jority of instances there is not, the slightest scrofulous element about the case. The trouble is that the original injury is usually of such a trifling nature that it is allowed to pass almost unheeded, and the patient goes about his ordinary business without thinking it worth while to do anything for it. If this man had had his hand almost half cut off, he would have been all right long ago, because he would have gone at once to a surgeon and had it properly attended to; but the seeming "Hibernianism," that "the less you are hurt the worse it is for you," often comes true in point of fact, on account of the time that is lost and the suffering that is endured before one finally recovers from the effects of an injury trivial in itself. The principles here laid down are applicable to all diseases of the joints. Only get a correct comprehension of the pathology in any case that may come under your care, and then, and then only, will you be able to treat it to advantage.

But now as to the treatment to be adopted here. The muscles and tendons may have remained so long contracted in this case that they have become *contractured*, as it is called, or, in other words, structurally shortened. Such a marked deformity cannot be reduced in a moment, and in treating it the important question first comes up, Can the contraction of the muscles and tendons be overcome by gradual traction, or will it be necessary to cut any of them? On making joint-pressure here while the muscles are on the stretch, I find that no reflex contractions are produced by it, and this at once convinces me that with the aid of gradual traction, maintained for a sufficient length of time, they can be fully restored to their original position; whereas, if reflex contractions had thus been caused, such gradual traction would have been of no service whatever, and we should have been obliged to use the knife. What we have to do, then, is to maintain extension and counter-extension, and at the same time keep the parts perfectly at rest. This can be most easily done by means of a piece of sole-leather about the width of half the circumference of the limb, and sufficiently long to reach from the upper part of the fore-arm to the extremities of the fingers, molded to the surface, and properly secured to the limb. Having cut the sole-leather the required shape, we dip it in cold water, and mold it accurately to the part, while the hand is extended in the position that overcomes the deformity to the greatest extent, after which we secure it by means of a roller. When the latter has been put on we should look carefully at the circulation of the finger ends, which should be left exposed, and if this is at all interfered with the bandage should immediately be taken off and reapplied. This dressing having now been properly adjusted, we find that the patient is entirely free from pain. To-morrow, when the leather splint has become perfectly hard, it will be taken off, lined with adhesive plaster, which should lap a couple of inches or more, and then bound again to the limb (extended as before), with the plaster against the fore-arm.

In this way permanent extension and counter-extension will be maintained, and the diseased surfaces of the joint consequently kept from coming in contact with each other. In a few days later, when the deformity has become to a certain extent reduced, the splint can be taken off and remolded to the part; and this can be repeated as often as necessary, until a cure has been effected.

Original Articles.

THE COMMITMENT AND CERTIFICATION OF THE INSANE.

BY THEO. W. FISHER, M. D. HARV.

A YEAR has passed since the Board of Health, Lunacy, and Charity was established, and the new law relating to the commitment of the insane enacted. Some comments and suggestions relating to the operation of these measures may not be premature at the present time. There had been for several years a certain pressure in favor of a lunacy commission to which should be given the functions of the old Board of State Charities, relating to lunacy, with such new powers as might seem desirable. There had also been in 1878 a legislative attempt to consolidate the management of the state institutions of all kinds under one central board, for convenience and economy. In 1879 the political pressure for economical administration was great, and any measure likely to result in a saving of expense was welcome in the legislature.

I am assured, however, that the union of the Board of Charities and the Board of Health with new functions relating to lunacy was advocated by Governor Talbot on purely administrative grounds, without any reference whatever to politics. It was believed that the Board of Health had accomplished a good work in the community at large in our own State, and an important missionary work in other States, and that it might now be properly called on to attend to the health interests of the state institutions. It was thought desirable that affairs relating to public health and public charities, which run so nearly parallel, should be under the supervision of a single board, thus avoiding complications and possible conflict of authority. A separate commission of lunacy could also be avoided by giving this board the supervision of the insane. The result was our tripartite Board of Health, Lunacy, and Charity.

Many physicians, who had been proud of the good work achieved by our State Board of Health, regretted the loss of identity which seemed to result from its immersion in the new board. They also shared the fears of Dr. Bowditch in respect to its future usefulness. It is necessary, however, to accept this consolidation as an accomplished fact, and make the best of it. Time will prove or disprove the wisdom of the change. Meanwhile, the new board should have the cordial support of all physicians who desire to promote social and sanitary reform. If a separate or supplementary health report be annually issued, it will stand as evidence of the comparative independence and efficiency of the health department.

Of the composition of the board I should not speak, except for the petition recently circulated to appoint one or more women in the place of two members of the lunacy department, whose terms soon expire. The functions of this department particularly should be exercised in the most purely judicial manner, and it should have the unquestioning confidence of the whole community and of the managers of our insane asylums also. It should no more be suspected of a hypercritical or hostile attitude towards asylums than of undue partiality towards them. Its action should always be based on the longest experience and most scientific information obtainable. If extremists are to be considered eligible to appointment, opposites should

be chosen, the most conservative as well as the most radical. I would willingly see a woman of the right sort appointed, and would also like to see upon the board some ex-superintendent who has made a life-long study of insanity from the inside.

The general powers in relation to the insane given the new board are contained in the Acts of 1879, Chapter 291, Section 5, and are as follows: —

"Said board shall act as commissioners of lunacy, with power to investigate the question of the insanity and condition of any person committed to any lunatic hospital, public or private, or restrained of his liberty by reason of alleged insanity at any place within this commonwealth, and shall discharge any person so committed or restrained if, in their opinion, such person is not insane, or can be cared for after such discharge without danger to others and with benefit to such person. And the members of said board, in person or by agents, shall visit and inspect every private asylum or receptacle for the insane within the commonwealth at least once in every six months."

Under this authority it is to be presumed that in the present full condition of all the state hospitals the policy of removing proper cases to town and state almshouses, or of discharging them to friends, will be frequently exercised. Every physician should therefore carefully consider before certifying in any case of lunacy whether a hospital is, under all the circumstances, the best and only proper place for the patient. His action, if the patient is committed, will be subject to examination by the board or its agent, and possibly to revision by a discharge to friends or transfer to an almshouse. While hospitals remain uncrowded it is desirable to care for as many harmless chronic insane as their accommodations will allow, but this class ought not to be permitted to crowd out cases more urgently demanding treatment and custody.

The new law in relation to the commitment of the insane remains, at the close of another legislative session, unaltered. It was the product, in part, of a popular demand, not entirely spontaneous, and based on exaggerated fears and unreasonable prejudices. It should, however, be considered impartially, and judged by its practical working. In Suffolk County the law has, I believe, been carried out faithfully, and even stringently in most of its provisions. The presence of the insane person in court has usually been required, and some judges have visited the patient out of court when his condition demanded it. The instances in which the personal appearance of the patient has been dispensed with, and reasons therefor given by the judge, have, in my experience, been very few. Great physical debility, with extreme excitement, in an undoubted case of insanity, has furnished the usual excuse. In a large number of cases the patient is willing to go to the hospital, but if able he is expected to come into court and tell the judge so. I remember one lady who considered the hospital a second home, and, having taken up her residence there, sent a polite request to the judge to be excused from attendance, which was granted.

I am not aware that the new law has diminished the number of commitments, or has proved much of a safeguard against fraud or improper certification. It was framed to meet an imaginary evil, and to guard against danger almost wholly chimerical. The result has been to put patients, their friends and physicians, to considerable trouble and annoyance without other adequate compensation than the satisfaction of popular clamor, and in this direction the result does seem to have been satisfactory so far. In certain cases the effect on the patient of appearing in court has been disturbing, and in some degree, no doubt, harmful. Melancholy patients, believing they have done some great wrong or committed some enormous crime, and, full of apprehensions of impending evil, are very apt to think the judicial process of commitment relates to their punishment. It confirms their delusions, strengthens their apprehensions, and sends them to the hospital under the burden of an imaginary sentence of death. Occasionally a patient falls on her knees in court in prayer, or piteously begs for mercy. The exhibition of these and other deplorable insane conditions even before the few attendants in a probate court room is sometimes a painful one. The English law does not require the patient's presence in court.

It should be observed that this feature tends to render the admission to hospital of certain cases difficult until the disease has reached a stage of chronicity in which treatment is of little avail. Patients and their friends shrink from this additional publicity, and fear an aggravation of the disease instead of its removal. Some cases of undoubted insanity, of the emotional or moral type, — dangerous, it may be, and at least very destructive of family and public peace, — are likely to be refused commitment, because the judge cannot discover the insanity. Such patients are more likely hereafter to go on to the commission of some act, for which they may be punished, or which requires an elaborate defense on the ground of insanity. Insane drunkards are allowed full swing, under the new law, unless they consent to their own confinement. The State should at least legislate upon this last rather frequent form of insanity.

The whole tendency of recent legislation and of lunacy reform, as known to the public, is to remove the insane person from family and medical control, and place him in the hands of the law. The physician's opinion of insanity must be supported by such facts as would satisfy a non-professional observer that the person was insane. The judge must be able to discover the insanity, either in the evidence or the patient's condition. Any lawyer may visit his insane client by order of the judge who committed him. No physician connected with any insane asylum, however experienced, can certify in any case of insanity, although his testimony as an expert will be taken in court. His opinion may determine the disposal of an estate, and the life of an insane homicide is often in his hands, but he cannot certify a demented patient from his own hospital into another. He really stands as family physician to many of his patients, but he cannot certify in any obscure case, although his testimony may be absolutely necessary to its proper disposal. In consequence of a law passed last winter the same discrimination holds in the matter of fees. The physician, whose reputation is at stake and whose practice may suffer through an error, who takes the chief risk of suits, in revenge or on speculation, who perhaps has visited the lunatic under circumstances of great personal risk, and without whose certificate no action can be inaugurated and no arrest made, gets two dollars and mileage. The justice, who sits in his chair and devotes five minutes to the case, gets three dollars, and a dollar extra if he visits the patient.

Aside from the absurdly inadequate fee, and the in-

creased trouble of getting the patient and all his friends into court at a time convenient to him, the physician ought, on some accounts, to be pleased with the new law. It is a great protection, though not a perfect safeguard, against suits for false certification, fraud, and conspiracy, to bring the patient into court and let him have his hearing once for all. It also divides the responsibility to have his friends appear with him. There is less chance that some impecunious and unscrupulous lawyer will conspire with the discharged but still irresponsible lunatic to put respectable physicians on their defense for fraud and perjury "on speculation." In many cases also it is a benefit to the patient to feel that he is judicially committed to an asylum, and that he need not waste valuable time in trying to get out, when he should be trying to get well. Superintendents are not so likely to be importuned for immediate discharge on the ground of hasty and unjust commitment.

The feature of the law requiring the physician to be a graduate of some legally organized medical college is of course a good one. The other requirement, that the certifying physicians shall specify the facts on which their opinion is founded, is, I fear, not generally understood. Many physicians, to my knowledge, still seem to consider the opinion that the patient is insane and a fit subject for hospital treatment as the important part of their certificate. They answer the questions attached to the Suffolk County blanks at least in a brief way, or not at all, and do not attempt to give the facts on which their opinion is based. One certificate, recently, contained only such information as could be derived from the single word "violent." It must be borne in mind that the physician is no longer the judge of the patient's insanity. He must so fortify his opinion with facts that the judge or justice shall be able to infer the existence of insanity. Unless this is done his certificate is not legal in form or substance.

Physicians should also remember that all their certificates now pass a critical examination, by order of the Board of Health, Lunacy, and Charity. Under English law, if not in accordance with the law, their certificates are returned to them for correction. Mr. F. B. Sanborn, inspector of charities, is charged with this duty, and he informs me that large numbers of certificates are wanting in the necessary specification of facts. It should be a matter of professional pride, as well as of obedience to law to make such a statement in every case as will justify the physician's opinion. This will be done when its necessity is generally understood. Certification in cases of persons arrested by the police, or otherwise brought to the notice of the proper authorities for summary disposal, is sometimes difficult. There may be entire lack of information, except what can be gathered from a stupid, demented, intoxicated, delirious, or incoherent person himself, and little time to obtain it. But this excuse will seldom apply to the certificates of physicians, who see patients in their homes, where delay is possible and all the facts are at hand.

Facts of hearsay as well as of observation may be given in the certificate, but they should be carefully distinguished. The two physicians should also specify any facts they may have separately observed. For instance, the one most familiar with the case may say, "Dr. A. observed," etc., and "was informed by the patient's wife that he," etc. Dr. B., if his information is identical, can say so over his own initials or signature. If not, he can add his facts in the same manner as Dr. A. The questions on some certificate blanks may be answered thus indirectly, and not in a categorical manner, as they are also answered on the statement required by law.

It requires some knowledge of insanity and some experience in certifying to make a perfectly correct certificate, with nothing superfluous, and complete in all respects. Any physician, however, who has come to the conclusion that a person is insane ought to be able to state clearly the facts which led him to this opinion. A careful setting forth of his reasons in the certificate will not only give clearness to his own ideas on the subject, but will prevent hasty action in doubtful or obscure cases. Although the English law differs somewhat from ours in its requirements, Dr. Brushfield's recent article On Medical Certificates of Insanity [1] will prove a useful guide to those desirous of perfecting themselves in the art of certificate-making. Our law does not particularize as to the form of the medical portion of the certificate, and makes no distinction between public and private patients. The English law requires but one certificate in the case of paupers, and most of the restrictions and safeguards seem to apply especially to private patients.

Dr. Brushfield considers the certificate as containing two distinct parts, — the statutory and the medical. In the case of private patients the two physicians must separately examine the patient and form an opinion, each independently of the other. Their certificates must be on separate sheets of paper, and neither must see that of the other or know its contents. The statement as to medical qualifications must be full, showing that the medical man is a licensed practitioner, and that he is in actual practice. The time and place of examination must be designated. It should be noted that in neither the English certificate nor ours is it necessary to state that the patient is dangerous. The words "and is a proper person to be taken charge of and detained under care and treatment" are equivalent to "is a proper subject for treatment in an insane hospital" of our certificate. This point should be insisted on, as lawyers and judges in some cases with us seem to think the element of danger the only important one in disputed cases. In the case of Nottidge *v.* Ripley the judge appeared to be of opinion that no insane person not dangerous to himself or others ought to be confined in an asylum. The English commissioners of lunacy, in reference to this case, wrote to the lord chancellor as follows: "The object of these acts is not, as your lordship is aware, so much to confine lunatics as to restore to a healthy state of mind such of them as are curable, and to afford comfort and protection to the rest.[2]

This opinion should be our guide in certifying, since the difficulty of ascertaining dangerous proclivities is great, and their detection may require prolonged observation. It is not necessary to wait till a patient has committed some violent act before certifying, as the non-existence of dangerous symptoms is not a reason against removal to an asylum, whether the patient is private or public. The patient, under English law, must go to an asylum within seven days of his examination by the physicians. With us this is discretionary with the judge. Our certificates must have been made within five days of the examination. The hear-

[1] London Lancet, April 24th, May 1st and 8th, et seq.
[2] Jurisprudence of Insanity, Brown, page 30.

ing is usually within a day or two, and the patient is sent to the asylum at once. Now and then a delay of a day or two unavoidably occurs. One other requirement, that the patient must not be examined in the asylum where he is to remain, is occasionally disregarded with us.

Dr. Brushfield thinks the greatest modern improvement in the lunacy law is that portion which requires physicians to state the reasons or "grounds" for their opinion that a person is insane in detail. It is no doubt a great improvement, but here physicians conversant with insanity always have stated their reasons more or less in detail, and supposed they were testifying to them under oath. It is well to have the law made clear on this point, and the practice should conform to it. Under the old law it was my aim in certifying to present as clear an idea of the form of insanity in each case as possible, under the headings of cause, duration, previous attacks, disposition, habits in regard to temperance, etc. This is now superfluous, or at least subordinate to the presentation of facts proving the insanity. These may by some ingenuity still be arranged so as to show that the physician knows what form of mental disease he is observing, but he must at any rate show by his facts that the party is insane. He is still supposed to give a medical opinion, but if his facts do not justify his opinion in the mind of a non-professional justice it will be without weight.

I am not sure of the advantages of some other requirements of the English law: that, for instance, confining the physician, however familiar with the case, to a statement of facts observed on some particular day, to the exclusion of all others, and that forbidding consultation between the certifying physicians. Why should the medical man about to certify be deprived of the experience of the family physician in forming his opinion? To be of any value it should be based on all the facts of the case obtainable, and not on the chance developments of an hour's examination. Why not set up some legal test of honesty and capacity, and then let physicians consult as in case of any other disease? Public examiners who could be trusted might better be appointed than to hamper the physician in search for the truth with too many restrictions. The English law seems designed to hold in check a set of medical villains who are desperately conspiring for money to put sane people into the licensed houses of other base physicians for their pecuniary profit.

The provision that no asylum superintendent shall certify a patient into his own hospital is so eminently proper, and the act so little likely to occur, as hardly to require legislation. Our legislature has, however, gone a step beyond this feature of the English law, and forbids an asylum physician to certify a patient into any hospital. He may neither be pecuniarily interested in his own nor any other asylum, but he is not to be trusted. The reason for this provision in our law was not, I believe, pecuniary. It was said that persons of long hospital experience with the insane knew too much about insanity, and could easily snap up a demented legislator or a crazy lobbyist, and consign him or her to the Bastile at Somerville! This would be laughable if it were not insulting to a body of as intelligent and trustworthy servants of the State as any to be found in our legislative halls.

This English legislation, which we have in part copied, grew out of a state of things never existing here. Until recently no private asylums were to be found here, and there is no probability that the small houses for private patients kept by physicians for their own profit will ever become so numerous as to require a special method of certification. Our law has the good feature of treating rich and poor alike. The safeguards against improper commitments protect one class as much as the other. In England a single certificate only is required in case of a pauper. If he be in an almshouse the certificate of the medical officer and an order from a justice, a relieving officer, or an officiating clergyman is sufficient.[1]

Upon the medical portion of the certificate Dr. Brushfield remarks that the physician should always bear in mind that he may have to defend his certificate in court. If the symptoms on the day of examination are obscure he must not certify, no matter how dangerous to himself or others the lunatic may have been. In epileptic mania, homicidal impulse, or suicidal mania the symptoms are very likely to be in abeyance at the time of examination; but the friends must be warned and the certificate refused, however strong the hearsay evidence may be.

All the chief symptoms should be detailed briefly, without comment or repetition. Statements represented as delusions which might by any possibility be true should be carefully investigated. Dr. Brushfield relates the case of an engineer whose claim of having made plans for tunneling the English Channel was supposed to be a delusion, but proved true. I remember a sea-captain who died of general paralysis, and who claimed to have discovered an island of solid guano in the Pacific Ocean, which was named after him. This supposed hallucination proved true. I also recently met with a physician who was willing to certify that a discharged lunatic was still insane, because he still claimed to own a silver mine and to have had in his pocket specimens of the ore, which claims were true.

Such physical conditions as blindness, deafness, paralysis, malformations, or loss of teeth, causing defects of speech, infirmities of temper, peculiarities of gesture, eccentricities in conduct, may sometimes make a person seem at first sight insane or demented, and should be allowed for. *Change* in habit, conversation, affection, disposition, dress, or conduct is more important than peculiarity. Coarse and violent language may indicate insanity in a person of refinement, but not in one of less culture. Care should be taken to use proper terms in describing these symptoms. *Manner*, for instance, is not *incoherent*, nor *conversation illusive*. The great difficulty for most physicians in certifying is due to imperfect knowledge of insanity and doubt as to which are the chief symptoms in a given case. Insanity is protean, and no two cases are exactly alike. The peculiarities of each case should be carefully described.

Dr. Brushfield would have the patient's appearance, speech, and conduct observed and described in their order. The attitude and movements as well as facial expression should be described. Occasionally obdurate silence on the part of the patient is an obstacle to certification. This may occur from simple inability, as in fright or shock, but is willful in most cases. Conversation may fail in general inertness, in fatuity, hysteria, melancholia, or from perversity. Try to ascertain the cause, and state it as hearsay if necessary. It has always been my habit to tell such patients that their silence may result in sending them to an asylum, or to

[1] Bucknill and Tuke, 4th edition, page 7.