patient, and then for first one and then the other to leave the room for a while, so that each might be left alone for a time with the patient, was, he said, a merely colourable compliance with that provision of the Act which requires that the examination by each practitioner shall be made separately from any other and that, "anything more calculated to excite suspicion could not be supposed than both the doctors meeting and going together."

The object of the provision manifestly is that the patient shall have the benefit of a second examination by a person who shall not be biassed nor prejudiced by the first examiner. In order to secure an examination by a person of completely open mind, the Act should have provided that the practitioners were not to communicate with each other about the case until the certificates were signed. Such a provision would, from a medical point of view, have been absurd, for it is in many cases impossible to arrive at a just conclusion without a knowledge of the previous medical history of the case. But, in the absence of such a provision, it seems immaterial whether the facts of the case are communicated to the second practitioner in the house of the patient or elsewhere; and, in spite of the judicial dictum above alluded to, the present practice, which is con-

venient, and which gives the patient the benefit of a consultation, will probably be continued. It should, however, always be arranged that, after hearing the facts of the case, the consultant should first see the patient alone, so that the examination on which his certificate is based should be held before he has seen the patient in conjunction with his brother practitioner. When this arrangement is adhered to, there would seem to be no objection to the visit in common. The certificate of the regular medical attendant of the patient can, of course, be based upon an examination made on quite another occasion, and thus the spirit as well as the letter of the Act will be complied with.

Then comes the chief clause in the certificate :

3. I formed this conclusion on the following grounds, viz. :

(*a*) Facts observed by myself at the time of examination [7].

[7] If the same or other facts were observed previous to the time of the examination, the certifier is at liberty to subjoin them in a separate paragraph.

Unless so subjoined, the facts set forth in the certificate must have been observed by the certifier at the actual interview which is held for the purpose of certification. It matters not that the certifier may have been attending the patient two or three times a day for weeks past, and may have become cognizant, while so attending, of irrefragable evidence of insanity ; unless he can observe these facts at the time of making the examination for the purpose of certifying, he must not introduce them into the certificate, except as secondary matter in a separate paragraph particularised as not then ob-

served. No certificate is valid unless it contains facts observed by the certifier himself.

(*b*) Facts communicated by others, viz. : [8]

[8] The names and Christian names (if known) of informants to be given with their addresses and descriptions.

The particulars required by this annotation are seldom given with the proper fulness. They are, however, very necessary. It must always be kept in mind that the certificate is a legal document, and that every person mentioned in it must be fully named and described, so that on any future occasion he or she can be *identified*. The particulars here required are not mere unnecessary verbiage, owing their insertion to the prolixity of the legal mind, and to be brushed aside and disregarded by the more practical good sense of the medical certifier. They are necessary for the legal identification of the person referred to, and must be inserted in full.

4. The said *A. B.* appeared to me to be [or not to be] in a fit condition of bodily health to be removed to an asylum, hospital, or licensed house [9].

[9] Strike out this clause in the case of a private patient whose removal is not proposed.

Certifiers are apt to forget that, unless the words in brackets are struck out, this paragraph is nonsense. They should be struck out unless, of course, the patient is unfit to be removed.

There is, however, another duty incumbent on the certifier under this clause. He should satisfy himself, not only that the patient is fit to be removed, but also in what bodily condition the patient is before removal. It must be remembered that upon admission

into asylums every patient is carefully examined, and a report of his bodily health and condition is sent to the Commissioners in Lunacy. If, upon admission, bruises, or fractures of ribs, or other injuries are found upon the patient, the certifying medical men will be called upon to give evidence as to their knowledge of the existence of these injuries; and if they are found to be ignorant they will have a very unpleasant time. Every patient, therefore, who has been excited, who has been rough, whose movements have had to be forcibly restrained, or who is feeble, or is known to have fallen, should be very carefully examined for signs of injury before being sent to an institution. If injuries are found, they should be accurately described in a note written at the time; and, if none are discovered, the fact should be noted.

5. I give this certificate having first read the section of the Act of Parliament printed below.

Dated . (Signed) *C. D.*, of [10]

[10] Insert full postal address.

The ordinary signature of the certifier is sufficient in this place.

Extract from Section 317 *of the Lunacy Act*, 1890.

Any person who makes a wilful misstatement of any material fact in any medical or other certificate, or in any statement or report of bodily or mental condition under this Act, shall be guilty of a misdemeanour.

The four documents above described, viz. the petition, the statement of particulars, and the two medical certificates, are not all that will be required by the judicial authority. He will expect to find

accompanying them a form of "order," with all particulars filled in and ready for his signature.

The following is the form of the order:

I, the undersigned E. F. [here insert the full Christian names and surname of the judicial authority], being a justice for [insert the name of the borough or county in which he has jurisdiction] [or the judge of the county court of or the stipendiary magistrate for], upon the petition of *C. D.* (insert full names, address, and description—rank or occupation—of petitioner) in the matter of *A. B.*, a lunatic (or idiot or person of unsound mind), accompanied by the medical certificates of G. H. and J. K. (insert the full names of the certifiers) hereto annexed, and upon the undertaking of the said *C. D.* to visit the said *A. B.* personally or by some one specially appointed by the said *C. D.* once at least in every six months while under care and treatment under this order, hereby authorise you to receive the said *A. B.* into your asylum (or hospital or licensed house or house as the case may be). And I declare that I have [or have not] personally seen the said *A. B.* before making this order.

Dated .

(Signed) E. F.,
A justice appointed under the above-named Act [or the judge of the county court of or a stipendiary magistrate].

To (insert the name of the medical superintendent of the asylum or hospital or the resident licensee of the licensed house or of the person in whose charge the patient is to be placed).

The petition, with the four accompanying documents, has now to be "presented" to a judicial authority. The name and address of this official are to be ascertained as directed in p. 8, and personal inquiry should be made at his house to discover whether he is at home or away. So that he is not *staying* away from home, it is not necessary that he should be actually indoors at the time that the documents are delivered. It is not necessary to

present them to him in person. If they are left at his house in the hands of a servant or other responsible person, that is a "presentation" of them, and the day on which they are so left may be considered the date of presentation of the petition, even although it does not actually come into the hands of the judicial authority until the following day.

On receipt of the petition, the judicial authority has three courses open to him.

1. He may, if satisfied with the evidence in the medical certificates, make an order forthwith (Section 6 [1]).

2. He may, if not satisfied with the evidence, appoint "as early a time as practicable, not being more than seven days after the presentation of the petition, for the consideration thereof" (Section 6 [1]); and he may visit the alleged lunatic at the place where he may happen to be (Section 6 [2]). The visit is usually made at the time that the petition is considered.

The persons signing the medical certificates have a right to be present when the petition is considered (Section 6 [3]).

At this further consideration of the petition, the judicial authority may make an order, or may dismiss the petition, or may adjourn the consideration for not more than fourteen days (Section 6 [4]).

It is important to note that all persons present at the consideration of a petition, or otherwise having official cognizance of the fact that a petition has been presented, are bound to keep secret all matters or documents which may come to his or their notice by reason thereof (Section 6 [5]).

3. He may refer the consideration of the petition to any other judicial authority who is willing to undertake it. The justice to whom the petition is referred need not have the same jurisdiction as he who transfers it.

Supposing that the judicial authority is dissatisfied with the evidence of insanity, and decides to dismiss the petition, occasion may subsequently arise for the presentation of another petition with respect to the same patient. In this case the petitioner has two new duties cast upon him. (1) He must state in his new petition the fact that a previous petition has been dismissed, and all that he knows about that previous petition and its dismissal. (2) He must obtain from the Commissioners in Lunacy, and present with his petition, a copy of the statement sent to them of the reasons for dismissing the previous petition. If he wilfully omits to do this he is guilty of a misdemeanour (Section 7 [4]).

Supposing, however, that the judicial authority make the order, then the order is a sufficient authority, not only for the detention of the patient in the place named in the order, but for the steps necessary, and for the constraint upon the patient's actions that may be required, for the purpose of taking him thither. The patient must, however, be taken by the petitioner or by some person authorised by the petitioner (Section 35).

It is to be noted that the order does not authorise the detention of the patient in any place not named in the order. It does not, for instance, authorise his detention in the house in which he is living when certified. Until he is removed, there is, after signa-

ture of the order, no more legal authority than there was before for the constraint of his actions, except in so far as constraint is necessary for the removal.

Although, therefore, the order is a valid authorisation for the admission of the patient for a period of seven days from its signature, it is no authorisation for his detention during those seven days in any place but the place named in the order.

The removal of the patient should therefore be effected as speedily as possible.

In effecting the removal of a patient a practical caution should be given to the practitioner and the friends of the patient, which, though it has no legal bearing, will be found of great service, and may usefully be introduced here. It is this : never use a subterfuge to effect the removal. It is unhappily a very common occurrence for the friends of a patient, dreading the opposition that he will make to the removal, and in horror of a " scene," to inveigle him into a carriage on the pretence of going for a drive, and to take him to an institution without letting him know whither he is going, or even warning him that he is not coming back. Such subterfuges are commonly most disastrous. They may serve their immediate purpose—that of getting the patient removed without the occurrence of a " scene,"—but their ultimate effect is to produce in the patient a feeling of violent and bitter hostility and distrust to all those who have taken part in the deception ; and the writer knows of cases in which this hostility and distrust have remained in full intensity for years after not only the occasion itself, but after the patient

had recovered and returned to his duties in the world.

It is much better on every account, if the patient is capable of understanding, to explain to him precisely what is going to be done, and to endeavour to reconcile him by persuasion to his removal. If his repugnance remains, it must be explained to him that legal authority to remove him has been obtained, and that if he do not submit, force will, if necessary, have to be used for the purpose. If he have sufficient sense to comprehend the whole matter, he will in all probability yield to this representation; and even if force have to be employed, it will never leave behind it the rankling hostility that is left by deception.

If the patient is maniacally excited, it will, of course, be necessary to administer an efficient sedative before removal is attempted.

The same caution as to deception in dealing with persons who are or are alleged to be insane should be observed in all dealings with them. A practitioner who is called in to examine a patient with a view to certification should never on any account stoop to subterfuge, often and urgently as he may be begged to do so by the friends of the patient. He should insist upon being introduced to the patient as a medical man, and should at once, if asked, state the purpose of his visit. Any other course is dishonest, derogatory, and likely to be disastrous.

The Urgency Order.

The second method by which a person who is not a pauper may be placed under control is by means of an urgency order; but this method is purely a

temporary expedient to obtain immediate control of a patient while the usual order by judicial authority is being obtained. The Legislature has recognised that the steps necessary to obtain an order by judicial authority upon petition must necessarily occupy some time, and that there are cases in which it is expedient that a patient should be placed under control at once, and before it is possible to obtain the order by petition. For these exceptional cases the machinery of the urgency order has been provided, so that neither the patient nor the public should suffer from his being at large while the steps necessary for obtaining an order on petition are being gone through.

It must be clearly understood, however, that an urgency order will not suffice for the permanent detention of a patient. It remains in force for seven days only, at the end of which the patient will be liberated, unless in the meantime steps have been taken to obtain an order on petition. It is not necessary that the order on petition should be *made* within the seven days, although there is a notion widely prevalent that unless the order is made within that time the patient must be liberated. So long as, during the seven days, a petition is "pending," the patient may legally be kept under control until the petition is finally disposed of, *i. e.* until the order is made or the petition dismissed (Section 11 [6]).

The question at once arises, what is meant by a petition being pending? No doubt, if a person has determined in his own mind to present a petition, but has taken no step whatever toward doing so, the petition is pending in a certain sense, but not in the

sense required by the Act. So, too, if the petition is made out and signed, and the statement and certificates completed, the petition is undoubtedly pending, but this degree of pendency will not satisfy the requirements of the Act. For the purpose of the continued detention of the patient beyond the seven days, the petition will not in law begin to "pend" until it has been *presented* to the judicial authority.

Supposing that at the end of the seven days the order of the judicial authority have not been obtained, it will be necessary to give notice to the superintendent of the asylum, or other person in charge of the patient, that a petition is pending, or he will be compelled to discharge the patient. This notice should, of course, be in writing.

Like the petition, the urgency order must be signed, if possible, by the husband or wife, or some other relative of the patient, and if not so signed it must contain a statement of the reasons why it is not; of the connection of the person signing with the patient; and of the circumstances under which he signs the order (Section 11 [1, 3]).

The person who signs the urgency order must be at least twenty-one years of age, and must, within two days before the date of the order, have personally seen the patient (Section 11 [4]).

An urgency order may be made before or after a petition has been presented. If made before, it must be referred to in the petition. If made after, a copy must be sent "forthwith" to the judicial authority to whom the petition has been presented (Section 11 [5]).

An urgency order must be accompanied by *one*

medical certificate, and by a statement of particulars similar to that which accompanies a petition (Section 11 [1, 7]).

The order of succession in which these documents are signed is not material. It is expressly provided in the Act that the urgency order may be signed before or after the medical certificate (Section 11 [2]), and, though not so provided, it may be taken that either of these documents may be signed before or after the statement of particulars.

The following is the form of an urgency order:

I, the undersigned, being a person twenty-one years of age, hereby authorise you to receive as a patient into your house [or hospital or asylum or as a single patient] *A. B.* [here insert the full Christian names and surname of the patient] as a lunatic [or an idiot or person of unsound mind], whom I last saw at [insert the full postal address, name of street, and number of house] on the day of 18 , [some day within two days of the date of the order, that is to say, the day before or the day but one before].

I am not related to or connected with the person signing the certificate which accompanies this order in any of the ways mentioned in the margin. [That is to say, husband, wife, father, father-in-law, mother, mother-in-law, son, son-in-law, daughter, daughter-in-law, sister, sister-in-law, partner, or assistant.]

Subjoined [or annexed] hereto is a statement of particulars relating to the said *A. B.* [This is identical with that which accompanies the petition, and is given on p. 11.]

(Signed)

Name and Christian names at length.

Rank, profession or occupation (if any) [if none, the fact to be stated].

Full postal address.

How related to or connected with the patient.

[If not the husband or wife or a relative of the patient, the person signing is to state here as briefly as possible—

1. Why the order is not signed by the husband or wife or a relative of the patient.

2. His or her connection with the patient, and the circumstances under which he or she signs (*see* petition, p. 9).]

Dated this day of 18 .

To [insert the name of the person who is to have charge of the patient], superintendent of the asylum [or hospital, or resident licensee of the house known as .]

It is not necessary to insert the full names of the superintendent or resident licensee, as he is sufficiently identified by his description. Where, however, the patient is to be placed in single care, the full names should be given, together with the full postal address of the house in which he is to be placed.

The medical certificate which accompanies the urgency order is in precisely the same form as that which accompanies a petition (p. 12). It contains, however, an addition in the following words, inserted at the end :

I certify that it is expedient for the welfare of the said *A. B.* [or for the public safety *as the case may be*] that the said *A. B.* should be forthwith placed under care and treatment.

My reasons for this conclusion are as follows : [state them].

It will be seen that these reasons must come under one of the two previous heads. They must show that his immediate detention is expedient either for the welfare of the patient *or* for the public safety.

The first heading—the welfare of the patient—was no doubt inserted into the Act to provide for the immediate control of actively suicidal patients ; but it is obvious that the words as they stand are much wider than is necessary to provide for this con-

tingency. If it can be shown that it would conduce *in any way* to the patient's welfare to place him under care and treatment forthwith, that is a sufficient reason for making an urgency order. It is not required that this measure is *necessary* for the welfare of the patient; it is sufficient that it be *expedient*. In other words, if it appear probable that the patient will gain by this step being taken, an urgency order may be made.

As a matter of experience it not unfrequently happens that it is expedient for the welfare of the patient that he should forthwith be placed under care and control, for reasons other than that of a suicidal tendency in him. For instance, he may refuse food and require to be forcibly fed, an operation that cannot be conveniently conducted several times a day in a private house. Or he may be living in lodgings or in an hotel, and the people of the house may insist upon his removal. Or he may have just arrived from abroad and be on shipboard. Or, if a woman, she may be suffering from exaggerated nymphomania, and it may be difficult to restrain her from acts of indecency. Or there may be other circumstances which render it expedient for his own welfare that he should be forthwith placed under care and treatment.

On the other hand, a patient may not be placed under control under an urgency order because it is expedient for the public welfare that he should be so placed. The step must be expedient for the public *safety* if the reason alleged is under the second heading. Primarily this provision was inserted in the Act to meet the cases of patients who are homi-

cidal or violent, and whom it is necessary to place forthwith under care and treatment in order to prevent them from assaulting and doing bodily harm to others; and such patients may properly be made the subjects of urgency orders.

But these are not the only patients to whom this provision of the Act applies. The public safety may be endangered in more ways than by the direct infliction of personal injury on members of the public. The patient may have a tendency to commit arson; or without having a direct tendency, he may have a strong inclination to dabble with fire, and to meddle with it in so negligent a way as to endanger the lives of persons in the same building. Or his insanity may exhibit itself in endeavours to stop railway trains by placing obstacles on the line. Or he may be suffering from satyriasis, and may have a tendency to indecently assault females. In such a case the "public safety" would undoubtedly be endangered, for it is inconsistent with public safety that a woman should be liable to be indecently assaulted.

Would, however, a tendency to mere indecent behaviour—as, for instance, exposure of the person—be such an encroachment on "public safety" as to warrant the signature of an urgency order with respect to a patient so behaving? It would not be safe to answer this question in the affirmative. But it is of little importance to decide this point, since a patient so behaving may undoubtedly be placed forthwith under care and treatment on the ground that it is expedient for his own welfare. His welfare includes, among other elements, the consideration and respect in which he is held by others; and a

person by behaving with manifest indecency would be so depreciating this consideration and respect as to render it "expedient for his own welfare" that he should forthwith be placed under care and treatment. In the case of a woman this argument applies with augmented force.

Moreover, if a patient have a tendency to indecency he will be as likely to exhibit this tendency in public as in private, and to behave indecently in public is a criminal offence; and it is certainly "expedient for the welfare" of a person that he should be prevented from committing a criminal offence.

The certifier must, however, elect on which ground to base his reason for making the certificate, for the Act requires that the ground be specifically stated. It is, of course, open to him to base his reason on *both* grounds, viz. that it is expedient for the patient's welfare *and* for the public safety.

The practitioner who signs the certificate accompanying the urgency order will usually be required to sign a second certificate to accompany the petition, which must, as has been seen, be presented within seven days of the date of the urgency order. To make this second certificate it is not necessary that he should have a second interview with the patient. A copy of the certificate accompanying the urgency order, made and signed by the same practitioner, will suffice for the petition, provided, of course, that the interview with the patient was not more than seven days before the petition is presented.

The Inquisition.

The duties of medical men with respect to an inquisition in lunacy are simply to examine the patient, to make an affidavit as to his condition, and to give evidence at the inquisition. All other proceedings in connection with an inquisition are conducted by solicitors, and with these proceedings the medical practitioner has nothing to do. He is, however, often consulted by the friends of the patient, in his capacity of confidential family adviser, as to the expediency of applying for an inquisition, and as to its effect; and it is advisable that he should have some knowledge on these subjects in order that his advice may be sound.

The question of applying for an inquisition arises always from some difficulty in dealing with the property of the patient; and this difficulty is often very great and pressing. When, for instance, the bread-winner of a family somewhat suddenly becomes insane, it often happens that those who are dependent on him for support are entirely deprived of funds; and although they may be in a thoroughly solvent and even opulent condition, they are put to the greatest inconvenience for the want of immediate control of money. There may be plenty of money in the bank, but the only person upon whose order it can be withdrawn is incapable of signing a cheque. Dividend warrants may flow in, but cannot be cashed for want of the signature of the recipient. Under these circumstances the medical man who has helped the family through their other troubles with respect to the patient, and who is often an intimate friend

of the family, is appealed to for advice as to what is best to be done.

Here it is necessary to give him a very important caution. Upon no account should he ever authorise, sanction, or assist in obtaining the signature to any document of a person whom he believes to be insane. The temptation is often very great. The wife of a patient who is not yet certified, or concerning whom an order is not yet made, or who may be actually under care at the time, will often ask the doctor to obtain for her the patient's signature to a cheque, or an authorisation for her to receive certain funds. The object may be in the highest degree praiseworthy. It may be to maintain the family of the patient, or to maintain himself, or to supply the the funds for his own removal. The need may be pressing. The ready money of the family may have been exhausted by the extravagance and waste of the patient himself. The *bona fides* of the applicant may be beyond all question. But the thing should not be done. It is on the face of it a wrong thing for anyone to do, but it is doubly wrong for the medical man, who has himself actually stated in a certificate, which has the force of an oath, that the patient is so unfit to manage his affairs that it is necessary to place him under legal restraint, for the purpose, *inter alia*, of preventing him from having any share in their management. If, after this, he allow the patient to take part in a business transaction, he completely stultifies himself; and if ever the matter comes up for review in a court of law (and it is impossible to say of any of these cases that it will not so come up), he is sure to suffer

very severely, either in reputation or in pocket, or both.

When necessity arises to deal with funds belonging to an insane person and standing in his name, it is usual to apply for an inquisition in lunacy, and until recently this was the only method by which power to deal with the property of a lunatic could be obtained. By the Act of 1889, since codified in the Act of 1890, a great and beneficial alteration was made in the law; and since this alteration is not generally known to solicitors, who, when applied to on this account, usually proceed as a matter of course to obtain an inquisition, it will be well to state here briefly the effect of the change.

As the law now stands, it is competent to a judge in lunacy to make an order giving to any person whom he may think fit, the same powers, practically, with respect to the property of any lunatic, as were before exercised by the committee of the estate of persons found lunatic by inquisition. Now the powers of the committee of the estate of a lunatic so found by inquisition are very large—are, in fact, almost plenary; and give to the committee, subject, of course, to the jurisdiction and authority of the judge, nearly the same powers of dealing with the property of the lunatic as the possessor of the property would, if sane, be entitled to. Any or all of these powers may now, by the order of a judge, and without the expensive and dilatory process of an inquisition, be conferred upon any person who is approved of by the judge.

These powers, or any of them, may be granted with regard to the property, not only of a person

who is lawfully detained as a lunatic, though not so found, but of any person, though not so found and not detained as a lunatic, who is proved to the satisfaction of the Judge in Lunacy to be, through mental infirmity arising from disease or age, incapable of managing his affairs, *whether such person is or is not a lunatic within the meaning of the Act.*

The method of obtaining this order is simple, is moderately inexpensive, and is moderately speedy; but it is one which can scarcely be effected without the intervention of a solicitor, nor is it wise to attempt to dispense with the solicitor's services.

Summary Reception Orders

The proceeding of the order on petition, and of the urgency order, can be followed in those cases only in which the patient has relatives or friends who are willing to act for him, and to initiate these proceedings. It may, however, happen that a person may become insane, and either may have no relatives or friends; or his relatives and friends may not be ascertainable; or the relative or other person who has care or charge of him may treat him cruelly or neglect him. For these cases the Act provides other modes of proceeding, and the procedure differs according as the patient is or is not "wandering at large."

If he is *not* wandering at large, but is either not under proper care and control, or is cruelly treated or neglected by the relative or other person having charge of him, then it becomes the duty of every constable, relieving officer, and overseer of the

parish in which the lunatic is, within three days of obtaining knowledge that there is in the parish a lunatic who is as above described, to give information thereof on oath to a justice who is a "judicial authority" (Sect. 13).

The justice is then to direct any two medical practitioners to visit and examine the alleged lunatic, and is to proceed as far as possible as if the information on oath were a petition for a reception order. If he is satisfied that the person is a lunatic and is not under proper care and control, or is cruelly treated and neglected, then he may make an order for the removal of the patient to an institution (Sect. 13).

In this mode of procedure the duty of the medical practitioner is secondary and appointed; that is to say, he does not act until required to do so by the direction of the justice. But, although his duty under the statute is thus postponed to that of others, it may well happen that he is the only person, or the proper person, to initiate the proceedings by giving information to the constable, relieving officer, or overseer, as to the existence and the circumstances of the lunatic. It may happen, for instance, and has happened, that a person living in lodgings or staying in an hotel becomes insane; that the doctor is sent for to see him; that his friends are unknown; and that the medical man is, as a matter of course, asked by the keeper of the hotel or lodging-house what course ought to be taken to get the patient under proper care and control; and this question he should be able to answer.

In the last case—that of a lunatic wandering at

large—the medical practitioner has no duty unless and until he is called in by a justice to examine the patient, nor is it likely that in this case he will be called upon for advice. It does, however, happen occasionally that a patient is apprehended by the police as a lunatic wandering at large, is brought before a justice, and by him sent to the county or borough asylum of the district, and that the fact that he has been so sent comes subsequently to the knowledge of his friends. The first object of the friends in such a case is to remove the patient from the pauper asylum to which he has been sent, and to place him in another institution that offers more comfortable surroundings, or in private care. The family medical man is usually the person entrusted with the business of obtaining this removal, and it is expedient that he should be aware of the steps that are necessary. These steps are very simple, and are as follows :

(1) Application must be made to the visitors of the asylum for permission for the relative or friend to take the patient under his care ; and (2) another application must be made to the Commissioners in Lunacy (19, Whitehall Place, S.W.) for the consent of a commissioner to the removal of the patient from the place in which he is to the place to which he is to be taken.

In the first application, the applicant must satisfy the visitors that proper care will be taken of the patient. If this is shown the application must be granted (Sect. 22).

The second application will be granted as soon as the commissioners have satisfied themselves by in-

quiry of the superintendent of the asylum that the patient is fit to be removed.

If the friends of the patient become aware, before he has been sent to an asylum, that he has been apprehended as a lunatic wandering at large, they may obtain the care of him direct from the magistrate, and thus prevent his being sent to an asylum at all (Sect. 22); or if he have passed out of the jurisdiction of the magistrate, may obtain control of the patient from two visitors of the asylum before even the patient has been taken to the asylum.

Pauper Patients

Section 14 of the Act of 1890 provides that every medical officer of a union who has knowledge that a pauper resident within the district of the officer is or is deemed to be a lunatic, and a proper person to be sent to an asylum, shall, within three days after obtaining such knowledge, give notice thereof in writing to the relieving officer of the district, or, if there is no such officer, to an overseer of the parish where the pauper resides.

A person not previously a pauper may, it is obvious, become one by becoming insane, and so losing his means of livelihood. He becomes a pauper by statute if he is visited by a medical officer of the union at the expense of the union.

The obligation to give notice to the relieving officer or overseer rests upon those medical practitioners only who are medical officers of unions.

The relieving officer or overseer, upon obtaining knowledge that a pauper resident within his district is deemed to be a lunatic, is, within three days of

obtaining such knowledge, to give notice thereof to a justice.

The justice is, within three days of receiving such notice, to have the alleged lunatic brought before him, to examine him, to call in a medical practitioner to examine him, and to make such inquiries as he thinks advisable; and if he is satisfied that the alleged lunatic is a lunatic and a proper person to be detained, and if the medical practitioner signs a certificate to that effect, the justice may make an order for the reception of the lunatic into an institution.

The justice may, if he chooses, visit the patient instead of having him brought before him.

The justice, after making the reception order, may suspend its execution for fourteen days or less, and in the meantime may give such directions for the care of the lunatic as he considers proper (Sect. 19).

If the medical practitioner who examines the patient certifies in writing that the patient is not fit to be removed, the removal shall be suspended until the same or some other practitioner certifies in writing that the lunatic is fit to be removed; and every medical practitioner who has certified that a lunatic is not fit to be removed shall, as soon as in his judgment the lunatic is in a fit state to be removed, be bound to certify accordingly. The execution of a summary reception order with respect to a pauper may therefore be suspended for an indefinite time by a medical certificate, and may be revived by another medical certificate (Sect. 19).

The main differences in the procedure with respect

to detention under care of paupers and non-paupers are therefore as follows :

Paupers.	Non-Paupers.
The initial proceeding is a notice by a relieving officer or overseer to any justice having jurisdiction in the district.	The initial proceeding is a petition by a relative of the patient to a justice who must be "specially appointed" under the Act.
The justice may have the patient brought before him or may visit him, but must personally examine him.	The justice cannot have the patient brought before him, but may visit him in the place where the patient may happen to be, and need not personally examine him.
One medical certificate is required, and is made by a medical practitioner called in by the justice.	Two medical certificates are required, and are made by medical practitioners, called in by the friends of the patient.
The execution of the reception order may be suspended for fourteen days by the justice, and may be suspended for an indefinite time by a medical certificate that the patient is unfit to be removed.	The reception order remains in force for seven days only, and if the patient be not admitted within that period the order lapses.

The procedure by which a private patient can be forthwith placed under care by an urgency order has its parallel in the case of pauper patients, in whose case the procedure is even more summary. A constable, relieving officer, or overseer, who is satisfied that it is necessary for the public safety, or for the welfare of an alleged lunatic, that the lunatic should be forthwith placed under control, may remove the alleged lunatic to the workhouse, where he may be detained for a period of three days (Sect. 20).

No medical certificate, such as must accompany an urgency order, is required in this case. The relieving or other officer acts entirely on his own responsibility. He must, however, be satisfied that it is *necessary* to place the patient at once under care and control, not merely that it is *expedient* to do so.

Lunatics in Workhouses

For quiet, harmless, and chronic lunatics a kind of limbo or intermediate state is provided, which is neither full freedom nor complete "detention under care and treatment." The locus of this purgatorial state is the workhouse, and the presiding genius who decides whether the patient shall remain therein, or be transferred to an asylum, is the medical officer of the workhouse.

A lunatic may be detained for fourteen days in a workhouse on the certificate of the medical officer of the workhouse in the following form:

I, the undersigned, medical officer of Workhouse of the Union, hereby certify that I have carefully examined into the state of health and mental condition of *A. B.*, a pauper in the said workhouse, and that he is in my opinion a lunatic, and a proper person to be allowed to remain in the workhouse as a lunatic and that the accommodation in the workhouse is sufficient for his proper care and treatment, separate from the inmates of the workhouse not lunatics [or that his condition is such that it is not necessary for the convenience of the lunatic or of the other inmates that he should be kept separate].

The grounds for my opinion that the said *A. B.* is a lunatic are as follows.

Dated

(Signed)
Medical Officer of the Workhouse.

The form of this certificate is peculiar, insomuch

as the medical officer is to state that he has *carefully* examined the patient, a statement which is not required in any other certificate under the Act, and which is probably inserted to remove any impression on the mind of the medical officer that the certificate is a mere matter of form, and one which need not be very carefully considered. There is an idea abroad that paupers in workhouses do not meet with the same sedulous care in matters connected with their welfare as do private patients, and the word in question is probably inserted to indicate that in this case, at any rate, the same care is required.

The detention under the above certificate may endure for fourteen days only. If the lunatic is to be detained in the workhouse for a longer period than this, it is necessary to obtain an order by a justice having jurisdiction in the place where the workhouse is situate (Sect. 24).

This order is made on the application of a relieving officer, supported by the certificate above mentioned, and by another certificate by another medical practitioner, who must not be an officer of the workhouse (Sect. 24 [4]).

No form for this second certificate is provided in the Act. It may, however, be taken that it should be in the same form as the previous certificate, *mutatis mutandis*,—that is to say, the words "medical officer of the workhouse" will be omitted in both places in which they occur. The practitioner who signs this second certificate will have to satisfy himself not only that the pauper is a lunatic and a proper person to be allowed to remain in the workhouse as a lunatic, but that the accommodation in

the workhouse is sufficient for his proper care and treatment separate from the inmates of the workhouse not lunatics, or that his condition is such that it is not necessary for the convenience of the lunatic or of the other inmates that he should be kept separate.

If there is a lunatic in a workhouse, and if the medical officer of the workhouse does not sign the foregoing certificate, or if the justice, before the expiration of the fourteen days, does not make such an order, or if the lunatic ceases to be a proper person to be detained in a workhouse, then, in either case, the medical officer of the workhouse is forthwith to give notice to the relieving officer that a pauper in the workhouse is a lunatic, and a proper person to be sent to an asylum; and thereupon the relieving officer and all other persons concerned are to take the steps already set forth for the removal of the lunatic to an asylum; and until he can be so removed he may, after the medical officer has given the notice, legally be detained in the workhouse.

Harmless and quiet lunatics may be removed from asylums to workhouses and detained therein under the following circumstances:

(1) If the lunatic is discharged from an institution for lunatics, and *two* certificates are given with regard to him: *one* by the medical officer of the institution that the lunatic has not recovered, and is a proper person to be kept in a workhouse as a lunatic; *the other* by the medical officer of the workhouse that the accommodation in the workhouse is sufficient for the lunatic's proper care and treatment, separate from the inmates of the workhouse not lunatics, or

that the lunatic's condition is such that it is not necessary for the convenience of the lunatic or of the other inmates that he should be kept separate (Sect. 25).

The first certificate, given by the medical officer of the institution, will of course accompany the patient to the workhouse. The second certificate, given by the workhouse medical officer, will be made in a book kept for that purpose in the workhouse.

A patient received into a workhouse under these circumstances, who subsequently becomes unfit to be detained in a workhouse, cannot be returned to the asylum without a fresh notice to the relieving officer and a fresh order under certificates, as provided in the previous section.

(2) Power is given by the Act to the visitors of any asylum under certain conditions to make arrangements with the guardians of any union for the reception into the workhouse of any chronic lunatics, not being dangerous, who are in the asylum, and have been selected and certified by the manager of the asylum as proper to be removed to the workhouse (Sect. 26).

In this case the certificate of the medical officer of the workhouse as to accommodation therein is not required. The certificate of the manager of the asylum alone is necessary (Sect. 26).

A patient received into a workhouse under this section is still a patient on the books of the asylum, and should he cease to be a fit person to be detained in the workhouse as a lunatic, he may be taken back to the asylum without any fresh justice's order.

The Act does not, however, prescribe the authority

upon which he may be removed to the asylum, should it be found necessary to do so. This may be settled by the arrangement which is made between the visitors of the asylum and the guardians. Should it not be so settled, the medical officer must act upon his own discretion, and his best course will probably be to cause the workhouse authorities to give notice to the manager of the asylum to take the patient back.

CONTROL AND MEDICAL ATTENDANCE OF INSANE PERSONS.

The legal obligations of medical practitioners who have the care of insane persons will be dealt with here only in so far as they refer to those who have patients under single care. The legal obligations of medical superintendents of institutions for lunatics have been dealt with by the writer in another book ('Lunatic Asylums, their Organization and Management').

A medical practitioner may be concerned with lunatics in single care in two ways; he may be either "the person having charge of" a single patient, or he may be "the medical attendant" of a single patient.

He cannot act in both capacities toward the same patient.

For the care of every patient who is placed in single care, and is not a lunatic so found by inquisition, there must be two persons responsible, viz.—

1. The "person having charge" of the patient, who may or may not be a medical practitioner.

2. The "medical attendant," who, of course, must be a medical practitioner.

The duties of the "medical attendant" are described at p. 109.

The duties of the "person having charge" of a single patient will now be dealt with.

In the first place, it is important that medical practitioners should be fully aware that they must not take charge of any person of unsound mind except under the sanction of an order by a judicial authority, nor must any person receive more than one lunatic unto an unlicensed house. The following is the section of the Act dealing with this subject:

"Section 315. (1) Every person who, except under the provisions of this Act, ... for payment takes charge of, receives to board or lodge, or detains a lunatic or alleged lunatic in an unlicensed house, shall be guilty of a misdemeanour, and shall also be liable to a penalty not exceeding £50.

"(2) Except under the provisions of this Act, it shall not be lawful for any person to receive or detain two or more lunatics in any house unless the house is an institution for lunatics or a workhouse.

"(3) Any person who receives or detains two or more lunatics in any house except as aforesaid shall be guilty of a misdemeanour."

It will be seen that the terms of the Act are very sweeping. It is illegal "for payment to take charge of" a lunatic *or alleged lunatic*, except under the provisions of the Act. It is very common for medical practitioners to receive into their houses and keep for care and treatment hysterical women, drunkards, and other persons who are bordering upon insanity,

and it behoves such practitioners to take especial care that the persons that they so receive and keep are neither lunatics nor "alleged lunatics." The term lunatic in the Act may be taken to mean a person who is *certified* to be a lunatic or an idiot, or a person of nnsound mind, or an imbecile; while an "alleged lunatic" in this section means a person who, without being actually certified, is *certifiably insane*,—that is to say, with regard to whom a certificate of unsound mind could be signed.

Not only should no medical practitioner receive into his house a certifiably insane patient, but upon any patient living in his house becoming certifiably insane, he should take immediate steps to have the patient certified, and an order made with regard to him; otherwise the practitioner will be contravening the Act, and will render himself liable to the penalties prescribed therein.

In case a medical practitioner renders himself liable to punishment under the Act for taking charge of a lunatic, it will be no defence to plead that the practitioner was not aware that the patient was insane. In "the Queen *v.* Bishop," the defendant was convicted under 8 and 9 Vict., c. 100, s. 44, of receiving two or more lunatics into her house, not being a registered asylum or hospital, or a house duly licensed under the Act; but it was specially found by the jury who convicted, that although the persons so received were lunatic, the defendant honestly and on reasonable grounds believed that they were not lunatic. It was held on appeal (five judges) that such belief was immaterial, and that the conviction was right.

In receiving into his house a patient under the order of a "judicial authority" as prescribed by the Act, the medical practitioner at once places himself under legal obligation to do a number of things—to keep documents, keep books, to send from time to time notices, to obtain permission for various things, and to do other things, neglect of any of which may bring him into serious trouble. It is most important, therefore, that he should be acquainted with all the duties which the law prescribes for him.

The following are the penalties to which a practitioner subjects himself by neglect of these duties:

Section 316. Any person having charge of a single patient who omits to send to the Commissioners the prescribed documents and information upon the admission of a patient, or to make the prescribed entries and give the prescribed notices upon the removal, discharge, or death of a patient, shall be guilty of a misdemeanour, and shall also be liable to a penalty not exceeding £50.

Section 319. If the person having charge of a single patient omits to send to the coroner notice of the death of a patient within the prescribed time, he shall be guilty of a misdemeanour.

Section 320. Any person who makes default in sending to the Commissioners or any other person any return, extract, copy, statement, notice, plan, or document, or any information within his knowledge when required to do so under this Act or any other Act relating to lunacy, or any rules made under this Act, or in complying with the said Acts or rules, shall for each day or part of a day during which the

default continues be liable to a penalty not exceeding £10, unless a penalty is expressly imposed by this or any other Act for such default.

Provision is made for the remission, at the discretion of the court, of all or part of the penalty in cases where the default was from mere accident or oversight, and not from wilful or culpable neglect.

In addition to the things hereinafter set forth which he is liable to a penalty for neglecting, there are other things the doing of which by the person in charge of a lunatic or supposed lunatic is made penal and even criminal.

Thus by Section 321 it is enacted that any person who obstructs any Commissioner, or Chancery or other visitor in the exercise of powers conferred by this or any other Act shall, for each offence, be liable to a penalty not exceeding fifty pounds, and shall also be guilty of a misdemeanour.

The powers conferred by the Act upon the Commissioners with regard to single patients are as follows:

A. One or more of the Commissioners have power at all reasonable times to visit a single patient, and to inquire into and report to the Commissioners or the Lord Chancellor on the treatment and state of health, both bodily and mental, of the patient, and as to the moneys paid on his account (Section 199).

As the Commissioners have power to inquire into these matters, any refusal to answer their inquiries with regard to such matters would be an "obstruction" to the exercise of their powers, and punishable under Section 321.

B. Upon every visit of one or more Commissioners

the medical journal must be produced to him or them (Section 199 [3]).

The non-production of the medical journal would be an "obstruction," and punishable.

c. Any Commissioners visiting an unlicensed house may inspect any part of the house and the grounds belonging thereto (Section 200).

Any refusal or obstruction to showing any part of the house or grounds would be an "obstruction" under the section.

The powers conferred by the Act upon Chancery Visitors extend to those lunatics only who are "so found" by inquisition, but with respect to them are plenary. They have power to visit when they please, and to make inquiries and investigations as to the care and treatment and mental and bodily health of such lunatics, and as to the arrangements for their maintenance and comfort, and "otherwise respecting them" (Section 183).

It will be seen that the Chancery visitors have power to make not only inquiries, but investigations; and this power they freely exercise. For instance, they may investigate the state of a patient's wardrobe, may have him undressed and satisfy themselves that his clothing is sufficient, may see his food served and taste it, examine his bedding, and so forth; and any difficulty placed in the way of these investigations, or any refusal to facilitate them, would be an "obstruction" under the Act.

The other visitors referred to in the section, obstruction of whom in the exercise of the powers conferred by the Act would be criminal, are as follows:

Any two of the "visitors appointed for the county or borough" in which the patient is residing have the same powers, A and B, as the Commissioners; as also has any one such visitor upon the request in writing of the Commissioners, or of any two of them. Such visitors have not the power C of inspecting any part of the house and grounds (Section 199).

The "visitors appointed for the county or borough" are the visitors appointed by the justices of the county or borough to visit licensed houses.

Section 254. The Commissioners may by order direct any competent person or persons to visit and report upon the mental and bodily condition of any lunatic or alleged lunatic under the charge of any person as a single patient, and to inquire into and report upon any matters into which the Commissioners are authorised to inquire. A visitor "directed" under this section to visit a patient has the same powers as a Commissioner, and therefore fuller powers than a visitor "requested" to visit under Section 199.

The Lord Chancellor may by order require any person to visit and examine a lunatic or alleged lunatic, and to inspect any place in which a lunatic or alleged lunatic is detained, and to report to the Lord Chancellor (Section 205).

A Secretary of State has the same power, except as to lunatics "so found" (Section 205).

A Judge in Lunacy has power to direct the Chancery visitors to visit persons alleged to be lunatics (Section 184).

If any person having charge of a lunatic ill-treats

or wilfully neglects the patient he shall be guilty of a misdemeanour, and be liable to fine or imprisonment, or both (Section 322).

"Wilful neglect" in this section means more than the neglect to supply the patient with necessaries, or to keep him in proper warmth and cleanliness. All this may be done, and yet the person in charge of the patient may be indictable for wilful neglect. If, for instance, a suicidal patient is left unwatched, and by that want of supervision is afforded an opportunity to commit suicide, and does commit suicide, then the person whose neglect of supervision afforded the opportunity for suicide may be prosecuted for wilful neglect, and for this offence persons have been convicted and punished.

Such being the things that a person in charge of a lunatic may not do, it remains to explain what are the things that by statute he is obliged to do. His obligations under the statute are numerous, and must be punctually observed. They fall under the following heads :

1. Those attending the reception of a patient (p. 70).
2. Those necessary for the retention of a patient (p. 89).
3. Those attending the recovery of a patient (p. 90).
4. Those attending the discharge and removal of a patient (pp. 90, 93).
5. Those attending the death of a patient (p. 95).
6. Those attending the escape and recapture of a patient (p. 97).

7. Those attending the use of mechanical restraint (p. 100).
8. That of obtaining the consent of the Commissioners, visitors, and others, in certain cases (p. 102).
9. Those attending a change of residence on the part of the person having charge of the patient (p. 104).
10. Those in connection with the correspondence of a patient (p. 105).
11. That of admitting certain persons to visit a patient (p. 106).
12. That of keeping certain books (p. 107).

Duties attending the Reception of a Patient

When a medical practitioner receives a lunatic into his house, it is his duty to satisfy himself that the documents presented with the patient are sufficient to authorise and justify him in receiving and detaining the patient.

These documents differ in number and in form in different cases, and it is very necessary that the practitioner should be familiar with the requirements of each case, in order that he may satisfy himself whether or no the requirements are fulfilled, and may consent or refuse accordingly to receive the patient.

The documents differ according to whether the candidate for reception is a lunatic "so found" or not, and according to whether he is now for the first time to be detained or is removed from other care.

Reception Order for a Lunatic "so found"

The documents that authorise the reception of a

lunatic "so found by inquisition," ordinarily known as a chancery patient, are *either*—

An order by a Master in Lunacy ; *or*—

(1) An order by the committee of the person of the lunatic, accompanied by—

(2) An "office copy" of the order appointing the committee (Section 12).

Where there are two committees of the person, the signature of both are required. Where there are three, the signatures of two are sufficient.

The "office copy" of the order appointing the committee may be a copy of so much only of the order as refers to the appointment of the committee, and is in the following form :

Extract from Order

In Lunacy

day the day of 18

In the matter of *A. B.*, a person of unsound mind.

Upon reading a certificate in this matter, dated

I do order as follows :

That the custody of the person and the regulation and government of the said *A. B.* be committed and granted to *C. D.*, of

(Signature of Judge.)

[L. S.]

(Signature of Clerk.)

The order by the committee of the person is usually in the following form :

I, C. D., being the committee of the person of *A. B.*, a lunatic so found by inquisition, hereby authorise you to receive the said *A. B.* into your house, and to detain him under care and treatment.

Dated (Signed)

To E. F., of

When a lunatic is not so found, and is to be placed under care now for the first time, the documents necessary to authorise his reception and detention in single care are either—

1. A judicial reception order on petition with the accompanying documents, or—

2. An urgency order with the accompanying documents.

Judicial Reception Order

In this case the authority for the reception and detention of the patient is the order; and if the order be in proper form, and be valid on the face of it, and if it be accompanied by the other documents required, viz. the petition, statements and medical certificates (*which also are in proper form and valid on their face*), then the practitioner may lawfully receive the patient, even though there are material errors in the documents sufficient to render some or all of them invalid.

The requirement in italics is not in the Act; nor is it in the rules of the Commissioners made under the Act. It is not, therefore, a statutory requirement, and in strict law the person who receives a patient is not bound to see that it is observed. His authority for receiving the patient is the order, and so long as the order is in proper form, he is under no statutory obligation to satisfy himself as to the validity of the accompanying documents. The Act provides that, unless certain regulations as to these documents are observed, *no order shall be made*; but if, in spite of this enactment, a judicial authority takes upon himself to make an order, the person to

whom it is directed may lawfully act upon it, and is under no legal compulsion to go behind it and discover whether the documents on which it is founded are in proper form.

Although, however, there is nothing, either in the Act or in the rules made under the Act by the Commissioners, to require the person who receives a patient to satisfy himself as to the proper form of the documents, yet in a *circular* issued by them, and dated April 16th, 1890, the Commissioners state that "the person receiving the patient must see that all requirements respecting reception orders *and certificates* as specified in Sections 28 to 33, both inclusive, appear on the face of the documents to have been complied with." It is evident, therefore, that the Commissioners expect the person receiving a private patient to examine the certificates; and, since it is always open to a person to refuse to receive such a patient, the order merely authorising, and not requiring or directing him to receive, it is to be presumed that, in the case of a patient being presented for reception with an order which, although in proper form, yet, owing to some invalidating defect in the certificates, ought not to have been made, the Commissioners will expect that the reception of such a patient will be refused.

There is no requirement in the circular, any more than in the Act, or in the rules under the Act, for the person receiving the patient to have regard to the petition or statement of particulars. He may therefore, without doubt receive a patient, even though these documents or either of them exhibit

some material and obvious defect.* He may not, however, admit a patient if either the petition or the statement is *altogether wanting*, for he is under statutory obligation to send copies of these documents to the Commissioners in Lunacy within one clear day of the patient's admission.

The Order.—The person who receives a patient under a judicial reception order is undoubtedly under obligation to see that the order is in proper form; and if it be not sufficient to authorise the reception of the patient, the person to whom it is directed cannot legally receive the patient, and if he do receive the patient will do so at his peril.

* In Lowe *v.* Fox, plaintiff was taken to and detained in the defendant's asylum as a person of unsound mind, under an order signed by plaintiff's husband, and containing a statement of questions and answers concerning the plaintiff. To the question "Age?" the answer was "50." To the question "Whether first attack?" the answer was "For the last 20 years has been subject to what is termed hysteria." To the question "Age, if known, on first attack?" the answer was "30." To the question "When and where previously under care and treatment?" the answer was "During this period of 20 years has been constantly under treatment." A few days after the plaintiff had been received into the asylum, the last answer was altered by adding to it the words "For hysteria by" several doctors whose names were given. No copy of the order as so altered was sent to the Commissioners, nor did they sanction the alteration. The plaintiff brought an action against the defendant for, *inter alia*, maliciously and without reasonable or probable cause assaulting and imprisoning her. Defendant relied upon 8 and 9 Vict., c. 100, ss. 99, 105. Held, affirming the decision of the Court of Appeal (15 Q. B. D. 667), that the answers were a sufficient compliance with the requirements of 16 and 17 Vict., c. 96, s. 4, and Sched. A, No. 1; and that the alteration, not being of a material part of the order, did not invalidate the order (15 Q. B. D. 637; 12 App. Cas. 206).

To put the order in proper form, all the blanks in Form 3, Schedule II, of the Act (see p. 37) must be filled in, all the superfluous words deleted, and no words must be deleted that are not superfluous.

An order may, however, be sufficient to authorise the reception of a patient until it can be amended, even though all these requirements are not complied with, provided always that it contain no damning or fundamental defect.

The fundamental or vitiating defects in an order, any one of which must prevent the person to whom it is dirccted from receiving the patient, are four :

(*a*) In the designation of the patient. If the name be omitted after the words "authorise you to receive the said ——" the patient cannot be received, for the order is not complete. There is virtually no order. The same is the case if the wrong name—that of the petitioner, for instance—is inadvertently inserted here. But if the name is merely misspelt, or if one or more of the Christian names be omitted, the order is good until amended. What is required is that the patient shall be sufficiently designated for identification.

(*b*) In the date. If the date of the order be more than seven clear days before the patient is brought for reception, he cannot be received. So if the date be omitted, the order is of no effect, for the patient must be received within seven clear days of "its date."

(*c*) In the signature. If the signature be omitted, there is no order ; neither does the order authorise the reception of the patient if it be signed by a relative of the petitioner, or of the husband or wife of

the patient. Such persons are incapable of making an order.

(*d*) In the designation of the person to whom the order is directed. If the person is not designated the order is not complete; there is no order.

Any other defect in the order may be amended on the requirement of the Commissioners by the judicial authority who made the order, and such amendment, if made within fourteen days of the reception of the patient, validates the document retrospectively from the time of the patient's reception.

Until the amending Act of 1891 was passed there was a fifth possible fundamental defect. This was the deletion of the words "specially appointed under the Lunacy Act, 1890." Under this latter Act an order was not valid if made by a justice not "specially appointed;" but an order made by such an unappointed justice did, if these words were not erased, *appear* to be in conformity with the Act, and therefore, though really invalid, was, under Section 35, a sufficient authority for the reception of the patient. If, however, the words were erased, the order was not only invalid, but as it did not "appear to be in conformity with the Act," it gave no authority for the patient's detention.

In the Act of 1891, Section 24, clause 3, it is provided that a reception order shall not be invalid on the ground only that the justice who signed the order shall *appear* (that is, appear on the face of the order) to have not been duly appointed under Section 10 of the Act of 1890, if the order is within fourteen days after its date (not after reception of the patient) approved and signed by a judicial authority.

An order in which the words "specially appointed under the Lunacy Act, 1890," are deleted, does therefore now authorise the reception and provisional detention of the patient until, within fourteen days, the order is validated.

This amendment, unlike all other amendments to the order and certificates, does not require the sanction of the Commissioners, nor of the justice who made the order.

The Certificates.—As in the case of the order, the defects in these documents may be corrigible or vital. The vital defects, which should prevent the justice from making the order, and which the person to whom the order is directed should require to be amended before he receives the patient, are five :

(*a*) If the words stating that the certifier is registered and in actual practice are deleted. Whether the certifier is or is not actually so registered and practising is a matter which the person receiving the patient is not called upon to investigate. If he be not registered or not in actual practice, yet if the certificate states that he is, the person receiving the patient need not go behind the certificate. If, however, the words are by inadvertence deleted, the certificate is invalid, even although the judicial authority and the person to whom the order is directed may have knowledge that the certifier is registered, and is in actual practice. The judicial authority ought not to make the order, and if he do make the order, the person to whom it is directed ought not, according to the circular of the Commissioners (p. 73), to receive the patient.

(*b*) If the date of the *examination* is omitted, or

is more than seven clear days before the date of *presentation* of the petition.

(*c*) If the words "separately from any other practitioner" are deleted.

(*d*) If either of the certificates is signed by any of the following persons :

1. The petitioner.
2. Any near relative, partner, or assistant of the petitioner.
3. The person who is to have charge of the patient.
4. Any person interested in the payments on account of the patient.
5. Any near relative, partner, or assistant of persons 3 and 4.
6. Any near relative, partner, or assistant of the other certifier.
7. A "visitor," *i. e.* a visitor of licensed houses appointed by the justices of the county or borough (except in cases authorised by Section 33).

(*e*) If no "fact indicating insanity" observed by the certifier himself at the time of examination be stated in the certificate.

The sufficiency of the facts indicating insanity stated in the certificate is not a matter with which the person receiving the patient need concern himself. They are to satisfy the judicial authority ; and if the judicial authority is satisfied, taking them into consideration, together with his own observations, and such inquiries as he thinks proper to make, it is no business of the person who receives the patient to question them.

Urgency Order

When a patient is received under an urgency order, it is most essential that the person receiving the patient should satisfy himself that the requirements of the law are complied with in every respect. In the case of an order by judicial authority, the documents have usually passed through the hands of the magistrate's clerk, whose business it is to see that they are in proper form, and in any case the order is made by a justice, who is accustomed to the proceeding, is familiar with the requirements, and is unlikely to make any gross and invalidating error in the order. But an urgency order is made without legal assistance by a person who is totally unused to legal documents, to whom the whole procedure is new, and who is rarely able, without guidance, to avoid some serious error in the form of the order. Urgency orders should therefore be scrutinised with the greatest care before they are acted on.

The requirements with which an urgency order must comply are as follows :

1. It must be signed by a near relative of the patient, or if not, must show the reason why not ; and the connection of the signator with the patient, and the circumstances under which he signs, (*see* p. 19) must be stated.

2. The order must set forth that the signator is of age, and that he has, within two days of its signature, seen the patient.

3. It must be dated not more than seven days before the reception of the patient, or must contain a statement that a petition for a reception order is pending (p. 42).

4. It must have annexed to it a "statement of particulars" and one medical certificate.

The certificate which accompanies an urgency order must state that the certifier has personally examined the patient not more than *two days* before the *reception of the patient*. The date of the certificate may be either anterior or subsequent to the date of the order, and the Act contemplates that it will usually be subsequent, for the order may be dated seven days before admission, but the certificate must not be more than two.

The certificate must contain a statement that it is expedient for the welfare of the patient or for the public safety that he should be forthwith placed under care and control, and must give the reasons for this statement (p. 45, *et seq.*).

No obligation is laid by the Act upon the person to whom the order is directed to satisfy himself of the sufficiency of the reasons contained in the certificate. His authority for the reception of the patient is the urgency order, and if the urgency order appears to be in conformity with the Act, and is accompanied by the certificate in proper form, he may legally receive the patient. Should he not do so, he may perhaps be considered responsible for acts committed by the patient which would have been prevented by his reception.

In other respects the certificate must comply with the requirements of certificates accompanying a petition (p. 77), except that the words "separately from any other practitioner" may be deleted.

An urgency order remains "in force" for seven days from its date; or if a petition for a reception order

is pending, then until the petition is finally disposed of. Unless, therefore, the person who receives a patient under an urgency order receives, before the expiration of seven days from the date of the order, a judicial reception order made on petition, *or* a written statement from the petitioner that a petition for a reception order is pending, he must, at the end of seven days from the date of the urgency order, discharge the patient.

Admission on Removal

If the case is that of a patient who is not now placed under care and control for the first time, but who is removed from an institution or from other care, the documents necessary to authorise a person to take charge of him are as follows :

In the Case of a Lunatic "so found"

1. An order by the committee or committees of the person of the lunatic.

2. An "office copy" of so much of the order appointing the committee as refers to this appointment.

The form of the office copy has already been given (p. 71).

The order for the reception of a Chancery patient on removal from other care differs from the original reception order in this respect, that it must be in duplicate; and one duplicate is to be delivered to the person from whose care, the other to the person to whose care, the lunatic is taken (Section 70). The following form of authority for the removal of a Chancery patient is convenient.

I, *C. D.*, being the committee of the person of *A. B.*, a lunatic so found by inquisition, hereby authorise the removal of the said *A. B.* from the care of *E. F.*, of , in the county of to the care of *G. H.*, of in the county of , and I authorise the said *G. H.* to receive the said *A. B.* into his house at , and to detain the said *A. B.* under care and treatment.

Dated. (Signed).

In the Case of a Lunatic not "so found"

1. An order of removal by a person having authority to discharge the patient (*see* p. 91) (Section 58).

2. The consent of a Commissioner in Lunacy (Section 58).

3. Copies of the documents on which the patient was originally received (Section 70).

The order of removal must set forth that the person who makes the order is a person having authority to discharge the patient.

These orders of removal are usually made on forms supplied by the Commissioners in Lunacy when their consent to the removal is given.

3. In addition to the order for removal, the patient must be accompanied by copies of the reception order, petition, statement, and certificates on which the patient was originally received. These copies are to be supplied free of expense, and are to be certified under the hand of the person whose duty it is to deliver them, *i. e.* the person under whose charge the patient has been (Section 70).

If the patient was received by transfer from some other care into the place from which he is now removed, the "reception order" under which he

was received was an order of removal, and a copy of this must be sent with him to his new abode, while the "documents accompanying the same" were the original reception order, statements, and certificates; and copies of these also are to be sent.

If the patient was originally received under an urgency order, which has been superseded by a judicial order on petition, it does not appear necessary that copies of the urgency order and certificate should accompany him on his removal, for these have been altogether superseded by the judicial reception order, and he is no longer detained under them. Although not strictly necessary, it is, however, advisable that, for the information of the person under whose care he is to be, copies of the urgency order and certificates should be sent.

If a patient is removed before the expiration of an urgency order, copies of that order and of the accompanying documents are, of course, required.

Reports and Proceedings on and after Reception

Upon receiving a patient into his care, the first duty of a medical practitioner is to examine the order and other documents, and see that they authorise him to receive the patient. His next is to examine the patient, and this he should do before the person who has brought the patient has left the house.

When a patient, who has previously been residing with the person who is to have charge of him as a single patient, is made the subject of a reception order, he is thereupon legally "received" into the charge of the person, and the same proceedings have

to be gone through as if the patient were then for the first time brought to the house.

The following are the matters which have to be noted upon this examination:

1. Identifying marks,—height, weight, complexion, colour of hair and eyes, deformities, malformations, moles, warts, callosities, scars, especially on penis, shins, and groins, pigment spots, and tattoo marks. These are necessary for the description of the patient in case of his escape, and in other contingencies.

2. State as to cleanliness,—dirt on skin; note especially round the toes and on tendo Achillis. Stickiness of hair. Signs of vermin. Fleabites are distinguished by a minute red puncture, surrounded, when fresh, by a pink flush, from $\frac{1}{8}$ to $\frac{1}{4}$ inch in diameter. Bites of bugs present a larger puncture, surrounded, when fresh, by a wheal from $\frac{1}{4}$ to $\frac{1}{2}$ inch or more in diameter. Body lice are indicated by scratches that have drawn blood about the shoulders and waist. Examine the hair for nits, and the roots of the fingers for scabies.

3. Mark the presence or absence of fever rashes.

4. Signs of injury. Never fail to examine for broken ribs. Note all bruises; their position, size, shape, and colour, the last particular being important as an indication of their age.

5. Note the presence or absence of goitre, enlarged glands, hernia, nodes, varicose veins, &c.

6. Take the temperature, pulse, respiration, and state of the tongue.

These particulars should be at once entered in the medical journal. The attention of the person who brought the patient should be called to any

signs of dirt, injury, or violence that may be present, and the description of such signs in the medical journal should be read over to that person and signed by him or her. This precaution is an extremely important one, for it settles once for all the question whether any injuries that are discovered on the patient were inflicted before or after reception.

The next duty of the person who receives a private patient into care is to send notice to the Commissioners in Lunacy of the reception of the patient. This notice must be sent within one clear day of the patient's reception, and must be accompanied by a copy of the order and other documents on which the patient was received (Section 10 [3], Rules 7, 5).

The NOTICE OF ADMISSION is in the following form:

Notice of Admission

Date of reception order, the day of 18

I hereby give you notice that *A. B.* was admitted into the house occupied by [here insert the full names *and occupation* of the occupier of the house], situate at [here insert *full* postal address], as a single patient on the day of , and I hereby transmit a copy of the reception order and medical certificates [or certificate] on which he was received.

A statement with respect to the bodily and mental condition of the above-named patient will be forwarded in due course.

(Signed)

the person having charge of the said lunatic as a single patient [the full names *and occupation* of this person must be given].

Dated the day of 18 .

To the Commissioners in Lunacy.

Where the person who has charge of the patient

is also the occupier of the house, his full names and occupation must be given in both places.

In case signs of injury are found upon the patient on reception, mention of the injuries should be made in the notice of admission.

If it appears from the reception order that the patient has not been personally seen by the judicial authority before admission, the person who has charge of the patient must, within twenty-four hours of his reception, give to the patient a notice in writing of his right to be taken before or visited by a judicial authority (Section 8 [2]).

If the patient, within seven days after his reception, expresses his desire to exercise this right, the person having charge of him must procure him to sign a notice of such desire, and must forthwith transmit it by post in a prepaid *registered* letter to a judicial authority, not being the judicial authority who made the order, or to the justices' clerk of the petty sessional division or borough where the lunatic is (Section 8 [2]).

If, however, the medical attendant of the patient within twenty-four hours after reception, in a certificate signed and sent to the Commissioners, states that the exercise of this right would be prejudicial to the patient, the notice of his right to see a judicial authority need not be given to the patient (Section 8 [2]).

The following are the forms of these notices and certificate.

Notice of Right, &c.

Take notice that you have the right, if you desire it, to be taken before or visited by a justice, a judge of county courts, or a magistrate. If you desire to exercise such right you must give me notice thereof by signing the enclosed form on or before the day of next .

Dated . (Signed)

Form to be enclosed with the foregoing.

Dated

Address

I desire to be taken before or visited by a justice, judge, or magistrate having jurisdiction in the district within which I am detained.

(Signed)

Certificate of Prejudice

I certify that it would be prejudicial to *A. B.*, a lunatic under the charge of *C. D.*, of [insert full postal address], to be taken before or visited by a justice, a judge of county courts, or a magistrate.

(Signed)

Medical attendant of the said *A. B.*

It will be observed that the medical attendant is not called on give the reasons which decide him that the interview would be prejudicial. He need merely state the fact. The cases in which the patient has not been seen by a judicial authority before reception are not numerous, and the cases in which it is necessary by certificate to prevent him from seeing a judicial authority after admission are very rare. It is, in fact, difficult to imagine a case in which such a certificate would be justified.

If the patient has been received under an urgency order, the person who has taken charge of him must, at the end of seven days from the date of the urgency order, ascertain whether a petition for a judicial

reception order is pending (*see* p. 42); and if no order has been made on petition, and no petition is pending, he must at once discharge the patient (Section 11 [6]).

As soon as an urgency order is superseded by a judicial order on petition, the person who has charge of the patient must transmit to the Commissioners in Lunacy copies of the judicial order, petition, statement, and certificates, as if no copy of the urgency order, &c., had been sent. With these he must send a second notice of admission in the following modified form.

Date of reception order [here give the date of the judicial, not the urgency order].

I hereby give you notice that *A. B.*, who was received into this house as a single patient on the day of 18 , on an urgency order, dated the day of 18 , has been examined by a judicial authority, and I herewith transmit a copy of the reception order made by the judicial authority, and of the certificates, and of the petition and statement of particulars on which the said *A. B.* was received.

A statement of the mental and bodily condition of the above-named patient will follow in due course.

Dated . (Signed)
the person having charge of the patient.

After the second and before the end of the seventh clear day after the reception of the patient, his *medical attendant* is to make, sign, and send to the Commissioners a statement of the bodily and mental condition of the patient (*see* Medical Attendant, p. 110).

At the expiration of one month the medical attendant is to send another report (p. 111).

Such are the statutory duties laid upon the person having charge of a single patient on the reception of

the patient. The second group of statutory duties refer to the retention of the patient.

Duties attending the Retention of a Patient

Every reception order made after the 1st January, 1890, expires at the end of one year from its date, and if it is not renewed at the end of the year, and thereafter from time to time, the patient cannot legally be detained, but must be discharged (Section 38).

The times at which the order must again be renewed are before the expiration of the second, fourth, seventh, twelfth, seventeenth, twenty-second, &c., years from the date of the original reception order, supposing the order to have been made since the 1st January, 1890 (Section 38).

If, however, the date of the original reception order was before January 1st, 1890, the order expired unless renewed on the 1st of May, 1891, and again on the 1st of May, 1892, and will expire unless renewed on the 1st May, 1894, and on the same day in 1897, 1902, 1907, 1912, &c. (Section 115).

The renewal of the reception order is effected by a "continuation order" made by the medical attendant of the patient, and sent to the Commissioners not more than one month nor less than seven days before the date fixed for the expiration of the order. For form of continuation order *see* p. 112.

In the case of lunatics so found by inquisition, the date of expiration of the order for the commitment of the lunatic does not depend on the date of the order, but is a fixed date, the same in every case, viz. the 1st of May in 1891, 1893, 1896, 1901, 1906,

1912, &c. The continuation orders for lunatics so found are to be sent, not to the Commissioners, but to the Masters in Lunacy; and, if they are not sent, the order for the commitment of the patient does not, as in the case of a lunatic not so found, necessarily determine, but determines only at the discretion of the Masters, and if they are not satisfied that the patient is still of unsound mind (Section 115).

Every person having charge of a single patient who detains a patient after he has knowledge that the order for his reception has expired is guilty of a misdemeanour (Section 38 [7]).

Duty attending the Recovery of a Patient

On the recovery of a patient, the person having charge of him must forthwith send notice of the recovery to the person on whose petition the reception order was made, or to the person by whom the last payment on account of the patient was made, and must state in the notice that unless the patient is removed within seven days from the date of the notice he will be discharged. If the patient is not removed within seven days of the date of this notice the person having charge of the patient must discharge him (Section 83).

Duties attending the Discharge and Removal of a Patient

When a patient is "discharged" his reception order lapses, and he becomes a free agent. When he is "removed" his reception order continues in force, and he is still "detained under care and treatment."

Discharge

The person having charge of a single patient must discharge him (except under the circumstances given below) if the person, on whose petition the reception order was made, by writing under his hand so directs (Section 72).

If that person is dead, or incapable by reason of insanity, absence from England, or otherwise, of signing an order for discharge, or if a patient having been originally classified as a pauper is afterwards classified as a private patient, the person who made the last payment on account of the patient, or the husband or wife, or if there is no husband or wife, or if the husband or wife is incapable as aforesaid, the father, or if there is no father, or he is incapable as aforesaid the mother, or if there is no mother, or she is incapable, then anyone of the nearest of kin of the patient may give the direction for his discharge (Section 72 [2]).

If there is no person qualified to direct the discharge of a patient under this section, or no person able or willing to act, the Commissioners may order his discharge (Section 72 [3]).

In spite of an order for discharge made under the above section the person in charge of a single patient may refuse to discharge him if the medical attendant of the patient certifies in writing that the patient is dangerous and unfit to be at large, together with the grounds upon which the certificate is founded (Section 74).

This certificate may, however, be overruled by any one Commissioner, and if any one Commissioner,

after the certificate has been produced, consent in writing to the discharge of the patient, the patient must be discharged, notwithstanding that such a certificate may have been made (Section 74).

Two of the Commissioners, one of whom must be a medical and the other a legal Commissioner, may visit a single patient, and may within seven days after their visit, if the patient appears to them to be detained without sufficient cause, make an order for his discharge, and such an order must be obeyed by the person having charge of the patient (Section 75) under the penalties of a misdemeanour (Section 76).

Within three clear days of the discharge of a patient, the person having charge of the patient is to send a notice to the Commissioners in the following form (Rule 23, Schedule Form 11) :

I hereby give you notice that *A. B.*, a private patient, received into this house on the day of 18 , was discharged therefrom recovered [or relieved or not improved] on the day of 18 , by the authority of [give the name of the person who signs the order for the discharge, and state whether he is the "petitioner," the "person who made the last payment," or the other circumstance which gives him authority to make the order] (p. 91).

(Signed)
the person having charge of the said lunatic as a single patient.

Dated the day of 18 .

To the Commissioners in Lunacy.

In the case of a lunatic "so found" a similar notice must be sent to the Chancery visitors.

Removal

Any person having authority to order the discharge of a private patient (*supra*, p. 91) may, with the previous consent in writing of a Commissioner, by order in writing direct the removal of the patient to any institution named in the order, or to the charge of any person named in the order (Section 58).

The consent of the Commissioners is obtained by application to their secretary, who will, after inquiries have been made, forward to the applicant a form of consent, having appended a form of order for removal. It is necessary that the order of removal should state the place from which and the place to which the patient is to be removed.

Upon the death of a person having charge of a single patient, the Commissioners may (if the person having authority to order the discharge of the patient does not within seven days of the death apply for their consent to the removal of the patient) direct the patient to be removed to the charge of a person named in their order (Section 59).

Any two Commissioners may at any time order the removal of a lunatic from the charge of any person under whose care he is as a single patient to the charge of any other person, or to an institution for lunatics (Section 59).

In the case of the removal of a patient, it is not necessary, as it is in the case of his discharge, that the Commissioners should be one a legal and the other a medical Commissioner, nor is it necessary that they should visit the patient.

When a patient is removed, the person from whose charge he is removed must give to the person who executes the removal, free of expense, a copy of the reception order, and of the documents accompanying the same, that is, of the petition, statement of particulars, and medical certificates (Section 70).

Every such copy must be certified under the hand of the person whose duty it is to deliver the same (Section 70). The following is a proper form of certificate :

I certify that the annexed documents are true and correct copies of the reception order, petition, statement of particulars, and medical certificates (or as the case may be) under which *A. B.* was received into my care.

Dated . (Signed)

Within three clear days of the removal of a patient, the person having charge of the patient is to send to the Commissioners in Lunacy, and in the case of a lunatic "so found," to the Chancery visitors, a written notice in the following form (Rule 23, Schedule Form 10) :

Notice of Removal

I hereby give you notice that *A. B.*, a private patient, received into this house on the day of 18 , was on the day of 18 , removed to relieved (or not improved), by the authority of *C. D.*, the person on whose petition the order for the reception of the said *A. B.* was made, [or the person who made the last payment on account of the said *A. B.*, *or* as the case may be (*see* p. 91)].

(Signed)
the person having charge of the said lunatic as a single patient.

Dated the day of 18 .

To the Commissioners in Lunacy
[*or as the case may be*].

Duties attending the Death of a Patient

Upon the death of a patient, a number of notices are to be sent to different persons. All these notices are to be sent within forty-eight hours of the death, and all are in the same form except that to the coroner, which is more detailed than the others.

The first notice is to be sent to the coroner of the district, whose name and address, if not known, may be learnt by inquiry at the nearest police station. The notice is to be *prepared and signed* by the "medical person or persons" who attended the patient in his last illness, and is to be *sent* by the person having charge of the patient. Where this latter person is a medical practitioner, he will take part in the preparation and will sign the document, but the signature of the "medical attendant" must be added (Rule 24).

The following is the form of the document:

Address of the person having charge of the patient.

I [*or* we] hereby give you notice that *A. B.*, a [1] lunatic aged years, a [2] , whose profession or occupation was that of , and whose place of abode immediately prior to being placed under care and treatment was

DIED in this house on the day of 18 , at o'clock in the noon, in the presence of .

The cause of death of the said *A. B.*, [as ascertained by *post-mortem* examination,] was of duration.

The circumstances attending his death were not unusual [*or* were unusual in respect that].

Dated . (Signed) C. D.
E. F.

[1] Male or female.

[2] Single or married, or widow or widower.

The second notice is to be signed by the person having charge of the patient, and by him sent to each of the following persons:

1. To the Commissioners.
2. If the lunatic was "so found," to the Chancery Visitors, Royal Courts of Justice, Strand, W.C.
3. To the registrar of deaths for the district.
4. To the person named in the statement of particulars as the person to whom notice of death is to be sent.
5. To the petitioner, or the person by whom the last payment on account of the patient was made (Rule 24).

These notices are to be in the following form (Rules, Schedule Form 14):

Notice of Death.

I hereby give you notice that *A. B.*, a private patient received into this house on the day of 18 , died therein on the day of 18 .

And I certify that was present at the death of the said *A. B.*, and that the apparent cause of his death [ascertained by *post-mortem* examination *if so*] was .

Dated . (Signed)
Address of person having charge of the patient.

The person in whose charge the patient was must not allow the body to be buried or removed from the house until permission to do so is received from the coroner.

Duties attending the Escape and Recapture of Patients

If any person detained as a lunatic under the Act escapes, he may, without a fresh order and certificates, be retaken at any time within fourteen days of his escape by the person in whose charge he was, or by anyone authorised in writing by such person (Section 85).

A lunatic may be deemed to have escaped if he go or remain, without the permission of the person having charge of him, outside the grounds attached to the house in which he is detained, and out of the observation of those who have charge of him.

A patient who conceals himself within the house or grounds in which he is detained need not be considered to have escaped.

A patient who leaves the grounds without permission, but is observed, followed, and brought back without being lost sight of by the person having charge of him, or by any person employed or authorised by such person, need not be deemed to have escaped.

A patient who is observed and followed, but who during pursuit is lost sight of, must be deemed to have escaped.

A patient who is allowed to go out on parole for a certain time, and who wilfully breaks his parole and does not return at the end of the time of his leave, must be deemed to have escaped. If, however, he is detained by unavoidable causes he need not be considered to have escaped.

A patient who has escaped may, at any time

within fourteen days of his escape, be retaken by anyone authorised in writing by the person having charge of him (Section 85).

If, the escaped patient is wandering at large, every constable, relieving officer, and overseer of the parish in which he is wandering, is bound, immediately on obtaining knowledge that the person wandering at large is a lunatic, to apprehend him (Section 15).

The patient cannot be retaken by any person authorised, by a verbal order only, of the person having charge of him.

In every case of escape of a patient, the person having charge of him is to send, within three clear days after the escape, notice thereof to the Commissioners, and in the case of a lunatic "so found" to the Chancery visitors (Rule 23).

The notice is to be in the following form (Rule 23, Schedule Form 12):

Notice of Escape

I hereby give you notice that *A. B.*, a private patient received into this house on the day of 18 , escaped therefrom on the day of .

The state of mind of the patient at the time of his escape was [*state it*].

The circumstances attending the escape were as follows: [*state them*].

Dated the day of the person having charge of the lunatic as a single patient.

To the Commissioners in Lunacy

The statement as to the state of mind of the patient should indicate how far the patient was

capable of managing himself, and whether he was suicidal or dangerous to others.

The circumstances attending the escape should be stated in sufficient detail to fix the responsibility for the escape.

If any person detained as a lunatic in England escapes into Scotland or Ireland, notice of the escape is to be given "as soon as practicable" to the Commissioners, who may, by writing under their seal, authorise an application to be made by such person as they think fit to any justice having jurisdiction in the place where the lunatic was detained, for a warrant authorising such person to retake the lunatic and bring him back to such place (Section 86).

The warrant so obtained must be countersigned in Scotland by a sheriff, and in Ireland by a justice, before it can be executed (Section 86, [2]).

The warrant must be executed within fourteen days of the escape of the patient, or it lapses and becomes of no effect (Section 89).

When a patient is retaken after escape, notice must be sent within three clear days of the recapture to the Commissioners in Lunacy, and, if the patient is a lunatic "so found," to the Chancery visitors (Rule 23).

The notice is to be in the following form (Rule 23, Schedule Form 13) :

Notice of Recapture

I hereby give you notice that *A. B.*, a private patient, who was received into this house on the day of 18 , and escaped therefrom on the day of 18 , was on the day of 18 , recaptured under the following circumstances.

The patient has again been received into this house under [or without] a fresh reception order and certificates.

(Signed)
the person having charge of the said lunatic as a single patient.

Dated the day of .

To the Commissioners in Lunacy
[*or* To the Lord Chancellor's Visitors].

Duties attending the use of Mechanical Restraint

Mechanical means of restraint may not legally be employed to any lunatic unless the restraint is necessary for the purpose of surgical or medical treatment, or to prevent the lunatic injuring himself or others (Section 40).

Mechanical means of restraint are defined to "be and include all instruments and appliances whereby the movements of the body or of any of the limbs of a lunatic are restrained or impeded" (Circular of Commissioners Act, 1890).

Under this definition are included not only specially constructed dresses, sleeves, and gloves, but all appliances by which a patient is restrained even when restraint is not their primary or ordinary use. For instance, the wet pack is a form of restraint, and the sheets and blankets used for the purpose of wet-packing a patient are mechanical means of restraint. So, too, are the sheets used to tie a patient into a chair to enable him to be forcibly fed.

All mechanical means that have been used for the purposes of restraining a patient must be produced and shown to the Commissioners at their next visit (Circular, 1890).

When restraint is employed for surgical treatment, it is usually to prevent the patient from tearing off bandages or dressings. When applied for medical treatment, it is usually in the form of the wet pack, or as inflexible gloves put on the patient's hands to prevent the practice of masturbation. There are cases, however, in which patients are even yet placed in strait-jackets and allowed to go freely about, this deprivation of liberty being considered by the medical attendant as less detrimental than that of seclusion. Such restraint might be considered to be for medical reasons, or it might be to prevent the patient injuring himself or others. Usually, however, a patient for whom mechanical restraint had to be resorted to for this latter reason would be unsuitable for single care, and ought to be removed to an institution.

In every case in which mechanical restraint is applied, a medical certificate must, as soon as it can be obtained, be signed, describing the mechanical means, and stating the grounds upon which the certificate is founded,—that is to say, (1) whether the restraint is used for surgical or medical treatment, or to prevent the patient injuring himself or others; and (2) the reasons which render it necessary. The certificate must be signed by the "medical attendant." The "person having charge of the patient," even if a medical man, has no power to sign the certificate (Section 40 [3]).

The certificate need not be signed before the restraint is used, but must be made "as soon as possible."

The certificate is made in the last column of the

Register of Mechanical Restraint (p. 108) (Rule 1 [3] ; Schedule Form 4), and in this register a "full record" must be kept of the use of mechanical restraint from day to day (Section 40 [3]) ; that is to say, the means employed, the number of hours during which it is maintained, the number and duration of the occasions on which it is employed, relaxed, and varied, and all particulars with regard to it.

At the end of every quarter, the person having charge of the patient is to send to the Commissioners a copy of every entry in the Register of Mechanical Restraint made during the quarter (Section 40 [4], Rule 16).

Any person who wilfully acts in contravention of these provisions is guilty of a misdemeanour (Section 40 [7]).

Duty of obtaining the Consent of the Commissioners and others in Certain Cases

In case any of the documents on which a patient is received is informal and requires amendment, it will be returned by the Commissioners to the person having charge of the patient, who will have to get the amendments made by the person who originally signed the document. To these amendments the consent of the judicial authority who made the order must also be obtained, and is signified by his signing his initials opposite the amendment. The amendment must be made within fourteen days after the reception of the patient. If the document is not amended within fourteen days to the satisfaction of

the Commissioners, they, or any two of them, may order the discharge of the patient (Section 34).

In case it is desired to take or send the patient away for the benefit of his health, it is necessary first to get the consent of the person on whose petition the reception order was made, or of the person who made the last payment on account of the patient; and secondly, to forward to the Commissioners this consent, and to ask for the further consent of a Commissioner (Section 56).

The consent of the petitioner or person who made the last payment must state the place to which, and the time for which, the patient is to be removed, and the application for the consent of a Commissioner must state these particulars, and must, in addition, set forth that the patient will be under proper control, and that the proposed removal is for the benefit of his health (Section 56).

The following form is convenient:

Address of person having charge of the patient.

Sir,

I beg to apply for the consent of a Commissioner to the removal of *A. B.* from this house to [insert the full postal address of the house to which it is proposed to send the patient], from the day of 18 , to the day of 18 , under proper control for the benefit of his health.

Enclosed is the approval of the person on whose petition the order for the reception of the said *A. B.* was made [or the person by whom the last payment on account of the said *A. B.* was made, *as the case may be*].

The Secretary, the Commissioners in Lunacy.

The consent of the Commissioner to the temporary absence of a patient will not be given except for the benefit of the patient's health.

When a patient is to be permanently removed to or from the care of any person, the consent of a Commissioner to the removal must previously be obtained (*see* p. 93).

Duty attending a Change of Residence on the Part of the Person having Charge of a Patient

A patient who is detained under a reception order cannot be moved to a new residence in Scotland or Ireland. The law of these kingdoms with respect to the detention of lunatics is different from that of England, and a reception order made in England will not legalise the permanent detention of a lunatic in Scotland or Ireland, although it will legalise his detention for a definite specified time in either of those countries, if removed thither with proper consent for the benefit of his health.

The patient may, however, be moved to a new residence in England under the care of the person who has charge of him, and such removal may legally be made without a removal order, and without the consent of either the Commissioners or the person on whose petition the reception order was made. No consent at all is, in fact, legally necessary to such a change of residence (Section 56).

The person having charge of the patient must, however, at least seven clear days before the change, send notice thereof with the full postal address of the new residence to the Commissioners, and to the person on whose petition the reception order was made, or by whom the last payment on account of the patient was made (Section 56).

In the case of a lunatic "so found" a similar notice should be sent to the Chancery visitors.

Duties in Connection with the Correspondence of Patients

Every person having charge of a single patient must forward unopened all letters written by the patient, and addressed to any of the following persons (Section 41):

The Lord Chancellor.

Any Judge in Lunacy.

A Secretary of State.

The Commissioners in Lunacy, or any one of them.

The person (judicial authority) who signed the reception order.

The person on whose petition the reception order was made.

The Chancery visitors or any one of them.

Every person who makes default in complying with the obligation imposed on him by this section is liable for each offence to a penalty of twenty pounds (Section 41).

Letters written by the patient to other persons than those in the above list may be forwarded, in the discretion of the person having charge of the patient, and should always be forwarded unless they are objectionable or calculated to give pain to the recipient, or unless they are addressed to persons unknown to the writer, and with whom he has no business to correspond.

Duty of admitting Certain Persons to visit a Patient

The following persons must be admitted to visit a patient in single care whenever they desire to do so:

A Chancery visitor.

A Commisioner in Lunacy (Sections 198, 199).

A visitor of licensed houses for the county or borough if he is requested in writing by the Commissioners to visit (Section 199).

Any two such visitors without such request.

Any person or persons directed by an order of the Commisssioners to visit the patient (Section 204).

Any person or persons required by an order in writing under the hand of the Lord Chancellor or a Secretary of State to visit the patient (Section 205)

The minimum of visits usually paid to patients in single care are one visit annually by one or more of the Commissioners, and in the case of a lunatic "so found" two annual visits by a Lord Chancellor's visitor.

Within the two years next following the inquisition, a lunatic "so found" will be visited four times in each such year by the Lord Chancellor's visitors. The intervals between the visits of the Chancery visitors must not be more than eight months.

The other visitors above enumerated are altogether exceptional, and do not visit in ordinary cases. (See also p. 66.)

Upon the visit of the Commissioners, or of the visitor or visitors of the county or borough, the Medical Journal must be produced (Section 199), and

the production of the Register of Mechanical Restraint will be expected also.

Duty of keeping Certain Books

The person having charge of a single patient must keep two books—the Medical Journal and the Register of Mechanical Restraint (Rule 1, 3).

The form of the Medical Journal is set forth in the Rules of the Commissioners, and is as follows (Schedule Form 3) :

Date.	Mental condition. What evidence of insanity? Any and what change since last visit.	Bodily health and condition.	Seclusion since last visit. When and how long?	Visits of friends; date of visit; name of friend.	State of house and furniture, bed and bedding supply, and condition of wearing apparel.	Dietary proper? If not, state the reason.	Employment, exercise, and amusements.

At the beginning of the Medical Journal blank pages are to be left for the record of the previous history of the case, and of the condition on admission (Rule 14).

The Medical Journal is to be kept in the house in which the patient is (Rule 1, 3). The entries are to be made by the medical attendant of the patient (see p. 113) at each visit (Rule 14, 2). But, in the case of a patient visited less often than once in two weeks, the person in charge of the patient, if a medical practitioner, is to make an entry at least once in every two weeks, such entry to contain full

particulars of the mental and bodily condition of the patient, with the date of the entry. The entry must be signed by the person who makes it (Rule 14, [3], [4]).

The entries in the fifth column, as to the visits of friends and the name of the friend, will be made, however, by the person having care of the patient, to whom alone these facts will be known, and each such entry should be signed by him.

Since the medical attendant is to report as to the state of the house, furniture, &c., the person in charge of the patient must allow the medical attendant to have access to all parts of the house used by the patient.

The Register of Mechanical Restraint is in the following form, as set forth in the Rules of the Commissioners (Rules, Schedule Form 4) (see p. 100) :

Date.	Name and sex of patient.	Means of restraint employed.	Duration in hours.	Certificate of medical attendant, stating grounds upon which restraint was employed.

In case the medical attendant of the patient fails to do so, it will become the duty of the medical practitioner having charge of a single patient to make the report on the 10th of January in every year described on p. 113 (Rule 15).

DUTIES OF THE MEDICAL ATTENDANT OF A SINGLE PATIENT.

As already stated, every patient in "single care" must have a medical attendant other than the person who has charge of the patient (Section 44).

The medical attendant is a neighbouring practitioner, and is usually selected by the person having charge of the patient. Care should, however, be taken to obtain the approval of the person on whose petition the order for the reception of the patient was made to the appointment of the medical attendant.

The following persons are disqualified by statute from acting as medical attendant to a single patient:

1. A practitioner who has signed a certificate on which the order for the reception of the patient was made.

2. One who derives, or whose partner, father, son, or brother derives any profit from the charge of the patient (Section 44, 2).

Any two Commissioners may direct that the medical attendant of a single patient shall cease to act in that capacity, and that some other person be employed in his place (Section 44 [3]).

The duties of the medical attendant of a single patient are as follows:

1. To make and sign the medical statement on the reception of the patient (Section 39 [1], Rule 7, 3, 5).

2. To prepare and send to the Commissioners a report of the mental and bodily condition of the patient at the end of one month after reception (Section 39 [1]).

3. To make and send to the Commissioners the continuation orders as they become due (p. 89).

4. To make and send to the Commissioners a report on the 10th of January in each year (Rule 15).

5. To visit the patient once at least in every two weeks unless otherwise ordered by the Commissioners (Section 44 [2]).

6. To make and sign entries in the Medical Journal and in the Register of Mechanical Restraint (Rule 14, Rule 1).

7. To send to the Commissioners at the end of every quarter a copy of every entry in the Register of Mechanical Restraint made during the quarter (Rule 16).

8. To report in writing to the Commissioners at such times, in such forms, and specifying such particulars as the Commissioners direct (Section 45).

1. After the second and before the end of the seventh clear day after the reception of a patient the person in charge of the patient is to send to the Commissioners a medical statement, which must be made and signed by the medical attendant.

This statement is to be in the following form (Rules, Schedule Form 8) :

Medical Statement

I have this day [some day not less than two nor more than seven clear days after the reception of the patient] seen and examined *A. B.*, the patient mentioned in the notice of admission, dated the day of 18 , and hereby certify that with respect to mental state he [*or* she] [*describing it*]
and with respect to bodily health and condition, he [*or* she] [describing it].

Dated the day of 18 .

(Signed)
the medical practitioner visiting the said patient.

The statement as to the mental state of the patient

should set forth sufficient facts to justify *primâ facie* the detention of the patient. The information need not be detailed, but it should be precise. For instance, it is not enough to say that the patient "suffers from delusions." The delusion should be stated. Nor is it enough to state that "he is demented," or "he suffers from loss of memory." An instance should be given of a demented act, or of a lapse of memory greater than can be considered normal.

The information as to mental state should refer to both mind and conduct. It should describe something that the patient does or does not do, as well as what he thinks or does not think. Only when thus descriptive does it exhibit *primâ facie* justification for the detention of the patient.

The second part of the report, which deals with the bodily health and condition, should state whether he is well or badly nourished, should describe any signs of injury, and should give the name of any bodily malady from which he is suffering.

2. At the expiration of one month after the reception of the patient the medical attendant is to send to the Commissioners a second notice, in the following form (Rules, Schedule Form 9):

Report as to Private Patient

Address.

I have this day seen and examined *A. B.*, received here on the day of 189 , and report that with respect to mental condition he is

and that with respect to bodily condition he is .

Dated this day of 189 .

(Signed) *C. D.*,

the medical practitioner visiting the said patient.

The object of this second report should be to amplify, elucidate, and where necessary correct, the previous report; as well as to record the change, if any, which has taken place in the condition of the patient since that report was made. Like the previous report, it should in its first part refer to both mind and conduct, and in its second part should describe in very general terms the bodily condition and health of the patient.

3. The times at which the continuation orders become due are given on p. 89. Unless these orders are duly sent, the detention of the patient becomes illegal.

The following is the form of the continuation order:

Lunacy Act, 1890, *Section* 38.

No. *

Name of Patient.

Date of Admission day of 189 .

Special Report and Certificate

I have this day seen and examined the above-named patient, admitted into this house under the reception order dated the day of 189 , [and which order was continued by special report and certificate dated the day of 189 ,] and I beg to report that with regard to mental condition he is

and with regard to bodily condition he is

and I certify that he is still of unsound mind, and a proper person to be detained under care and treatment.

Address.

(Signed) Medical Attendant.

To the Commissioners in Lunacy. Dated 189 .

* For the use of the Commissioners only.

The purport of the report must be to show that the continued detention of the patient is justified, and the remarks made with regard to the report on reception apply to this.

4. On the 10th of January in every year, or within seven days of that date, every medical practitioner who visits a single patient must report in writing to the Commissioners the state of health, mental and bodily, of the patient, with such other circumstances as he may deem it necessary to communicate (Rule 15).

This report is supplementary to the continuation order, and takes the place of that order in years in which the latter is not required to be sent. It should, therefore, be framed upon the same plan.

As to the time at which it is to be sent, it may be at any time within seven days of the 10th of January, that is to say, seven days before or after, or between the 3rd and the 17th of the month.

5. The medical attendant is to visit the patient once at least in every two weeks unless otherwise ordered by the Commissioners (Section 44 [2]).

The Commissioners have power to direct how often any single patient is to be visited by his medical attendant, and may require the latter to visit more often, or may permit him to visit less often, than once in two weeks (Section 44 [1]).

6. "As soon as possible" after the reception of the patient the medical attendant is to enter on blank pages to be left for this purpose at the beginning of the medical journal a sketch of the previous history of the case, with full particulars of

the mental and bodily condition of the patient on admission (Rule 14).

At every subsequent visit he is to make an entry in the journal, and each entry is to include the date of the visit and full particulars of the mental and bodily condition of the patient, and a statement of the condition of the house. Every entry must be signed (Rule 14, 2, 4). The form of the medical journal will be found at p. 107.

When occasion arises he is to make entries in the register of mechanical restraint.

7. At the end of every quarter he must send to the Commissioners a copy of every entry in the register of mechanical restraint made during the quarter (Rule 16).

PART III

TESTAMENTARY AND CONTRACTING CAPACITY.

"THERE is something both contemptible and frightful in the sort of evidence on which of late years any person can be judicially declared unfit for the management of his affairs, and after his death the disposition of his property can be set aside, if there is enough of it to pay the expenses of litigation—which are charged on the property itself. All the minute details of his daily life are pried into, and whatever is found which, seen through the medium of the perceiving and describing faculties of the lowest of the low, bears an appearance unlike

absolute commonplace, is laid before the jury as evidence of insanity, and often with success; the jurors being little, if at all, less vulgar and ignorant than the witnesses; while the judges, with that extraordinary want of knowledge of human nature and life which continually astonishes us in English lawyers, often help to mislead them." ('On Liberty,' note to Chap. III.)

If John Stuart Mill were alive now, he would certainly find reason to modify very largely the opinion that is quoted above. Not only is there no such tendency now existing to declare a person unfit for the management of his affairs, or to set aside after his death his disposition of his property, but it is extremely difficult to induce a jury, even with the plainest evidence of insanity, and of dangerous insanity, before them, to find that a person is of unsound mind and incapable of managing himself and his affairs; and it has over and over again been held that a person who was unquestionably insane at the time his will was made, was capable of making a valid will, and the wills of many such persons have been admitted to probate. (Cartwright *v.* Cartwright, 1 Phill., 90, 122.)

How difficult it is to convince a jury that anyone, no matter what his conduct may be, is insane is shown by the following cases.

The 'Times' of 1891 reports an inquisition upon a lady, in which it was proved that she repeatedly complained of poison being put in her food; that she stated that she had reason to know that her counsel were bought; that she had seen an eminent barrister outside a pawnbroker's who told her that

he had been bought by that money-lender; that she declared that Her Majesty's judges had been bribed to allow her to be taken to an asylum; that the Home Secretary was at the head of a conspiracy to injure her. It was proved that she had written scores of letters containing extravagant charges against all sorts of people to the secretary of a club who was an entire stranger to her; that she declared that the Home Secretary was trying to poison her; was trying to "send her blind," and that she had many other delusions of persecution. Most of her own witnesses admitted that she had delusions. In spite of this evidence, a jury, after a trial lasting about a fortnight, found that she was of sound mind and capable of managing herself and her affairs.

In March, 1894, the 'Times' reported the trial of a Dr. S. at the Old Bailey for unlawfully receiving lunatics in an unlicensed house. The trial turned upon the question whether certain persons who had been inmates of Dr. S.'s house were or were not lunatics at the time of their residence there.

It was proved that one such inmate, a lady, had delusions as to people walking about and calling out names; that she used to wander about the house at night; that she had swallowed the contents of a bottle of Condy's fluid; that she had been to a police station to give herself up for an imaginary crime; that she had jumped out of a window at night and walked eighteen Irish miles to give herself up for a crime; that on another occasion she had gone out and wandered about the country all night; that she spent the whole night on the roof of a house, from which she had to be lowered so as

to be got into the house through a window; that she had many times expressed her intention of committing suicide, which she did eventually carry into effect.

Another inmate of the house was proved to have been possessed with the idea that he was bound to obey the behests of a spirit, and it was proved that he did in fact regulate his conduct according to these imaginary behests; that he imagined that he had had, "in the spirit," carnal intercourse with the spirit of a lady; that he had religious delusions; that he would enter his father's office, shake hands all round with the clients there, and then bless them; that he had suicidal tendencies.

The prisoner was acquitted, and since, if either of the above patients had been, in the opinion of the jury, insane, they must have found the prisoner guilty, it follows that the verdict was practically a finding that both of them were sane.

A duty is often cast upon a medical practitioner of informing himself, and of expressing his opinion upon the soundness of mind of a testator.

It should be first understood that the "sound and disposing mind" which is essential to the validity of a will, is very different from complete sanity, and that a person may be notoriously insane, may even be a lunatic so found by inquisition, and yet may possess sufficient soundness of mind to execute a valid will; while, on the other hand, a person may not be insane in the ordinary sense, and may yet have a mind so weakened as to destroy, in the view of the law, its "sound and disposing" capacity.

The exact constitution of a sound and disposing mind has been variously described by different judges.

The following are the judgments from which the most assistance can be derived by the medical practitioner in examining into this most difficult matter:

"There is no country in the world," said Sir J. P. Wilde, afterwards Lord Penzance (Smith *v.* Tebbett, L. R., 2 P. & D. 400), "in which the law permits a larger exercise of volition in the disposal of property after death than in England. But it requires as a condition that this volition should be that of a mind of natural capacity, not unduly impaired by old age, enfeebled by illness, or tainted by morbid influence. Such a mind the law calls a 'sound and disposing mind.'"

The law contemplates, therefore, four conditions which may interfere with and vitiate the "soundness" and "disposing" capacity of the mind, viz.:

1. Natural incapacity, *i. e.* idiocy or imbecility existing from birth or from an early age.
2. Impairment by old age.
3. Enfeeblement by illness.
4. The taint of a morbid influence, *i. e.* insanity ordinarily so called.

In every case, however, a certain *degree* of the vitiating condition must be present in order to destroy the disposing capacity of the mind. In the first case the capacity must fall short of what is "natural" or normal to civilised man. In the other cases the mind must be impaired, enfeebled, or tainted *unduly* in order to incapacitate the testator. So that the question has yet to be determined, What is "*natural* capacity," and what is that *undue* degree of impairment, enfeeblement, or taint which is sufficient to be incapacitating?

Guidance to the answers to these questions is found in another judgment, delivered in 1870 by Chief Justice Cockburn, and concurred in by three other very strong judges—Blackburn, Mellor, and Hannen (Banks *v.* Goodfellow, 5 Q. B. 549). "It is admitted on all hands that in these cases [of unsoundness of mind arising from want of intelligence occasioned by defective organisation, or by supervening physical infirmity, or the decay of advancing age, as distinguished from mental derangement[1]], though the mental power may be reduced below the ordinary standard, yet if there be sufficient intelligence to understand and appreciate the testamentary act in its different bearings the power to make a will remains."

The next point is to explain what is meant by the "sufficient intelligence" referred to.

In a case of Harwood *v.* Baker before the Judicial Committee of the Privy Council, in which case a will had been executed by a testator on his deathbed in favour of a second wife to the exclusion of the other members of his family, he being in a state of weakened and impaired capacity from disease producing torpor of the brain, and rendering his mind incapable of exertion unless roused, Erskine, J., delivered the judgment of the court in these terms: "Their lordships are of opinion that in order to constitute a sound disposing mind, a testator must not only be able to understand that he is by his will giving the whole of his property to one object of his regard, but he must also have capacity to comprehend the extent of his property, and the

[1] That is to say, in the first three of our four classes.

nature of the claims of others, whom, by his will, he is excluding from all participation in that property; and that the protection of the law is in no cases more needed than it is in those where the mind has been too much enfeebled to comprehend more objects than one, and more especially when that one object may be so forced upon the attention of the invalid as to shut out all others that might require consideration; and therefore the question which their lordships propose to decide in this case is not whether Mr. Baker knew, when he executed this will, that he was giving all his property to his wife, and excluding all his other relations from any share in it, but whether he was at that time capable of recollecting who those relations were, of understanding their respective claims on his regard and bounty, and of deliberately forming an intelligent purpose of excluding them from any share of his property. If he had not the capacity required, the propriety of the disposition made by the will is a matter of no importance. If he had it, the injustice of the exclusion would not affect the validity of the disposition, though the justice or injustice of the disposition might cast some light upon the question as to his capacity."

"From this language," says Chief Justice Cockburn, "it is to be inferred that the standard of capacity in cases of impaired mental power [*i. e.* in the first three of our classes] is, to use the words of the judgment, the capacity on the part of the testator to comprehend the extent of the property to be disposed of, and the nature of the claims of those he is excluding. Why should not this standard be

also applicable to mental unsoundness produced by mental disease ?"

The Chief Justice then goes on to apply this doctrine to the fourth and last of our classes, and decides that it is applicable to them also.

In both the cases here referred to (Harwood *v.* Baker and Banks *v.* Goodfellow) the testator by will in dispute left his property to one relative to the exclusion of others, and since the occasion of the litigation in most disputed wills is the exclusion of one or more relatives, it is obvious that the considerations above laid down will afford guidance in the majority of cases.

But in the latter case a somewhat wider and more generally applicable doctrine is laid down. "It is essential," says Chief Justice Cockburn, "to the exercise of such a power [the disposing power] that a testator shall understand *the nature of the act and its effects;* shall understand the extent of the property of which he is disposing; shall be able to comprehend *and appreciate* the claims to which he ought to give effect.

Hence it appears that when a medical practitioner is called upon to form an opinion as to the testamentary capacity of a person, the points to which he should address himself to elucidate are—

Is the testator by reason of (*a*) natural incapacity, or (*b*) old age, or (*c*) illness, or (*d*) insanity, so affected in his mind that he is incapable of comprehending and appreciating (1) the nature of the act and its effects, (2) the extent of the property of which he is disposing, or (3) the claims to which he ought to give effect ?

It is essential that all three of these conditions should be fulfilled,—that is, that he should comprehend the nature of the act, the extent of the property, and the claims upon him; and inability to comprehend any one of them would invalidate the disposing capacity of his mind.

1. He must understand the nature of the act and its effects. That is to say, he must know that he is making a disposition of his property which will take effect after his death; must know whom he is benefiting and whom he is excluding from benefit, and the degrees in which his legatees respectively are to benefit by the disposition that he makes.

2. He must understand the extent of the property to be disposed of.

3. The testator must also comprehend the nature of the claims to which he ought to give effect. What is meant by a "comprehension" of the claims upon him? Clearly it does not mean a *recognition* of those claims, for the judgments quoted, and other judgments, expressly state that the justice or injustice of the exclusion does not affect the validity of the will. What is required is better expressed by the terms "comprehend and appreciate," also used in this judgment. The testator must have a clear knowledge and recollection of the existence of the persons that he excludes, and of the relation in which they stand to him; must have sufficient intelligence to compare the claims of those whom he excludes with those whom he includes; and his mind must not only have sufficient intelligence, but must be such "that no disorder of the mind shall poison his affections, pervert his sense of right, or prevent the exer-

cise of his natural faculties ; that no insane delusion shall influence his will in disposing of his property, and bring about a disposal of it which, if the mind had been sound, would not have been made." "If the human instincts and affections, or the moral sense, become perverted by mental disease—if insane suspicion or aversion take the place of natural affection—if reason and judgment are lost, and the mind becomes a prey to insane delusion calculated to interfere with and disturb its functions, and to lead to a testamentary disposition due only to their baneful influence—in such a case it is obvious that the condition of the testamentary power fails, and that a will made under such circumstances ought not to stand" (Cockburn, C. J., Banks *v.* Goodfellow).

It is in determining the ability of the testator to fulfil this third set of requirements that the great difficulty of the medical practitioner lies. The questions that he has to determine are—Is or was the testator subject to disorder of mind ? Is or was the disorder of mind of such a character that it is likely to influence him in the disposition of his property ?

The first question to be determined is, Is the testator, or was he when the will was made, subject to disorder of the mind ? This is, as has been already explained, a different question from whether the testator was of *unsound* mind, the latter being the crucial question which all these subsidiary questions help to determine. The question now under consideration is, is or was the testator subject to disorder, or, as the law sometimes terms it, disease of the mind ?

Until recent years the answer to this question

was easily given, and depended entirely upon whether or no the testator was subject to delusion. If there was delusion there was disorder of mind; if there was no delusion there was no such disorder.

Sir J. Nicholl, in the famous case of Dew *v.* Clark and Clark, lays down this doctrine with much emphasis :—"The true criterion, the true test, of the absence or presence of insanity I take to be the absence or presence of what, used in a certain sense of it, is comprisable in a single term, namely, delusion. Whenever the patient once conceives something extravagant to exist which has still no existence whatever but in his own heated imagination, and whenever at the same time, having once so conceived, he is incapable of being, or at least of being permanently, reasoned out of that conception, such a patient is said to be under a delusion in a peculiar half-technical sense of the term, and the absence or presence of delusions so understood forms, in my judgment, the true and only test or criterion of absent or present insanity. In short, I look upon delusion, in this sense of it, and insanity, to be almost, if not altogether, convertible terms; so that a patient under a delusion, so understood, on any subjects, in any degree, is for that reason essentially mad or insane on such subject or subjects in that degree."

For many years this was undoubtedly the law, and were it so now it would be necessary to inquire what is the peculiar half-technical sense in which the term delusion is used. But that criterion of insanity is no longer accepted by the courts.

Sir J. P. Wilde was the first to call in question

the sufficiency of delusion as a test of insanity, not, however, because he thought that there was any other manifestation of insanity than delusion, but because he considered that insanity and delusion were identical, and that it was no more easy to define delusion than to define insanity. In his judment in Smith *v.* Tebbett he says:

"I search the decided cases in vain for a guide. What is to be the proof of disease? What is to be the test, if there be a test, of morbid mental action? The existence of mental "delusions," it would, perhaps, be answered. But this only postpones the question in place of answering it. For what is a mental delusion? How is it to be defined so as to constitute a test, universally applicable, of mental disorder or disease? The word is not a very fortunate one. In common parlance a man may be said to be under a "delusion" when he only labours under a mistake. The "delusion" intended is, of course, something very different. To say that a morbid or insane delusion is meant, is to beg the question; for the delusion to be sought is to be the test of insanity, and to say that an insane or morbid delusion is the test of insanity or disease does not advance the inquiry. "A belief of facts which no rational person would have believed," says Sir John Nicholl. No *rational* person. This, too, appears open to a like objection, for what are the limits of a rational man's belief? And to say that a belief exceeds them is only to say that it is irrational or insane. "The belief of things as realities which exist only in the imagination of the patient," says Lord Brougham in Waring *v.* Waring. But surely

sane people often imagine things to exist which have no existence in reality, both in the physical and the moral world. What else gives rise to unfounded fears, unjust suspicions, baseless hopes, or romantic dreams? I turn to another definition. It is by Dr. Willis, a man of great eminence, and is quoted by Sir J. Nicholl in Dew *v.* Clark. "A pertinacious adherence to some delusive idea in opposition to plain evidence of its falsity." This seems to offer surer ground, but then the "evidence" of the falsity is to be "plain," and who shall say if it be so or not?" And so the judge goes on refining until he reaches the conclusion that practically insanity means delusion, and delusion means insanity, and that to say that insanity means delusion is to define the unknown by the equally unknown. "What I mean to convey on this head is this, that the question of insanity and the question of delusions is really one and the same—that the *only* delusions which prove insanity are insane delusions, and that the broad inquiry into mental health or disease cannot in all cases be narrowed or determined by any previous or substituted inquiry into the existence of what are called delusions. . . . . In what form of words could a 'delusion' be defined which would be a positive test? . . . . In none, I conceive, but 'insane delusions' or words of the like import, which carry with them the whole breadth of the general inquiry.

"How, then, is this question of insanity to be approached by a legal tribunal? What tests are to be applied for disease? What limits assigned within which extravagance of thought is to be pro-

nounced compatible with mental health? The decided cases afford no light on these heads. I nowhere find any attempt to devise such test or assign such limits. Nor do I conceive that any tests, however elaborate, beyond the common and ordinary method of judging in such matters would be competent to bear the strain of individual cases in the course of experience."

The "common and ordinary method" the judge defines as follows:

"It is when the words or deeds of others referred to our own standard, and that which by experience is found to be the common standard of the human race, appear to transgress those limits, that we suspect these common senses, emotions, and faculties, which we know to exist, to be the subjects of disorder or disease. If the divergence be very marked, and exhibit itself either on many subjects, or with uniform constancy in the behaviour of the individual, we pronounce disease without hesitation. In proportion as the divergence is either casual or trifling, or open to some other probable solution, the inquiry is difficult and the judgment hesitates. Here, then, I think, is the general rule by which mankind in general pronounce upon mental disease."

Two points present themselves for notice in this method of judging of mental disorder. The first is that the judge discards altogether the inquiry into the *mind* of the testator, and decides that the subject to which the investigation is to be addressed is his *words or deeds*. It is at once manifest that this is an immense advance. As has been pointed out elsewhere by the present writer, there is only one

person who can possibly know what is passing in the mind of any man, and that is the man himself. Any opinion that we may form as to the operations of the mind of another person can only be inferential and doubly inferential. They can be gathered and inferred only from his words and deeds. How much more certain and secure is our ground when the investigation that we have to make is into the words and deeds that we can directly observe, than when it is into a state of mind which we can only infer from those observations,—than when it is an inference which it is open to any other person to dispute or to deny?

The next point to be noted in this judgment is of a less satisfactory character. The words and deeds have to be "referred to our own standard, and that which by experience is found to be the common standard of the human race." This appears to be open to the objection which the judge himself raises to the method of judging of a delusion. What is the "common standard of the human race"? Is it any more fixed or certain than the judgment of a "rational person"? or than the "plainness of the proof" which the judge has already discarded? The difficulty in the one case seems as great as in the other, but in neither does it appear so insuperable as it appeared to the learned judge. To either case the same test would surely apply. The "common standard" by which the words and deeds of the testator must be judged is the standard of the jury that tries the case. So, too, the belief that no "rational person" would entertain must be a belief that would not be enter-

tained by the jury; and the "plain proof" must be proof which is plain to them.

Sir J. Wilde's means of judging of sanity are not yet exhausted, however. There is "another road by which to approach the determination of insanity in a doubtful case." Not only can the conduct of the person whose sanity is in question be compared with that of sane persons, and the degree of divergence noted; but it can also, by medical men who are familiar with insanity, be compared with that of insane persons, and the degree of approximation observed. "Thus, while the world at large can only contrast the doubtful case with the sane, the physician has at hand the alternative contrast with the insane. It is a consequence of these alternative methods of judgment that the question of insanity, though it falls to the lot of a legal tribunal, is properly a mixed one,—partly within the range of common observation, and in so far fit to be considered by a jury; partly within the range of special experience, and in so far the proper subject of medical inquiry. It is the office of the court, then, to inform itself, as far as opportunity permits, of the general results of medical observation, and to approach the subject of this case on the two opposite sides thus indicated, searching for a fit conclusion by alternately presenting the parallel of sanity and insanity to the sayings and doings of the deceased."

Here, then, the function of the medical practitioner in his inquiry into the sanity of a testator is defined. He is to observe the words and deeds of the subject of the inquiry, and he is, as one of "the

world at large," to compare those words and deeds with the common standard of mankind, and to note any divergence therefrom. In his own proper function as a practitioner of medicine, and a person familiar with the manifestations of insanity, he is to compare the conduct of the testator with the conduct of insane persons, and to note any peculiarities which are common to both, or in which the conduct of the one approximates to the conduct of the other.

The judge limits the scope of the medical observations to the sphere of conduct, but it is of course open to the medical practitioner to notice physical symptoms which bear upon the question, and it is evident that, especially when these are included, he is in a much better position to judge, and is more qualified to give a trustworthy opinion than is the non-medical observer. Let us suppose, for instance, the case of a person who in his words and deeds exhibits a busy, meddling restlessness, an eager, incessant activity, a jovial and hilarious disposition, but to no one of whose speeches or acts would it be possible to point as an insane speech or act. By the recital of no one specimen of conduct in particular, nor of all taken together, would it be possible to convince a jury that the exhibitor of them was disordered in mind. Yet if the medical practitioner were to discover in such a patient the peculiar thickness of articulation, the peculiar muscular tremor, and the pupillary symptoms of general paralysis, he could speak with positive certainty to the disorder that must necessarily be present in the mind of the patient so affected.

Having determined whether or no the mind of the testator is or was disordered, the next question that has to be determined is whether the disorder was of such a character that it influenced him, or was likely to influence him, in the disposition of his property ; and this inquiry will be greatly facilitated by the abandonment of the position that delusion is the criterion of disorder of the mind. For there are forms of disorder of mind which do not come into the category of delusion, at least in the medical sense of that term, and which yet are capable of materially influencing a person who is subject to them in the disposition of his property. The guide to the inquiry should be, not whether the testator was biassed by delusion ; but whether the disorder of the mind was such as to "poison his affections, pervert his sense of right, or prevent the exercise of his natural faculties,"—such as to "influence his will in disposing of his property, and bring about a disposal of it which, if the mind had been sound, would not have been made."

Medical practitioners who are familiar with many manifestations of insanity need scarcely be reminded that there are forms of insanity, some of them deep and hopeless, in which no delusion, properly so called, can be detected in the mind of the sufferer, but in which the patient exhibits an extreme and baseless hatred of those who should be dearest to him,—of those very persons whom, if he were sane, he would most desire to benefit by a will. In puerperal insanity this peculiarity is often noticed, though it is by no means confined to puerperal insanity. Again, in "moral insanity" the "sense

of right" is "perverted" without any intellectual disorder of the nature of delusion being discoverable.

Lastly, if delusion was present, was it such as was likely to influence the testator in the disposition of his property? The question whether it did, in fact, so influence him is one for the jury.

It has been decided that the mere existence of a delusion in the mind of a person making a disposition or contract is not sufficient to avoid it, even though the delusion is connected with the subject-matter of such disposition or contract. It is a question for the jury whether the delusion did in fact influence the disposition or contract. A lessor at the time when he made the lease of a farm laboured under the delusion that he and his belongings were impregnated with sulphur. Among other acts, he bored holes in the barns to let the sulphur out, and administered castor oil to the cows to rid them of the sulphur. Yet, since the lease was a reasonable one, and rational letters written by the lessor relating to the lease were put in evidence, the jury found that the lease was valid (Jenkins *v.* Morris, 14 Ch. D. 674).

On the other hand, a man may be capable of transacting business of a complicated and important kind, involving the exercise of considerable powers of intellect, and yet may be subject to delusions so as to be unfit to make a will (Smee *v.* Smee, 5 P. D. 84).

Upon the whole, then, the business of a medical practitioner who is called upon to testify as to the soundness or unsoundness of mind of a testator is to

investigate the matters stated on p. 122, viz.: Does the testator comprehend the nature of the act and its effects? Does he comprehend the extent of his property? Does he comprehend and appreciate the claims to which he ought to give effect? To determine these questions he must decide—1, whether the mind of the testator is feeble or disordered; and 2, if disordered whether the disorder is of such a character as to be likely to influence his will in the disposal of his property.

It should never be forgotten that when a medical man witnesses the execution of a will he thereby gives to the testator a certificate of mental competence. He should never, therefore, witness a will unless in his opinion the competence of the testator is beyond all doubt.

Contracting Capacity

The question of contracting capacity does not arise so frequently as that of testamentary capacity, and when it does arise, is decided on practically the same grounds, and the function of the medical practitioner with regard to it is much the same. He will have to form an opinion as to whether, at the time the contract was made, the contracting party comprehended the nature of the act that he was doing and its effects; whether he then suffered from any disorder of mind; and if so, whether the disorder of mind was such as to influence him in making the contract (*see*, however, Jenkins *v.* Morris, previous page).

This has been specially laid down in cases in which the contract of marriage has been called

in question. It has been held that the question that the court has to determine is whether the respondent was capable of understanding the nature of the contract and the duties and responsibilities which it creates, and was free from the influence of morbid delusions upon the subject.

CRIMINAL RESPONSIBILITY

The last of the occasions on which a medical practitioner may be called upon to come into contact with the law in dealing with persons who are, or are alleged to be insane, is in the case of a criminal with respect to whom the plea of insanity is raised.

In the proceedings against a criminal, every step is arrested by his or her becoming a lunatic ; and the judgment with regard to the lunacy of a criminal or alleged criminal will be formed on the same grounds, and guided by the same principles, as the judgment with respect to a non-criminal person. Where, however, the plea of insanity is raised, not in arrest of criminal proceedings, but at the trial, and it is alleged that the criminal was insane at the time the crime was committed, then the question to which the medical practitioner who is consulted about the case has to address himself is a very peculiar, limited, and difficult one, and is altogether different from that which has to be determined in ordinary cases of insanity.

The law is that the question which the jury have to determine is, Did the prisoner, at the time the crime was committed, know the nature and quality of the act that he was committing, and that it was

wrong? That is the literal text of the law, but different judges interpret it so differently that it is scarcely any guide to the medical practitioner in inquiring into any individual case.

Some judges adhere with literal accuracy to the text of the law, and require the jury to find whether the prisoner at the time the crime was committed knew the nature and quality of the act, and that it was wrong. In such cases the evidence of the medical witnesses would have to be addressed solely to the state of the prisoner's mind at the time of the crime, and what evidence they were able to give on this obscure subject would probably be excluded by the judge.

Other judges, following Mr. Justice Stephen, leave to the jury the question whether the prisoner "was prevented by any disease affecting his mind from controlling his own conduct." In this case, again, the difficulty of the expert witness is equally great. He has to form an opinion on the state of mind of another person at a time when he did not see that other person, and the opinion that he forms he will probably not be allowed to state; for that is the very question that the jury have to determine.

Lastly, there are judges—*e. g.* Mr. Justice Day—who tell the jury that to find the prisoner guilty they must determine that he knew the nature and quality of the act, and that he was not of unsound mind. This last question is a very much wider one than any that have gone before, and lets in evidence not only of conduct, and usually of expert opinion, but even of family history.

If the literal text of the law is adhered to, the

question is, upon the face of it, indeterminable. The sure ground of the words and deeds of the criminal, as a foundation on which to stand in judging of his sanity, does not in this case exist. He is to be judged, not by what he has said or done, but by the state of his mind; and how is it possible for one person to enter into the mind of another, and to say what at some time, weeks or months before, that other mind knew and thought?

When a judge interprets the law literally, and refuses to hear any evidence but that which directly shows whether or no the prisoner knew the nature and quality of his act, and that it was wrong, the mouths of medical witnesses are closed; and unless the jury takes the bit between its teeth and disregards the judge's ruling, the conviction of the prisoner is almost certain.

Some judges—*e. g.* Mr. Justice Day in the case of Gouldstone, tried in September, 1884—will allow evidence to be given of the existence of insanity in the family of the prisoner, and will even allow a medical man, who has not seen the prisoner until after the crime, to give an opinion as to the state of mind of the prisoner at the time the crime was committed. Other judges—*e. g.* Mr. Justice Field in the case of Hitchins—refuse to allow the evidence of medical witnesses as to the state of the mind of the prisoner, even at the time he was examined by them.

Some judges, as Mr. Justice Field in the case of Hitchins, refuse to allow any *opinion* to be given by a medical witness. They will require the witness to state in evidence what has passed between him and the prisoner, so that the jury, who, they say,

is just as capable as the medical witness of forming an opinion upon the facts, may have the facts before them, and may come to their own conclusion. On the other hand, other judges, not less eminent, take a precisely opposite course. "What I want to hear from you," said the Lord Chief Justice to a medical witness in the Maclean case, "is not, strictly speaking, what passed between you and him. You are to tell us, as a man of great science and experience, what is your scientific conclusion."

This wide divergence in the judicial views of the functions of the medical witness in criminal cases in which insanity is pleaded renders it difficult to lay down rules as to the duties of medical witnesses in such cases, but the following procedure is probably as good as could be devised.

In examining a prisoner with reference to his sanity the medical examiner should be provided with writing materials, and should make his notes of the prisoner's remarks in the prisoner's own words, and in his presence. The examiner thus secures himself against lapses of memory, and moreover secures the right to refer to his notes, and refresh his memory in the witness box should he desire to do so.

It is a civilised custom, upon commencing an interview with any person, to ask him how he does; and a medical examiner will commonly open his interview with a prisoner with this formal question. The prisoner, even if undoubtedly and deeply insane, will in the great majority of cases be able to give to this question the usual formal reply. If, however, the medical witness states in his evidence that he asked the prisoner how he was, and that the

prisoner answered that he was pretty well, judge, counsel, and jury will throw up their hands and eyes in amazement, and ask the witness if he considers that that is evidence of insanity. It has happened in cases that the writer has observed, that a medical witness has interviewed a prisoner, and has formed, doubtless upon sufficient grounds, an opinion that the latter was insane, but has carried away from the interview his opinion only, and has not made a note of the grounds upon which the opinion was formed. When he was placed in the witness box he has not been allowed to give his opinion, but he has been asked to state the grounds upon which the opinion was founded. This demand, coming upon him unexpectedly, has completely nonplussed him. Not having prepared himself to answer such a question, not having recurred to the examination since it took place, he is now, in the presence of an expectant court, asked to state what took place between himself and the prisoner—what he said to the prisoner, and what the prisoner said to him. The consequence is that, unless he is a man of unusual self-possession, the whole interview is erased from his mind for the time being almost as completely as if it had never taken place; and the only passage that he can remember is the opening question and answer, the statement of which produces, indeed, a profound effect in court, but not the effect that the witness desires. It is by no means uncommon for a medical witness, when thus unexpectedly called upon, to be unable to recollect anything that passed between himself and the prisoner beyond a question as to the health of the

latter, and as to the day of the month, or some such triviality. On no account, then, should a medical examiner omit to make, in the presence of the prisoner, a written note, in the prisoner's own words, of those statements upon which the examiner bases his opinion of the prisoner's insanity.

In case the prisoner shows evidence of a delusion which is not upon the face of it, and without further evidence, a delusion, the examiner must be careful to obtain the necessary evidence that the belief has no foundation in fact, and must ascertain that upon placing this evidence before the prisoner the latter still retains his belief (*see* p. 22).

The examiner must remember throughout the examination that it is not enough to form his own opinion as to the sanity or insanity of the prisoner. He must obtain evidence of sufficient cogency, and in such a form as to enable him to lay it before the court, should he be required to do so.

Medical witnesses very seldom appear to advantage when they are called upon to state the facts upon which they have based their opinion of the insanity of a prisoner. Such a statement as that a prisoner "had a vacant appearance" does not carry conviction to those who hear the statement, though to those who witnessed the appearance it may be important. What a judge wants, and what a jury wants, is some definite statement of what the prisoner said or did. That the prisoner's manner was hesitating and doubtful is a statement sometimes made in the witness box, and such statements do not carry much weight. But if the witness is able to say, "I put to him such and such a question. He did not answer,

but looked at me stupidly as if he did not understand. I repeated it twice, and after so many minutes he slowly answered so-and-so," that is a definite statement which will carry great weight. So, too, instead of stating in general terms that "his conversation was incoherent," take down examples of incoherency in the prisoner's own words and read them in court; in fact, the rules given in the previous part of the book for making certificates apply with additional force to thesecases.

A medical examiner may, if the prisoner introduces the subject, ask him in general terms of circumstances connected with the crime of which the prisoner stands charged, but he must not ask the prisoner whether he did the act alleged against him, nor how he came to do it, nor any similar question. He may ask the prisoner if he knows why he is in prison, but he must not put to him any leading question about the crime. A medical witness has been severely reprimanded in open court by a judge for transgressing this rule.

Although it is doubtful whether such evidence would be admitted, some judges admitting and others excluding it, he should obtain evidence as to the heredity of the prisoner, and as to the existence of insanity in his near relatives. He must, however, be careful in giving evidence on this point not to state positively that such and such conditions *will* produce insanity. All that he can safely state is that they are likely to do so.

INDEX

PRINTED BY ADLARD AND SON,
BARTHOLOMEW CLOSE, E.C., AND 20, HANOVER SQUARE, W.

No. 2.

London, 11, *New Burlington Street*,
May, 1894.

A SELECTION

FROM

J. & A. CHURCHILL'S CATALOGUE,

COMPRISING

MOST OF THE RECENT WORKS PUBLISHED BY THEM.

N.B.—J. & A. Churchill's larger Catalogue, which contains over 600 works with a Complete Index to their Subjects, will be sent on application.

Human Anatomy: a Treatise by various Authors. Edited by HENRY MORRIS, M.A., M.B. Lond., F.R.C.S., Surgeon to, and Lecturer on Surgery at, the Middlesex Hospital. Roy. 8vo, with 791 Illustrations, nearly all original, and many of them in several colours, 40s. (In one vol. or in three parts.)

Heath's Practical Anatomy: a Manual of Dissections. Eighth Edition. Edited by WILLIAM ANDERSON, F.R.C.S., Surgeon and Lecturer on Anatomy at St. Thomas's Hospital; Examiner in Anatomy for R.C.P. and S. Crown 8vo, with 329 En gravings. 15s.

Wilson's Anatomist's Vade-Mecum. Eleventh Edition, by HENRY E. CLARK, M.R.C.S. Eng., F.F.P.S. Glasg., Examiner in Anatomy F.P.S., and Professor of Surgery in St. Mungo's College, Glasgow. Crown 8vo, with 492 Engravings and 26 Coloured Plates, 18s.

An Atlas of Human Anatomy. By Rickman J. GODLEE, M.S., F.R.C.S., Surgeon and late Demonstrator of Anatomy, University College Hospital. With 48 Imp. 4to Plates (112 figures), and a volume of Explanatory Text. 8vo, £4 14s. 6d.

Human Osteology. By Luther Holden, Consulting Surgeon to St. Bartholomew's Hospital. Seventh Edition, edited by CHARLES STEWART, Conservator of the Museum R.C.S., and ROBERT W. REID, M.D., F.R.C.S., Professor of Anatomy in the University of Aberdeen. 8vo, with 59 Lithographic Plates and 75 Engravings, 16s.

By the same Author.

Landmarks, Medical and Surgical. Fourth Edition. 8vo, 3s. 6d.

The Student's Guide to Surgical Anatomy. By EDWARD BELLAMY, F.R.C.S., and Member of the Board of Examiners. Third Edition. Fcap. 8vo, with 81 Engravings, 7s. 6d.

Diagrams of the Nerves of the Human Body, exhibiting their Origin, Divisions, and Connections, with their Distribution to the Various Regions of the Cutaneous Surface, and to all the Muscles. By Sir W. H. FLOWER, K.C.B., F.R.S., F.R.C.S. Third Edition, with 6 Plates. Royal 4to, 12s.

Pathological Anatomy of Diseases. Arranged according to the nomenclature of the R.C.P. Lond. (Student's Guide Series). By NORMAN MOORE, M.D., F.R.C.P., Assistant Physician and Lecturer on Pathological Anatomy to St. Bartholomew's Hospital. Fcap. 8vo, with 111 Engravings, 8s. 6d.

A Manual of Clinical and Practical Pathology. By W. E. WYNTER, M.D., M.R.C.P., F.R.C.S., Medical Registrar to Middlesex Hospital, and F. J. WETHERED, M.D., M.R.C.P., Assistant Physician to Victoria Park Hospital. With 4 Coloured Plates and 67 Engravings. 8vo, 12s. 6d.

Lectures on Pathology: delivered at the London Hospital. By the late HENRY GAWEN SUTTON, M.B., F.R.C.P., Physician to, and Lecturer on Pathology at, the London Hospital. Edited by MAURICE E. PAUL, M.D., and Revised by SAMUEL WILKS, M.D., LL.D., F.R.S. 8vo, 15s.

General Pathology (an Introduction to). By JOHN BLAND SUTTON, F.R.C.S., Sir E. Wilson Lecturer on Pathology, R.C.S.; Assistant Surgeon to, and Lecturer on Anatomy at, Middlesex Hospital. 8vo, with 149 Engravings, 14s.

Atlas of Pathological Anatomy. By Dr. LANCEREAUX. Translated by W. S. GREENFIELD, M.D., Professor of Pathology in the University of Edinburgh. Imp. 8vo, with 70 Coloured Plates, £5 5s.

Index Pathologicus, for the Registrations of the Lesions recorded in Pathological Records or Case-books of Hospitals and Asylums. By JAMES C. HOWDEN, M.D., Superintendent of the Royal Lunatic Asylum, Montrose. Fcap. folio, 6s.

Atlas of the Central Nervous System. From the larger work of Hirschfeld and Léveillé. Edited by HOWARD H. TOOTH, M.D., F.R.C.P., Assistant Physician to the National Hospital for the Paralysed and Epileptic. With 37 Plates carefully coloured by Hand. Large Imp. 8vo, 40s.

The Human Brain: Histological and Coarse Methods of Research. A Manual for Students and Asylum Medical Officers. By W. BEVAN LEWIS, L.R.C.P. Lond., Medical Superintendent, West Riding Lunatic Asylum. 8vo, with Wood Engravings and Photographs, 8s.

Elements of Human Physiology. (Student's Guide Series.) By ERNEST H. STARLING, M.D., M.R.C.P., Joint Lecturer on Physiology at Guy's Hospital. Fcap. 8vo, with 94 Engravings, 6s. 6d.

Manual of Physiology: for the Use of Junior Students of Medicine. By GERALD F. YEO, M.D., F.R.S., Emeritus Professor of Physiology in King's College, London. Third Edition. Crown 8vo, with 254 Engravings (many figures), and Coloured Plate of Spectra, 14s.

Principles of Human Physiology. By W. B. CARPENTER, C.B., M.D., F.R.S. Ninth Edition, by HENRY POWER, M.B., F.R.C.S. 8vo, with 3 Steel Plates and 377 Wood Engravings, 31s. 6d.

Medical Jurisprudence: its Principles and Practice. By ALFRED S. TAYLOR, M.D., F.R.C.P., F.R.S. Fourth Edition, by THOMAS STEVENSON, M.D., F.R.C.P., Lecturer on Medical Jurisprudence at Guy's Hospital. 2 vols. 8vo, with Engravings.

[*Nearly Ready.*

By the same Authors.

A Manual of Medical Jurisprudence. Twelfth Edition. Crown 8vo, with 55 Engravings, 14s.

The Student's Guide to Medical Jurisprudence. By JOHN ABERCROMBIE, M.D., F.R.C.P., Physician to Charing Cross Hospital. Fcap. 8vo, 7s. 6d.

Hospitals, Infirmaries, and Dispensaries: their Construction, Interior Arrangement, and Management; with Descriptions of existing Institutions, and 74 Illustrations. By F. OPPERT, M.D., M.R.C.P.L. Second Edition. Royal 8vo, 12s.

Sanitary Examinations of Water, Air, and Food. A Vade-Mecum for the Medical Officer of Health. By CORNELIUS B. FOX, M.D., F.R.C.P. Second Edition. Crown 8vo, with 110 Engravings, 12s. 6d.

Microscopical Examination of Drinking Water and of Air. By J. D. MACDONALD, M.D., F.R.S., Ex-Professor of Naval Hygiene in the Army Medical School. Second Edition. 8vo, with 25 Plates, 7s. 6d.

Hygiene and Public Health: a Treatise by various Authors. Edited by THOMAS STEVENSON, M.D., F.R.C.P., Lecturer on Chemistry and Medical Jurisprudence at Guy's Hospital; Official Analyst to the Home Office; and SHIRLEY F. MURPHY, Medical Officer of Health of the County of London. In 3 vols., royal 8vo, fully Illustrated. Vol. I., 28s.; Vol. II., 32s.

A Manual of Practical Hygiene. By the late E. A. PARKES, M.D., F.R.S. Eighth Edition, by J. LANE NOTTER, A.M., M.D., F.R.S., Professor of Military Hygiene in the Army Medical School. 8vo, with 10 Plates and 103 Engravings, 18s.

A Handbook of Hygiene and Sanitary Science. By GEO. WILSON, M.A., M.D., LL.D., D.P.H. Camb. Medical Officer of Health for Mid-Warwickshire. Seventh Edition. Crown 8vo, with Engravings, 12s. 6d.

Public Health Reports. By Sir John Simon, C.B., F.R.S. Edited by EDWARD SEATON, M.D., F.R.C.P. 2 vols. 8vo, with Portrait, 36s.

Hospitals and Asylums of the World: their Origin, History, Construction, Administration, Management, and Legislation. By HENRY C. BURDETT. In 4 vols., super-royal 8vo, and Portfolio. Complete, 168s. Vols. I and II—Asylums: their History, Administration, and Construction, with Plans and Bibliography, 90s. Vols. III and IV—Hospitals: their History, Administration, and Construction, with Plans, Bibliography and Portfolio, 120s.

Mental Diseases: Clinical Lectures. By T. S. CLOUSTON, M.D., F.R.C.P. Edin., Lecturer on Mental Diseases in the University of Edinburgh. Third Edition. Crown 8vo, with 13 Plates, 14s.

Illustrations of the Influence of the Mind upon the Body in Health and Disease: Designed to elucidate the Action of the Imagination. By D. HACK TUKE, M.D., F.R.C.P., LL.D. Second Edition. 2 vols. crown 8vo, 15s.

By the same Author.

Prichard and Symonds in Especial Relation to Mental Science. With Chapters on Moral Insanity. 8vo, with Portraits, 5s.

Also.

Reform in the Treatment of the Insane. Early History of the Retreat, York its Objects and Influence. With a Report of the Celebrations of its Centenary. 8vo, 4s.

A Dictionary of Psychological Medicine, giving the Definition, Etymology, and Synonyms of the Terms used in Medical Psychology; with the Symptoms, Treatment, and Pathology of Insanity; and THE LAW OF LUNACY IN GREAT BRITAIN AND IRELAND. Edited by D. HACK TUKE, M.D., LL.D., assisted by nearly 130 Contributors, British, Continental and American. 2 vols., 1,500 pages, royal 8vo, Illustrated, 42s.

The Journal of Mental Science. Published Quarterly, by Authority of the Medico-Psychological Association. 8vo, 3s. 6d.

Mental Affections of Childhood and Youth (Lettsomian Lectures for 1887, etc.). By J. LANGDON DOWN, M.D., F.R.C.P., Consulting Physician to the London Hospital. 8vo, 6s.

Manual of Midwifery, including all that is likely to be required by Students and Practitioners. By ALFRED L. GALABIN, M.A., M.D., F.R.C.P., Obstetric Physician and Lecturer on Midwifery and Diseases of Women to Guy's Hospital. Third Edition. Crown 8vo, with 261 Engravings, 15s.

The Student's Guide to the Practice of Mid- wifery. By D. LLOYD ROBERTS, M.D., F.R.C.P., Lecturer on Clinical Midwifery and Diseases of Women at the Owens College; Obstetric Physician to the Manchester Royal Infirmary. Fourth Edition. Fcap. 8vo, with Coloured Plates and Wood Engravings.

[*Preparing.*

Female Pelvic Organs (The Surgery, Surgical Pathology, and Surgical Anatomy of): in a Series of Plates taken from Nature. With Commentaries, Notes, and Cases. By HENRY SAVAGE, M.D., Consulting Physician to the Samaritan Hospital for Women and Children. Fifth Edition. 4to, Uncoloured, 15s.

Obstetric Aphorisms: for the Use of Students commencing Midwifery Practice. By JOSEPH G. SWAYNE, M.D., Lecturer on Midwifery in the Bristol Medical School. Tenth Edition. Fcap. 8vo, with 20 Engravings. 3s. 6d.

Clinical Lectures on Diseases of Women: delivered in St. Bartholomew's Hospital, by J. MATTHEWS DUNCAN, M.D., LL.D., F.R.C.P., F.R.Ss. L. & E., late Obstetric Physician to St. Bartholomew's Hospital. Fourth Edition. 8vo, 16s.

Lectures on Obstetric Operations: including the Treatment of Hæmorrhage, and forming a Guide to the Management of Difficult Labour. By ROBERT BARNES, M.D., F.R.C.P., Consulting Obstetric Physician to St. George's Hospital. Fourth Edition. 8vo, with 121 Engravings, 12s. 6d.

By the same Author.

A Clinical History of Medical and Surgical Diseases of Women. Second Edition. 8vo, with 181 Engravings, 28s.

Gynæcological Operations (Handbook of). By ALBAN H. G. DORAN, F.R.C.S., Surgeon to the Samaritan Hospital. 8vo, with 167 Engravings, 15s.

Diseases of Women. (Student's Guide Series.) By ALFRED L. GALABIN, M.A., M.D., F.R.C.P., Obstetric Physician to, and Lecturer on Midwifery and Diseases of Women at, Guy's Hospital. Fifth Edition. Fcap. 8vo, with 142 Engravings, 8s. 6d.

Manual of the Diseases peculiar to Women. By JAMES OLIVER, M.D., F.R.S.E., M.R.C.P., Physician to the Hospital for Women, etc. Fcap. 8vo, 3s. 6d.

A Practical Treatise on the Diseases of Women. By T. GAILLARD THOMAS, M.D. Sixth Edition, by PAUL F. MUNDÉ, M.D., Professor of Gynæcology at the New York Polyclinic and at Dartmouth College. Roy. 8vo, with 347 Engravings, 25s.

Notes on Diseases of Women: specially de- signed to assist the Student in preparing for Examination. By JAMES J. REYNOLDS, L.R.C.P., M.R.C.S. Fourth Edition, Fcap. 8vo.

Abdominal Surgery. By J. Greig Smith, M.A., F.R.S.E., Surgeon to the Bristol Royal Infirmary, and Lecturer on Surgery in the Bristol Medical School. Fourth Edition. 8vo, with 82 Engravings, 21s.

The Physiology of Death from Traumatic Fever; a Study in Abdominal Surgery. By JOHN D. MALCOLM, M.B., C.M., F.R.C.S.E., Surgeon to the Samaritan Free Hospital. 8vo, 3s. 6d.

Notes on Gynæcological Nursing. By John BENJAMIN HELLIER, M.D., M.R.C.S. Lecturer on the Diseases of Women and Children in the Yorkshire College, and Surgeon to the Hospital for Women, etc., Leeds. Crown 8vo, 1s. 6d.

A Manual for Hospital Nurses and others engaged in Attending on the Sick, with a Glossary. By EDWARD J. DOMVILLE, Surgeon to the Exeter Lying-in Charity. Seventh Edition. Crown 8vo, 2s. 6d.

A Manual of Nursing, Medical and Surgical. By CHARLES J. CULLINGWORTH, M.D., F.R.C.P., Obstetric Physician to St. Thomas's Hospital. Third Edition. Fcap. 8vo, with Engravings, 2s. 6d.

By the same Author.

A Short Manual for Monthly Nurses. Third Edition. Fcap. 8vo, 1s. 6d.

A Practical Treatise on Disease in Children. By EUSTACE SMITH, M.D., F.R.C.P., Physician to the King of the Belgians, and to the East London Hospital for Children, etc. Second Edition. 8vo, 22s.

By the same Author.

Clinical Studies of Disease in Children. Second Edition. Post 8vo, 7s. 6d.

Also.

The Wasting Diseases of Infants and Children. Fifth Edition Post 8vo, 8s. 6d.

The Diseases of Children. (Student's Guide Series.) By JAS. F. GOODHART, M.D., F.R.C.P., Physician to Guy's Hospital. Fourth Edition. Fcap. 8vo, 10s. 6d.

Manual of Diseases of Children, for Practitioners and Students. By W. H. DAY, M.D., Physician to the Samaritan Hospital. Second Edition. Crown 8vo, 12s. 6d.

A Practical Manual of the Diseases of Children. With a Formulary. By EDWARD ELLIS, M.D. Fifth Edition. Crown 8vo, 10s.

Materia Medica: a Manual for the Use of Students. By ISAMBARD OWEN, M.D., F.R.C.P., Lecturer on Materia Medica, etc., to St. George's Hospital. Second Edition. Crown 8vo, 6s. 6d.

Materia Medica, Pharmacy, Pharmacology, and Therapeutics. By W. HALE WHITE, M.D., F.R.C.P., Physician to, and Lecturer on Materia Medica and Therapeutics at, Guy's Hospital; Examiner in Materia Medica on the Conjoint Board of the Royal Colleges of Physicians and Surgeons. Fcap. 8vo, 7s. 6d.

Materia Medica and Therapeutics. By Charles D. F. PHILLIPS, M.D., LL.D., F.R.S. Edin.
Vegetable Kingdom—Organic Compounds—Animal Kingdom. 8vo, 25s.
Inorganic Substances. Second Edition. 8vo, 21s.

The National Dispensatory: Containing the Natural History, Chemistry, Pharmacy, Actions and Uses of Medicines, &c. By ALFRED STILLÉ, M.D., LL.D., JOHN M. MAISCH, Phar.D., CHAS. CASPARI, jun., Ph.G., and HENRY C. C. MAISCH, Ph.G., Ph.D. Fifth Edition, with 320 Engravings. Imp. 8vo, 36s.

Galenic Pharmacy: a Practical Handbook to the Processes of the British Pharmacopœia. By R. A CRIPPS, M.P.S. 8vo, with 76 Engravings, 8s. 6d.

Practical Pharmacy. By Barnard S. Proctor, formerly Lecturer on Pharmacy at the College of Medicine, Newcastle-on-Tyne. Third Edition. 8vo, with 44 Wood Engravings and 32 Lithograph Fac-Simile Prescriptions, 14s.

Selecta è Prescriptis: containing Lists of Terms, Phrases, Contractions and Abbreviations used in Prescriptions, with Explanatory Notes, etc. Also, a Series of Abbreviated Prescriptions and Key to the same, with Translations. By JONATHAN PEREIRA, M.D., F.R.S. Eighteenth Edition, by JOSEPH INCE, F.C.S., F.L.S. 24mo, 5s.

Pocket Formulary and Synopsis of the British and Foreign Pharmacopœias. By HENRY BEASLEY. Eleventh Edition. 18mo, 6s. 6d.

By the same Author.

Druggist's General Receipt-Book. Ninth Edition. 18mo, 6s. 6d.

Also.

Book of Prescriptions: containing upwards of 3,000 Prescriptions collected from the Practice of the most eminent Physicians and Surgeons, English and Foreign. Seventh Edition, 18mo, 6s. 6d.

A Companion to the British Pharmacopœia. By PETER SQUIRE, Revised by his Sons, P. W. and A. H. SQUIRE. Sixteenth Edition. 8vo, 12s. 6d.

By the same Authors.

The Pharmacopœias of the London Hospitals, arranged in Groups for Easy Reference and Comparison. Sixth Edition. 18mo, 6s.

Royle's Manual of Materia Medica and Therapeutics. Sixth Edition, including additions and alterations in the B.P. 1885. By JOHN HARLEY, M.D., Physician to St. Thomas's Hospital. Crown 8vo, with 139 Engravings, 15s.

The Prescriber's Pharmacopœia: the Medi- cines arranged in Classes according to their Action, with their Composition and Doses. By NESTOR J. C. TIRARD, M.D., F.R.C.P., Professor of Materia Medica and Therapeutics in King's College, London. Sixth Edition. 32mo, bound in leather, 3s.

Recent Materia Medica. Notes on their Origin and Therapeutics. By F. HARWOOD LESCHER, F.C.S., Pereira Medallist. Fourth Edition. 8vo, 2s. 6d.

Year-Book of Pharmacy: containing the Trans- actions of the British Pharmaceutical Conference. Annually. 8vo, 10s.

Manual of Botany: including the Structure, Classification, Properties, Uses, and Functions of Plants. By ROBERT BENTLEY, Emeritus Professor of Botany in King's College and to the Pharmaceutical Society. Fifth Edition. Crown 8vo, with 1,178 Engravings, 15s.

By the same Author.

The Student's Guide to Structural, Morpho- logical, and Physiological Botany. With 660 Engravings. Fcap. 8vo, 7s. 6d.

Also.

The Student's Guide to Systematic Botany, including the Classification of Plants and Descriptive Botany. Fcap. 8vo, with 350 Engravings, 3s. 6d.

Medicinal Plants: being Descriptions with original figures, of the Principal Plants employed in Medicine, and an account of their Properties and Uses. By Prof. BENTLEY and Dr. H. TRIMEN, F.R.S. In 4 vols., large 8vo, with 306 Coloured Plates, bound in Half Morocco, Gilt Edges, £11 11s.

Practical Therapeutics: a Manual. By EDWARD J. WARING, C.I.E., M.D., F.R.C.P., and DUDLEY W. BUXTON, M.D., B.S. Lond. Fourth Edition. Crown 8vo, 14s.

By the same Author.

Bazaar Medicines of India, and Common Medical Plants. With Full Index of Diseases, indicating their Treatment by these and other Agents procurable throughout India, etc. Fourth Edition. Fcap. 8vo, 5s.

Climate and Fevers of India, with a Series of Cases (Croonian Lectures, 1882). By Sir JOSEPH FAYRER K.C.S.I., M.D. 8vo, with 17 Temperature Charts, 12s.

By the same Author.

The Natural History and Epidemiology of Cholera: being the Annual Oration of the Medical Society of London, 1888. 8vo, 3s. 6d.

A Manual of Family Medicine and Hygiene for India. Published under the Authority of the Government of India. By Sir WILLIAM J. MOORE, K.C.I.E., M.D., late Surgeon-General with the Government of Bombay. Sixth Edition. Post 8vo, with 71 Engravings, 12s.

By the same Author.

A Manual of the Diseases of India: with a Compendium of Diseases generally. Second Edition. Post 8vo, 10s.

Also.

The Constitutional Requirements for Tropical Climates, etc. Crown 8vo, 4s.

The Prevention of Disease in Tropical and Sub-Tropical Campaigns. (Parkes Memorial Prize for 1886.) By ANDREW DUNCAN, M.D., B.S. Lond., F.R.C.S., Surgeon, Bengal Army. 8vo, 12s. 6d.

A Commentary on the Diseases of India. By NORMAN CHEVERS, C.I.E., M.D., F.R.C.S., Deputy Surgeon-General H.M. Indian Army. 8vo, 24s.

Hooper's Physicians' Vade-Mecum: a Manual of the Principles and Practice of Physic. Tenth Edition. By W. A. GUY, F.R.C.P., F.R.S., and J. HARLEY, M.D., F.R.C.P. With 118 Engravings. Fcap. 8vo, 12s. 6d.

The Principles and Practice of Medicine. (Text-book.) By the late C. HILTON FAGGE, M.D., and P. H. PYE-SMITH, M.D., F.R.S., F.R.C.P., Physician to, and Lecturer on Medicine at, Guy's Hospital. Third Edition. 2 vols. 8vo, cloth, 40s.; Half Leather, 46s.

Manual of the Practice of Medicine. By FREDERICK TAYLOR, M.D., F.R.C.P., Physician to, and Lecturer on Medicine at, Guy's Hospital. Third Edition. Cr. 8vo, with Engravings, 15s.

A Dictionary of Practical Medicine. By various writers. Edited by JAS. KINGSTON FOWLER, M.A., M.D., F.R.C.P., Physician to Middlesex Hospital and the Hospital for Consumption. 8vo, cloth, 21s.; half calf, 25s.

The Practice of Medicine. (Student's Guide Series.) By M. CHARTERIS, M.D., Professor of Therapeutics and Materia Medica in the University of Glasgow. Sixth Edition. Fcap. 8vo, with Engravings on Copper and Wood, 9s.

How to Examine the Chest: a Practical Guide for the use of Students. By SAMUEL WEST, M.D., F.R.C.P. Assistant Physician to St. Bartholomew's Hospital. Second Edition. With Engravings. Fcap. 8vo, 5s.

The Bronchi and Pulmonary Blood-vessels: their Anatomy and Nomenclature. By WILLIAM EWART, M.D., F.R.C.P., Physician to St. George's Hospital. 4to, with 20 Illustrations, 21s.

An Atlas of the Pathological Anatomy of the Lungs. By the late WILSON FOX, M.D., F.R.S., F.R.C.P., Physician to H.M. the Queen. With 45 Plates (mostly Coloured) and Engravings. 4to, half-bound in Calf, 70s.

By the same Author.

A Treatise on Diseases of the Lungs and Pleura. Edited by SIDNEY COUPLAND, M.D., F.R.C.P., Physician to Middlesex Hospital. Roy. 8vo, with Engravings; also Portrait and Memoir of the Author, 36s.

The Student's Guide to Diseases of the Chest. By VINCENT D. HARRIS, M.D. Lond., F.R.C.P., Physician to the City of London Hospital for Diseases of the Chest, Victoria Park. Fcap. 8vo, with 55 Illustrations (some Coloured), 7s. 6d.

Antiseptic Dry-Air Treatment of Consump- tion. By JOHN J. HARTNETT, M.D., M.Ch., Q.U.I. With Engravings. Crown 8vo, 3s. 6d.

Guy's Hospital Reports. By the Medical and Surgical Staff. Vol. XXXIV. Third Series. 8vo, 10s. 6d.

St. Thomas's Hospital Reports. By the Medical and Surgical Staff. Vol. XXI. New Series. 8vo, 8s. 6d.

Westminster Hospital Reports. By the Medical and Surgical Staff. Vol. VIII. 8vo, 6s.

Medical Diagnosis. (Student's Guide Series.) By SAMUEL FENWICK, M.D., F.R.C.P., Physician to the London Hospital. Seventh Edition. Fcap. 8vo, with 117 Engravings, 7s.

By the same Author.

Outlines of Medical Treatment. Fourth Edition. Crown 8vo, with 35 Engravings, 10s.

Also.

Clinical Lectures on some Obscure Diseases of the Abdomen. Delivered at the London Hospital. 8vo, with Engravings, 7s. 6d.

Also.

The Saliva as a Test for Functional Diseases of the Liver. Crown 8vo, 2s.

The Microscope in Medicine. By Lionel S. BEALE, M.B., F.R.S., Physician to King's College Hospital. Fourth Edition. 8vo, with 86 plates, 21s.

By the same Author.

The Liver. With 24 Plates (85 Figures). 8vo, 5s.

Also.

On Slight Ailments: and on Treating Disease. Third Edition. 8vo, 5s.

Medical Lectures and Essays. By Sir G. JOHNSON, M.D., F.R.C.P., F.R.S., Consulting Physician to King's College Hospital. 8vo, with 46 Engravings, 25s.

By the same Author.

An Essay on Asphyxia (Apnœa). 8vo, 3s.

The Climate of Rome and the Roman Malaria. By Professor TOMMASI-CRUDELI. Translated by CHARLES CRAMOND DICK. Crown 8vo, 5s.

Uric Acid as a Factor in the Causation of Disease. By ALEXANDER HAIG, M.D., F.R.C.P. Physician to the Metropolitan Hospital and the Royal Hospital for Children and Women. Second Edition. 8vo, with Illustrations, 10s. 6d.

Bronchial Affections: Pneumonia and Fibroid Pneumonia (their Pathological Histology) An Original Investigation. By A. G. AULD, M.D., Assistant Physician to the Glasgow Royal Infirmary. 8vo, with Illustrations, 7s. 6d.

Bronchial Asthma: its Pathology and Treatment. By J. B. BERKART, M.D., late Physician to the City of London Hospital for Diseases of the Chest. Second Edition, with 7 Plates (35 Figures). 8vo, 10s. 6d.

Vaccinia and Variola: a Study of their Life History. By JOHN B. BUIST, M.D., F.R.S.E., Teacher of Vaccination for the Local Government Board. Crown 8vo, with 24 Coloured Plates, 7s. 6d.

Treatment of Some of the Forms of Valvular Disease of the Heart. By A. E. SANSOM, M.D., F.R.C.P., Physician to the London Hospital. Second Edition. Fcap. 8vo, with 26 Engravings, 4s. 6d.

Medical Ophthalmoscopy: a Manual and Atlas. By W. R. GOWERS, M.D., F.R.C.P., F.R.S., Physician to the National Hospital for the Paralyzed and Epileptic. Third Edition. Edited with the assistance of MARCUS GUNN, M.B., F.R.C.S., Surgeon to the Royal London Ophthalmic Hospital. With Coloured Plates and Woodcuts. 8vo, 16s.

By the same Author.

A Manual of Diseases of the Nervous System.

VOL. I.—**Diseases of the Nerves and Spinal Cord.** Second Edition. Roy. 8vo, with 179 Engravings, 15s.

VOL. II.—**Diseases of the Brain and Cranial Nerves: General and Functional Diseases of the Nervous System.** Second Edition. Roy. 8vo, with 182 Engravings, 20s.

Also.

Diagnosis of Diseases of the Brain. Second Edition. 8vo, with Engravings, 7s. 6d.

Also.

Syphilis and the Nervous System: being a Revised Reprint of the Lettsomian Lectures for 1890. Delivered before the Medical Society of London. 8vo, 4s.

The Nervous System, Diseases of. By J. A. ORMEROD, M.D., F.R.C.P., Physician to the National Hospital for the Paralysed and Epileptic. With 66 Illustrations. Fcap. 8vo, 8s. 6d.

Diseases of the Nervous System. Lectures delivered at Guy's Hospital. By SAMUEL WILKS, M.D., F.R.S. Second Edition. 8vo, 18s.

Handbook of the Diseases of the Nervous System. By JAMES ROSS, M.D., F.R.C.P., late Professor of Medicine in the Victoria University, and Physician to the Royal Infirmary, Manchester. Roy. 8vo, with 184 Engravings, 18s.

By the same Author.

Aphasia : being a Contribution to the Subject of the Dissolution of Speech from Cerebral Disease. 8vo, with Engravings, 4s. 6d.

Stammering : its Causes, Treatment, and Cure. By A. G. BERNARD, M.R.C.S., L.R.C.P. Crown 8vo, 2s.

Secondary Degenerations of the Spinal Cord (Gulstonian Lectures, 1889). By HOWARD H. TOOTH, M.D., F.R.C.P., Assistant Physician to the National Hospital for the Paralysed and Epileptic. With Plates and Engravings. 8vo, 3s. 6d.

Diseases of the Nervous System. Clinical Lectures. By THOMAS BUZZARD, M.D., F.R.C.P., Physician to the National Hospital for the Paralysed and Epileptic. With Engravings. 8vo, 15s.

By the same Author.

Some Forms of Paralysis from Peripheral Neuritis; of Gouty, Alcoholic, Diphtheritic, and other origin. Crown 8vo, 5s.

Also.

On the Simulation of Hysteria by Organic Disease of the Nervous System. Crown 8vo, 4s. 6d.

Gout in its Clinical Aspects. By J. Mortimer GRANVILLE, M.D. Crown 8vo, 6s.

Diseases of the Liver : with and without Jaundice. By GEORGE HARLEY, M.D., F.R.C.P., F.R.S. 8vo, with 2 Plates and 36 Engravings, 21s.

Rheumatic Diseases (Differentiation in). By HUGH LANE, Surgeon to the Royal Mineral Water Hospital, Bath, and Hon. Medical Officer to the Royal United Hospital, Bath. Second Edition, much Enlarged, with 8 Plates. Crown 8vo, 3s. 6d.

Diseases of the Abdomen, comprising those of the Stomach and other parts of the Alimentary Canal, Œsophagus, Cæcum, Intestines, and Peritoneum. By S. O. HABERSHON, M.D., F.R.C.P. Fourth Edition. 8vo, with 5 Plates, 21s.

On the Relief of Excessive and Dangerous Tympanites by Puncture of the Abdomen. By JOHN W. OGLE, M.A., M.D., F.R.C.P., Consulting Physician to St. George's Hospital. 8vo, 5s. 6d.

Headaches: their Nature, Causes, and Treat- ment. By W. H. DAY, M.D., Physician to the Samaritan Hospital. Fourth Edition. Crown 8vo, with Engravings, 7s. 6d.

Health Resorts at Home and Abroad. By M. CHARTERIS, M.D., Professor of Therapeutics and Materia Medica in Glasgow University. Second Edition. Crown 8vo, with Map, 5s. 6d.

The Mineral Waters of France, and its Wintering Stations (Medical Guide to). With a Special Map. By A. VINTRAS, M.D., Physician to the French Embassy, and to the French Hospital, London. Second Edition. Crown 8vo, 8s.

Health Resorts of the Canary Islands in their Climatological and Medical Aspects. By J. CLEASBY TAYLOR, M.D., M.R.C.S. 8vo, 3s. 6d.

Homburg-Spa: an Introduction to its Waters and their use. By Dr. ARNOLD SCHETELIG. Crown 8vo, with Synoptical Table, 2s. 6d.

Surgery: its Theory and Practice. (Student's Guide.) By WILLIAM J. WALSHAM, F.R.C.S., Senior Assistant Surgeon to, and Lecturer on Anatomy at, St. Bartholomew's Hospital. Fourth Edition. Fcap. 8vo, with 335 Engravings, 12s.

Surgical Emergencies: together with the Emergencies attendant on Parturition and the Treatment of Poisoning. By W. PAUL SWAIN, F.R.C.S., Surgeon to the South Devon and East Cornwall Hospital. Fourth Edition. Crown 8vo, with 120 Engravings, 5s.

Illustrated Ambulance Lectures: to which is added a NURSING LECTURE. By JOHN M. H. MARTIN, M.D., F.R.C.S., Honorary Surgeon to the Blackburn Infirmary. Third Edition. Crown 8vo, with 60 Engravings, 2s.

Operations on the Brain (a Guide to). By ALEC FRASER, Professor of Anatomy, Royal College of Surgeons in Ireland. Illustrated by 42 life-size Plates in Autotype, and 2 Woodcuts in the text. Folio, 63s.

Surgery. By C. W. Mansell Moullin, M.A., M.D. Oxon., F.R.C.S., Surgeon and Lecturer on Physiology to the London Hospital. Large 8vo, with 497 Engravings, 34s.

A Course of Operative Surgery. By CHRISTOPHER HEATH, Surgeon to University College Hospital. Second Edition. With 20 Coloured Plates (180 figures) from Nature, by M. LÉVEILLÉ, and several Woodcuts. Large 8vo, 30s.

By the same Author.

The Student's Guide to Surgical Diagnosis. Second Edition. Fcap. 8vo, 6s. 6d.

Also.

Manual of Minor Surgery and Bandaging. For the use of House-Surgeons, Dressers, and Junior Practitioners. Tenth Edition. Fcap. 8vo, with 158 Engravings, 6s.

Also.

Injuries and Diseases of the Jaws. Fourth Edition. By HENRY PERCY DEAN, M.S., F.R.C.S., Assistant Surgeon to the London Hospital. 8vo, with 187 Wood Engravings, 14s.

Also.

Lectures on Certain Diseases of the Jaws. Delivered at the R.C.S., England, 1887. 8vo, with 64 Engravings, 2s. 6d.

Also.

Clinical Lectures on Surgical Subjects. Delivered in University College Hospital. Fcap. 8vo, with 23 Engravings, 6s.

The Practice of Surgery: a Manual. By THOMAS BRYANT, Consulting Surgeon to Guy's Hospital. Fourth Edition. 2 vols. crown 8vo, with 750 Engravings (many being Coloured), and including 6 chromo plates, 32s.

By the same Author.

On Tension: Inflammation of Bone, and Head Injuries. Hunterian Lectures, 1888. 8vo, 6s.

Diseases of Bones and Joints. By Charles MACNAMARA, F.R.C.S., Surgeon to, and Lecturer on Surgery at, the Westminster Hospital. 8vo, with Plates and Engravings, 12s.

The Surgeon's Vade-Mecum: a Manual of Modern Surgery. By R. DRUITT, F.R.C.S. Twelfth Edition. By STANLEY BOYD, M.B., F.R.C.S., Assistant Surgeon and Pathologist to Charing Cross Hospital. Crown 8vo, with 373 Engravings, 16s.

The Operations of Surgery: intended for use on the Dead and Living Subject alike. By W. H. A. JACOBSON, M.A., M.B., M.Ch. Oxon., F.R.C.S., Assistant Surgeon to, and Lecturer on Anatomy at, Guy's Hospital. Second Edition. 8vo, with 235 Illustrations, 30s.

On Anchylosis. By Bernard E. Brodhurst, F.R.C.S., Surgeon to the Royal Orthopædic Hospital. Fourth Edition. 8vo, with Engravings, 5s.

By the same Author.

Curvatures and Disease of the Spine. Fourth Edition. 8vo, with Engravings, 7s. 6d.

Also.

Talipes Equino-Varus or Club-Foot. 8vo, with Engravings, 3s. 6d.

Surgical Pathology and Morbid Anatomy. (Student's Guide Series.) By ANTHONY A. BOWLBY, F.R.C.S., Assistant Surgeon to St. Bartholomew's Hospital. Second Edition. Fcap. 8vo, with 158 Engravings, 9s.

By the same Author.

Injuries and Diseases of Nerves, and their Surgical Treatment. 8vo, with 20 Plates, 14s.

Illustrations of Clinical Surgery. By JONATHAN HUTCHINSON, F.R.S., Senior Surgeon to the London Hospital. In 23 fasciculi. 6s. 6d. each. Fasc. I. to X. bound, with Appendix and Index, £3 10s. Fasc. XI. to XXIII. bound, with Index, £4 10s.

By the same Author.

Archives of Surgery; Quarterly. Nos. I. to XX. 8vo, 2s. 6d. each. Vols. I. to V., each containing 4 Nos., cloth, 10s. 6d. each.

The Human Foot: its Form and Structure, Functions and Clothing. By THOMAS S. ELLIS, Consulting Surgeon to the Gloucester Infirmary. With 7 Plates and Engravings (50 Figures). 8vo, 7s. 6d.

Clubfoot: its Causes, Pathology, and Treatment. By WM. ADAMS, F.R.C.S., Consulting Surgeon to the Great Northern and other Hospitals. Second Edition. 8vo, with 106 Engravings and 6 Lithographic Plates, 15s.

By the same Author.

Lateral and other Forms of Curvature of the Spine: their Pathology and Treatment. Second Edition. 8vo, with 5 Lithographic Plates and 72 Wood Engravings, 10s. 6d.

Also.

Contraction of the Fingers (Dupuytren's and Congenital Contractions): their Treatment by Subcutaneous Divisions of the Fascia, and Immediate Extension. Also on Hammer Toe; its Curability by Subcutaneous Division. And on The Obliteration of Depressed Cicatrices by a Subcutaneous Operation. 8vo, with 8 Plates and 31 Engravings, 6s. 6d.

Treatment of Internal Derangements of the Knee-Joint, by Operation. By HERBERT W. ALLINGHAM, F.R.C.S., Surgeon to the Great Northern Central Hospital, etc. 8vo, with Engravings, 5s.

Short Manual of Orthopædy. By Heather BIGG, F.R.C.S.Ed., Part I. Deformities and Deficiencies of the Head and Neck. 8vo, 2s. 6d.

Face and Foot Deformities. By Frederick CHURCHILL, C.M. 8vo, with Plates and Illustrations, 10s. 6d.

Royal London Ophthalmic Hospital Reports. By the Medical and Surgical Staff. Vol. XIII, Part 4. 8vo, 5s.

Ophthalmological Society of the United Kingdom. Transactions. Vol. XIII. 8vo, 12s. 6d.

The Diseases of the Eye. (Student's Guide Series.) By EDWARD NETTLESHIP, F.R.C.S., Ophthalmic Surgeon to St. Thomas's Hospital. Fifth Edition. Fcap. 8vo, with 164 Engravings and a Coloured Plate illustrating Colour-Blindness. 7s. 6d.

Diseases and Refraction of the Eye. By N. C. MACNAMARA, F.R.C.S., Surgeon to Westminster Hospital, and GUSTAVUS HARTRIDGE, F.R.C.S., Surgeon to the Royal Westminster Ophthalmic Hospital. Fifth Edition. Crown 8vo, with Plate, 156 Engravings, also Test-types, 10s. 6d.

On Diseases and Injuries of the Eye: a Course of Systematic and Clinical Lectures to Students and Medical Practitioners. By J. R. WOLFE, M.D., F.R.C.S.E. With 10 Coloured Plates and 157 Wood Engravings. 8vo, 21s.

Normal and Pathological Histology of the Human Eye and Eyelids. By C. FRED. POLLOCK, M.D., F.R.C.S., and F.R.S.E., Surgeon for Diseases of the Eye to Anderson's College Dispensary, Glasgow. Crown 8vo, with 100 Plates (230 drawings), 15s.

Diseases of the Eye: a Handbook of Ophthal- mic Practice for Students and Practitioners. By G. E. DE SCHWEINITZ, M.D., Professor of Diseases of the Eye in the Philadelphia Polyclinic. With 216 Illustrations, and 2 Chromo-Lithographic Plates. 8vo, 18s.

Atlas of Ophthalmoscopy. Composed of 12 Chromo-lithographic Plates (59 Figures drawn from nature) and Explanatory Text. By RICHARD LIEBREICH, M.R.C.S. Translated by H. ROSBOROUGH SWANZY, M.B. Third Edition, 4to, 40s.

Refraction of the Eye: a Manual for Students. By GUSTAVUS HARTRIDGE, F.R.C.S., Surgeon to the Royal Westminster Ophthalmic Hospital. Sixth Edition. Crown 8vo, with 98 Illustrations, also Test-types, etc., 6s.

By the same Author.

The Ophthalmoscope: a Manual for Students. Second Edition. Crown 8vo, with 67 Illustrations and 4 Plates, 4s. 6d.

Glaucoma: its Pathology and Treatment. By PRIESTLEY SMITH, Ophthalmic Surgeon to the Queen's Hospital, Birmingham. 8vo, with 64 Engravings and 12 Zinco-photographs. 7s. 6d.

Hints on Ophthalmic Out-Patient Practice. By CHARLES HIGGENS, Ophthalmic Surgeon to Guy's Hospital. Third Edition. Fcap. 8vo, 3s.

Eyestrain (commonly called Asthenopia). By ERNEST CLARKE, M.D., B.S. Lond., Surgeon to the Central London Ophthalmic Hospital, Surgeon and Ophthalmic Surgeon to the Miller Hospital. 8vo, with 22 Illustrations, 5s.

Sore Throat: its Nature, Varieties, and Treat- ment. By PROSSER JAMES, M.D. Fifth Edition. Post 8vo, with Coloured Plates and Engravings, 6s. 6d.

Diseases and Injuries of the Ear. By Sir WILLIAM B. DALBY, F.R.C.S., M.B., Consulting Aural Surgeon to St. George's Hospital. Fourth Edition. Crown 8vo, with 8 Coloured Plates and 38 Wood Engravings. 10s. 6d.

By the same Author.

Short Contributions to Aural Surgery, between 1875 and 1889. Second Edition. 8vo, with Engravings, 3s. 6d.

A System of Dental Surgery. By Sir John TOMES, F.R.S., and C. S. TOMES, M.A., F.R.S. Third Edition. Crown 8vo, with 292 Engravings, 15s.

Dental Anatomy, Human and Comparative: A Manual. By CHARLES S. TOMES, M.A., F.R.S. Fourth Edition. Crown 8vo, with Engravings. [*In the press.*

A Manual of Nitrous Oxide Anæsthesia. By J. FREDERICK W. SILK, M.D. Lond., M.R.C.S., Assistant Anæsthetist to Guy's Hospital, Anæsthetist to the Dental School of Guy's Hospital, and to the Royal Free Hospital. 8vo, with 26 Engravings, 5s.

Notes on Dental Practice. By Henry C. Quinby, L.D.S.I., late President of the British Dental Association. Second Edition. 8vo, with 92 Illustrations, 8s.

Elements of Dental Materia Medica and Therapeutics, with Pharmacopœia. By JAMES STOCKEN, L.D.S., R.C.S., Pereira Prizeman for Materia Medica, and THOMAS GADDES, L.D.S. Eng. and Edin. Third Edition. Fcap. 8vo, 7s. 6d.

Practical Treatise on Mechanical Dentistry. By JOSEPH RICHARDSON, M.D., D.D.S. Sixth Edition, revised and edited by GEORGE W WARREN, D.D.S. Royal 8vo. With 600 Engravings, 21s.

Papers on Dermatology. By E. D. Mapother, M.D., Ex-Pres. R.C.S.I. 8vo, 3s. 6d.

Atlas of Skin Diseases. By Tilbury Fox, M.D., F.R.C.P. With 72 Coloured Plates. Royal 4to, half morocco, £6 6s.

Leprosy in British Guiana. By John D. Hillis, F.R.C.S., M.R.I.A., Medical Superintendent of the Leper Asylum, British Guiana. Imp. 8vo, with 22 Lithographic Coloured Plates and Wood Engravings, £1 11s. 6d.

Diseases of the Skin (Introduction to the Study of). By P. H. PYE-SMITH, M.D., F.R.S., F.R.C.P., Physician to Guy's Hospital. Crown 8vo, with 26 Engravings, 7s. 6d.

Diseases of the Skin: a Practical Treatise for the Use of Students and Practitioners. By J. N. HYDE, A.M., M.D., Professor of Skin and Venereal Diseases, Rush Medical College, Chicago. Second Edition. 8vo, with 2 Coloured Plates and 96 Engravings, 20s.

Sarcoma and Carcinoma: their Pathology, Diagnosis, and Treatment. By HENRY T. BUTLIN, F.R.C.S., Assistant Surgeon to St. Bartholomew's Hospital. 8vo, with 4 Plates, 8s.

By the same Author.

Malignant Disease of the Larynx (Sarcoma and Carcinoma). 8vo, with 5 Engravings, 5s.

Also.

Operative Surgery of Malignant Disease. 8vo, 14s.

On Cancer: its Allies, and other Tumours: their Medical and Surgical Treatment. By F. A. PURCELL, M.D., M.C., Surgeon to the Cancer Hospital, Brompton. 8vo, with 21 Engravings, 10s. 6d.

Cancers and the Cancer Process: a Treatise, Practical and Theoretic. By HERBERT L. SNOW, M.D., Surgeon to the Cancer Hospital, Brompton. 8vo, with 15 Lithographic Plates. 15s.

By the same Author.

The Re-appearance (Recurrence) of Cancer after apparent Extirpation. 8vo, 5s. 6d.

Also.

The Palliative Treatment of Incurable Cancer. Crown 8vo, 2s. 6d.

Cancerous Affections of the Skin (Epithelioma and Rodent Ulcer). By GEORGE THIN, M.D. Post 8vo, with 8 Engravings, 5s.

By the same Author.

Pathology and Treatment of Ringworm. 8vo, with 21 Engravings, 5s.

Diagnosis and Treatment of Syphilis. By TOM ROBINSON, M.D., Physician to St. John's Hospital for Diseases of the Skin. Crown 8vo, 3s. 6d.

By the same Author.

Eczema: its Etiology, Pathology, and Treatment. Crown 8vo, 3s. 6d.

Also.

Illustrations of Diseases of the Skin and Syphilis, with Remarks. Fasc. I. with 3 Plates. Imp. 4to, 5s.

Urinary and Renal Derangements and Calculous Disorders. By LIONEL S. BEALE, F.R.C.P., F.R.S., Physician to King's College Hospital. 8vo, 5s.

Clinical Chemistry of Urine (Outlines of the). By C. A. MACMUNN, M.A., M.D. 8vo, with 64 Engravings and Plate of Spectra, 9s.

Diseases of the Male Organs of Generation. By W. H. A. JACOBSON, M.Ch.Oxon., F.R.C.S., Assistant-Surgeon to Guy's Hospital. 8vo, with 88 Engravings, 22s.

The Surgical Diseases of the Genito-Urinary Organs, including Syphilis. By E. L. KEYES, M.D., Professor of Genito-Urinary Surgery, Syphiology, and Dermatology in Bellevue Hospital Medical College, New York (a revision of VAN BUREN and KEYES' Text-book). Roy. 8vo, with 114 Engravings, 21s.

Atlas of Electric Cystoscopy. By Dr. Emil BURCKHARDT, late of the Surgical Clinique of the University of Bâle, and E. HURRY FENWICK, F.R.C.S., Surgeon to the London Hospital and St. Peter's Hospital for Stone. Royal 8vo, with 34 Coloured Plates, embracing 83 Figures. 21s.

Electric Illumination of the Bladder and Urethra, as a Means of Diagnosis of Obscure Vesico-Urethral Diseases. By E. HURRY FENWICK, F.R.C.S., Surgeon to London Hospital and St. Peter's Hospital for Stone. Second Edition. 8vo, with 54 Engravings, 6s. 6d.

By the same Author.

The Cardinal Symptoms of Urinary Disease: their Diagnostic Significance and Treatment. 8vo, with 36 Illustrations, 8s. 6d.

By SIR HENRY THOMPSON, F.R.C.S.

Diseases of the Urinary Organs. Clinical Lectures. Eighth Edition. 8vo, with 121 Engravings, 10s. 6d.

Diseases of the Prostate: their Pathology and Treatment. Sixth Edition. 8vo, with 39 Engravings, 6s.

Some Important Points connected with the Surgery of the Urinary Organs. Lectures delivered in the R.C.S. 8vo, with 44 Engravings. Student's Edition, 2s. 6d.

Practical Lithotomy and Lithotrity; or, an Inquiry into the Best Modes of Removing Stone from the Bladder. Third Edition. 8vo, with 87 Engravings, 10s.

The Preventive Treatment of Calculous Dis- ease, and the Use of Solvent Remedies. Third Edition. Cr. 8vo, 2s. 6d.

Tumours of the Bladder: their Nature, Symp- toms, and Surgical Treatment. 8vo, with numerous Illustrations, 5s.

Stricture of the Urethra, and Urinary Fistulæ: their Pathology and Treatment. Fourth Edition. 8vo, with 74 Engravings, 6s.

The Suprapubic Operation of Opening the Bladder for Stone and for Tumours. 8vo, with Engravings, 3s. 6d.

Introduction to the Catalogue; being Notes of 1,000 Cases of Calculi of the Bladder removed by the Author, and now in the Museum of R.C.S. 8vo, 2s.6d.

Lectures on the Surgical Disorders of the Urinary Organs. By REGINALD HARRISON, F.R.C.S., Surgeon to St. Peter's Hospital. Fourth Edition. 8vo, with 156 Engravings, 16s.

The Surgery of the Rectum. By Henry Smith, Emeritus Professor of Surgery in King's College, Consulting Surgeon to the Hospital. Fifth Edition. 8vo, 6s.

Diseases of the Rectum and Anus. By Alfred Cooper, F.R.C.S., Senior Surgeon to St. Mark's Hospital for Fistula; and F. Swinford Edwards, F.R.C.S., Senior Assistant Surgeon to St. Mark's Hospital. Second Edition, with Illustrations. 8vo, 12s.

Diseases of the Rectum and Anus. By Harrison Cripps, F.R.C.S., Assistant Surgeon to St. Bartholomew's Hospital, etc. Second Edition. 8vo, with 13 Lithographic Plates and numerous Wood Engravings, 12s. 6d.

By the same Author.

Cancer of the Rectum. Especially considered with regard to its Surgical Treatment. Jacksonian Prize Essay. Third Edition. 8vo, with 13 Plates and several Wood Engravings, 6s.

The Diagnosis and Treatment of Diseases of the Rectum. By William Allingham, F.R.C.S., Surgeon to St. Mark's Hospital for Fistula. Fifth Edition. By Herbert Wm. Allingham, F.R.C.S., Surgeon to the Great Northern Central Hospital, Demonstrator of Anatomy at St. George's Hospital. 8vo, with 53 Engravings, 10s. 6d.

A Medical Vocabulary: an Explanation of all Terms and Phrases used in the various Departments of Medical Science and Practice, their Derivation, Meaning, Application, and Pronunciation. By R. G. Mayne, M.D., LL.D. Sixth Edition, by W. W. Wagstaffe, B.A., F.R.C.S. Crown 8vo, 10s. 6d.

A Short Dictionary of Medical Terms. Being an Abridgment of Mayne's Vocabulary. 64mo, 2s. 6d.

Dunglison's Dictionary of Medical Science. Containing a full Explanation of its various Subjects and Terms, with their Pronunciation, Accentuation, and Derivation. Twenty-first Edition. By Richard J. Dunglison, A.M., M.D. Royal 8vo, 30s.

Terminologia Medica Polyglotta: a Concise International Dictionary of Medical Terms (French, Latin, English, German, Italian, Spanish, and Russian). By Theodore Maxwell, M.D., B.Sc., F.R.C.S. Edin. Royal 8vo, 16s.

A German-English Dictionary of Medical Terms. By Frederick Treves, F.R.C.S., Surgeon to the London Hospital; and Hugo Lang, B.A. Crown 8vo, half-Persian calf, 12s.

Chemistry, Inorganic and Organic. With Experiments. By CHARLES L. BLOXAM. Seventh Edition, by JOHN MILLAR THOMSON, Professor of Chemistry in King's College, London, and ARTHUR G. BLOXAM, Head of the Chemistry Department, the Goldsmiths' Institute, New Cross. 8vo, with 282 Illustrations, 18s.

By the same Author.

Laboratory Teaching; or, Progressive Exercises in Practical Chemistry. Sixth Edition, by ARTHUR G. BLOXAM. Crown 8vo, with 80 Engravings, 6s. 6d.

Watts' Manual of Chemistry, Theoretical and Practical. Edited by WILLIAM A. TILDEN, D.Sc., F.R.S., Professor of Chemistry in the Mason College, Birmingham. Second Edition.

Inorganic Chemistry. Crown 8vo, 8s. 6d.

Organic Chemistry. Crown 8vo, 10s.

Practical Chemistry, and Qualitative Analysis. By FRANK CLOWES, D.Sc. Lond., Professor of Chemistry in the University College, Nottingham. Fifth Edition. Post 8vo, with 57 Engravings and Frontispiece, 7s. 6d.

Quantitative Analysis. By Frank Clowes. D.Sc. Lond., Professor of Chemistry in the University College, Nottingham, and J. BERNARD COLEMAN, Assoc. R. C. Sci. Dublin; Senior Demonstrator of Chemistry in the University College, Nottingham. Second Edition. Post 8vo, with 94 Engravings, 8s. 6d.

Qualitative Analysis. By R. Fresenius. Translated by CHARLES E. GROVES, F.R.S. Tenth Edition. 8vo, with Coloured Plate of Spectra and 46 Engravings, 15s.

By the same Author.

Quantitative Analysis. Seventh Edition.

VOL. I., Translated by A. VACHER. 8vo, with 106 Engravings, 15s.

VOL. II., Parts 1 to 3, Translated by C. E. GROVES, F.R.S. 8vo, with Engravings, 2s. 6d. each.

Practical Chemistry, including Analysis. By JOHN E. BOWMAN and CHARLES L. BLOXAM. Fcap. 8vo. Eighth Edition, with 90 Engravings, 5s. 6d.

Organic Chemistry (Outlines of). By H. FORSTER MORLEY, M.A., D.Sc., Joint Editor of Watts' "Dictionary of Chemistry." Crown 8vo, 7s. 6d.

Inorganic Chemistry. By Edward Frankland, Ph.D., D.C.L., LL.D., F.R.S., Professor of Chemistry in the Normal School of Science, and FRANCIS R. JAPP, M.A., Ph.D., F.I.C., F.R.S., Professor of Chemistry in the University of Aberdeen. 8vo, with numerous Illustrations on Stone and Wood, 24s.

Inorganic Chemistry (A System of). By WILLIAM RAMSAY, Ph.D., F.R.S., Professor of Chemistry in the University College, London. 8vo, with Engravings, 15s.

By the same Author.

Elementary Systematic Chemistry for the Use of Schools and Colleges. With Engravings. Crown 8vo, 4s. 6d.; Interleaved, 5s. 6d.

Valentin's Qualitative Chemical Analysis. Eighth Edition. By Dr. W. R. HODGKINSON, F.R.S.E., Professor of Chemistry and Physics at the Royal Military Academy, and Artillery College, Woolwich. 8vo, with Engravings and Map of Spectra. 8s. 6d.

Analytical Chemistry. Notes for Students in Medicine. By ALBERT J. BERNAYS, Ph.D., F.C.S., F.I.C., late Professor of Chemistry, etc., at St. Thomas's Hospital Medical School. Third Edition. Crown 8vo, 4s. 6d.

Commercial Organic Analysis: a Treatise on the Properties, Modes of Assaying, Proximate Analytical Examination, etc., of the various Organic Chemicals and Products employed in the Arts, Manufactures, Medicine, etc. By ALFRED H. ALLEN, F.I.C., F.C.S., Public Analyst for the West Riding of Yorkshire, the Northern Division of Derbyshire, etc.

VOL. I.—**Alcohols, Neutral Alcoholic Deri-** vatives, Sugars, Starch and its Isomers, Vegetable Acids, etc. With Illustrations. Third Edition. 8vo. [*Preparing.*

VOL. II.—**Fixed Oils and Fats, Hydrocarbons,** Phenols, etc. With Illustrations. Third Edition. 8vo. [*Preparing.*

VOL. III.—Part I. **Aromatic Acids, Tannins,** Dyes, and Colouring Matters. Second Edition. 8vo, 14s.

Part II. **Amines and Ammonium Bases,** Hydrazines, Bases from Tar, Vegetable Alkaloids. Second Edition. 8vo, 18s.

Volumetric Analysis (A Systematic Hand-book of); or the Quantitative Estimation of Chemical Substances by Measure, applied to Liquids, Solids, and Gases. By FRANCIS SUTTON, F.C.S., F.I.C., Public Analyst for the County of Norfolk. Sixth Edition. 8vo, with 102 Engravings, 17s. 6d.

Fuel and its Applications. By E. J. Mills, D.Sc., F.R.S., and F. J. ROWAN, C.E. Being Vol. I. of Chemical Technology, or Chemistry in its application to Arts and Manufactures. Edited by CHARLES E. GROVES, F.R.S., and WILLIAM THORP, B.Sc. Royal 8vo, with 606 Engravings, 30s.

Potable Waters: their Organic Analysis. By J. A. BLAIR, M.B., C.M., D.Sc., L.R.C.P. Second Edition. Crown 8vo, 3s. 6d.

Cooley's Cyclopædia of Practical Receipts, and Collateral Information in the Arts, Manufactures, Professions, and Trades: including Medicine, Pharmacy, Hygiene, and Domestic Economy. Seventh Edition, by W. NORTH, M.A. Camb., F.C.S. 2 Vols., Roy. 8vo, with 371 Engravings, 42s.

Chemical Technology: a Manual. By Rudolf VON WAGNER. Translated and Edited by WILLIAM CROOKES, F.R.S., from the Thirteenth Enlarged German Edition as remodelled by Dr. FERDINAND FISCHER. 8vo, with 596 Engravings, 32s.

Technological Handbooks. Edited by John GARDNER, F.I.C., F.C.S., and JAMES CAMERON, F.I.C.

Brewing, Distilling, and Wine Manu-facture. Crown 8vo, with Engravings, 6s. 6d.

Bleaching, Dyeing, and Calico Printing. With Formulæ. Crown 8vo, with Engravings, 5s.

Oils, Resins, and Varnishes. Crown 8vo, with Engravings, 7s. 6d.

Soaps and Candles. Crown 8vo, with 54 Engravings, 7s.

Methods and Formulæ used in the Preparation of Animal and Vegetable Tissues for Microscopical Examination, including the Staining of Bacteria. By PETER WYATT SQUIRE, F.L.S Crown 8vo, 3s. 6d.

The Microscope and its Revelations. By the late WILLIAM B. CARPENTER, C.B., M.D., LL.D., F.R.S. Seventh Edition, by the Rev. W. H. DALLINGER, LL.D., F.R.S. With 21 Plates and 800 Wood Engravings. 8vo, 26s. Half Calf, 30s.

The Microtomist's Vade-Mecum: a Handbook of the Methods of Microscopic Anatomy. By ARTHUR BOLLES LEE. Third Edition, 8vo, 14s.

The Quarterly Journal of Microscopical Science. Edited by E. RAY LANKESTER, M.A., LL.D., F.R.S.; with the co-operation of ADAM SEDGWICK, M.A., F.R.S., and W. F. R. WELDON, M.A., F.R.S. Each Number,

Photo-Micrography (Guide to the Science of). By EDWARD C. BOUSFIELD, L.R.C.P. Lond. 8vo, with 34 Engravings and Frontispiece, 6s.

The Principles and Practice of Veterinary Medicine. By WILLIAM WILLIAMS, F.R.C.V.S., F.R.S.E., Principal, and Professor of Veterinary Medicine and Surgery at the New Veterinary College, Edinburgh. Seventh Edition, 8vo, with several Coloured Plates and Woodcuts, 30s.

By the same Author.

The Principles and Practice of Veterinary Surgery. Eighth Edition. 8vo, with 9 Plates and 147 Woodcuts, 30s.

The Veterinarian's Pocket Remembrancer: being Concise Directions for the Treatment of Urgent or Rare Cases, embracing Semeiology, Diagnosis, Prognosis, Surgery, Therapeutics, Toxicology, Detection of Poisons by their Appropriate Tests, Hygiene, etc. By GEORGE ARMATAGE, M.R.C.V.S. Second Edition. Post 8vo, 3s.

Chauveau's Comparative Anatomy of the Domesticated Animals. Revised and Enlarged, with the Co-operation of S. ARLOING, Director of the Lyons Veterinary School, and Edited by GEORGE FLEMING, C.B., LL.D., F.R.C.V.S., late Principal Veterinary Surgeon of the British Army. Second English Edition. 8vo, with 585 Engravings, 31s. 6d.

[*Continued on next page.*

[*Continued on next page.*

[*Continued on next page.*

N.B.—J. & A. Churchill's larger Catalogue of about 600 works on Anatomy, Physiology, Hygiene, Midwifery, Materia Medica, Medicine, Surgery, Chemistry, Botany, &c. &c., with a complete Index to their Subjects, for easy reference, will be forwarded post free on application.

AMERICA.—*J. & A. Churchill being in constant communication with various publishing houses in America are able to conduct negotiations favourable to English Authors.*

LONDON: 11, NEW BURLINGTON STREET.