that a representation should be drafted by the Chairman and forwarded to the proper quarter.

Dr. URQUHART pointed out that they must not commit the Association.

Dr. CARLYLE JOHNSTONE said that they could commit the meeting, and he thought that would be in order. He therefore moved that the Chairman be given authority to show the feeling of the meeting in the proper way by communicating with Dr. Clouston. The motion was seconded by Dr. Rutherford, and was carried.

After the meeting the members dined together as usual in the Palace Hotel.

[We understand that Dr. Clouston's name has been added to the Committee under the Inebriates Act by Lord Balfour of Burleigh, the Secretary of State for Scotland, on the nomination of the three Scottish medical corporations.—ED.]

BRITISH MEDICAL ASSOCIATION.—EDINBURGH MEETING.

ADDRESS IN PSYCHOLOGICAL MEDICINE BY SIR JOHN BATTY TUKE.

Sir JOHN B. TUKE heralded his address by drawing attention to the facts that it was the second upon this subject which the British Medical Association in annual meeting had demanded, and that the previous address by Sir J. Crichton-Browne (delivered in 1890) was the first address on Psychological Medicine in the history of the Association. That such a discourse should be required twice within eight years is indeed a striking proof of the important position which our specialty has taken of recent years in the hierarchy of the medical sciences. To some degree, perhaps, it is also due to the personal distinction of the deliverers of the respective addresses—men who have so largely contributed by their labours to the advance which these addresses at once denote and illustrate.

The immediate topic with which Sir John B. Tuke dealt was "the modern conceptions of the etiology of insanity." The study of the insanities in former times was surveyed in a not very sympathetic way. Our unfortunate predecessors must not be judged too severely, especially when we consider that they admittedly did not possess the data which now afford "starting-points to the psychiatric physician for the scientific study of his subject." Unhappily, the art of medicine has often to be practised while knowledge is still very deficient, and the sad havoc which time has played with favourite views in general medicine which prevailed a quarter of a century ago, should make us modest in boasting of our advance. Sir John presented a telling contrast between the state of knowledge in 1864 and at the present day. But it is only, as it were, yesterday that we were talking about the cortical cells as centres of energy, or else as storehouses for residual impressions, while now they are but victual stores—

> ". . . . And who doth know
> How long we please they may continue so."

Nothing is final in our knowledge; and, indeed, in cerebral anatomy and pathology we have hardly yet reached beyond the initial stage. "I verily believe," says Sir J. Batty Tuke, "that the changes of conception of the nature of the insanities is much more due to the establishment of scientific data bearing on the antecedents of mental action than to the generalisations of the philosopher as to mental activities. . . . Gradually—no, I should say rapidly; perhaps too rapidly for complete assimilation—there has been presented to the physician knowledge of a cerebral apparatus on which he is warranted in basing working hypotheses and practice. Until that apparatus was demonstrated he could not assert, except as an assumption, the fundamental physiological principle that mental action is a function of connection, or the pathological corollary that interruption of connection is the cause of impaired mental action." The members of our specialty, "knowing that they have a mechanism to deal with, solution of the continuity of which in any part of its course may affect its function, have a scientific foundation for the study of morbific influences productive of interruption of connection." The great work which has been done of late years in the pathology of insanity was considered, and two illustrations of a general character are given of the good results from such study. "In former times the theory of the effect of the mind on the body held a

foremost place, and gave rise to many misconceptions. For instance, the general degradation of the system, the complications in the intestinal and reproductive systems, which are such marked and important symptoms in many of the insanities, were regarded either as the results of abnormal action or as its cause. Now that we recognise that the brain exerts trophesic functions over all the organs of the body, we are alive to the fact that such degradations are referable to imperfect brain action, that they are secondary on the reduction of its nourishing action, and are to be treated accordingly." "Another evidence of change is afforded by the acceptance and extension by the psychiatrist of the principle that all mental symptoms are produced by the action of the same causes of disease which act in other systems than the nervous." Sir J. Batty Tuke concludes by advocating warmly the modern hospital system of treating the insane. Incidentally he remarks, "We know that if we exclude general paralysis and epileptic insanity from consideration, at least 80 per cent. of recent cases are amenable to treatment." We agree with his observation that valuable time is often lost, particularly in England, where "the procedure for the transmission of insane persons to asylums is so absurdly cumbrous as to prevent many persons being placed under treatment until such time as the probabilities of recovery are seriously lessened or the case is hopeless."

Psychology Section.

President's Address.—The Neuroses and Psychoses of Decadence.

Dr. Clouston, in opening his address, briefly referred to his corresponding paper of 1890 on "The Neuroses of Development." One of these groups has as its cause a faulty development, the other an unphysiological decadence of the brain. As during development so during decay, one organ may change more rapidly than another. Thus in the latter case may be established a neurosis through unrelational decadence. The speaker glanced briefly at climacteric influence and the influence of neuro-vascular decay, and pointed out how in the life history of the neuron we see in its youth a susceptibility to external impressions, and in its age a liability to succumb to poisonous and degenerative agencies which are respectively characteristic. Heredity is not as powerful an agency in the production of decadent neuroses as in the origin of developmental. It seems to act in a different way. In the latter case it stops the reproduction of a bad stock; it is an actively destructive force. In the former it shows itself as a mere weakening of normal supports, so that the organism thus tainted yields unduly to the strain of life or to other morbid conditions. Comparing the statistics of the number of the population at a given time whose age was between 1 and 25, between 26 and 50, between 51 and 75, and between 75 and 100 with the proportion of deaths from nervous diseases occurring in each group, it appears that the neuroses prevail largely in the period of brain growth; that the best years of life are very free from them, and that decadence brings them on with a rush, senility being the most deadly neurotic period of all. The signs of nerve decadence, the clinical characters of the psychoses of old age, and the remarkable diminution in old age of the power of resisting toxic agents, notably alcohol, were dealt with at some length, and in Dr. Clouston's usual impressive way. To him it appears that there are three types of nervous and mental lesions connected with decadence. First, those connected with vaso-trophic degeneration. Second, the degeneration of the motor and sensory systems, which constitute the progressive degenerations. Third, the climacteric and senile insanities, in which the primary lesion begins in the mental tissues and mental areas. Dr. Clouston ventures on an hypothesis with regard to the history of senile mental decay. The mental faculties do not undergo decadence in the order of their development. Therefore probably the same is true of the cortical neuron. As the memory—the permanent recording of impressions—is the first to disappear, it is probable that the molecular structure of the protoplasm of the neuron is the first to suffer in decadence. Probably the gradual destruction of the dendrites and their gemmules and the neuraxons next takes place, and is the cause of decadent reasoning in senility.

A Discussion on Suicide in its Psychiatric and Social Aspects

was opened by Dr. Sibbald, who presented a series of most interesting statistical tables. From these it would appear that the figures for Great Britain show, as similar tables for most other countries do, a gradual though fluctuating rise in the

suicide rates during thirty years. England and Wales show a rise from 67 to 86 per million—an increase of 28 per cent. Scotland in the same period rose from 40 to 54 per million—an increase of 35 per cent. The rates throughout are considerably higher for England and Wales than for Scotland. It is suggested that suicide is of late more often regarded as dependent upon insanity, and is therefore not concealed so much as before. The various methods by which suicide is effected are analysed with very striking results. Hanging is the mode least open to error, either by concealment or mistaken diagnosis. In the fifteen years 1865-79 suicides by hanging amounted in England and Wales to 25 per million, in Scotland to 16 per million. In the following fifteen years the rates were 24 per million in England and Wales, and 16 per million in Scotland. Statistics for shorter periods show, of course, more fluctuation, but no progressive increase. Dr. Sibbald has studied the rates for smaller areas in Scotland, and finds that the incidence of suicide varies very much in different localities, but that in each locality the ratio remains the same from period to period. He gives tables showing the number of deaths by firearms and cutting and stabbing for thirty years, also the deaths by poisoning and drowning. These tables show that the proportion of deaths per million from these various causes remain steady, but that of such proportion the proportion attributed to suicide has increased, and the proportion to accident has diminished. The conclusion to which the author of this most carefully worked paper comes is that with regard to suicide there has been really a wonderful steadiness in the rates, and that there is ground for believing that the apparent increase is due to the registering of deaths in recent times as suicides which would in former times have been registered as accidents.

Dr. HAIG discussed suicide as a result of error of diet. He regards melancholia as due to the circulation of impure blood in the brain—uricacidæmia or collæmia. If, he thinks, we could wipe out of our diet two substances, animal flesh and tea, we should almost completely eliminate its pathological excesses. Dr. Haig calls attention to special features in the depression of "collæmia," such as that it is paroxysmal and temporary. He ingeniously accounts for this, as well as for diurnal, accidental, and annual fluctuations in melancholia, by explaining the various modes by which, under varying circumstances and conditions, the amount of uric acid circulating in the blood varies. A number of other influences—season, age, sex, various diseases, &c.—are, according to this view, if we rightly understand it, capable of being explained by varying conditions of collæmia. In fine, Dr. Haig holds that in diet lies the cause of suicide, and in a proper and scientific revision of diet lies the hope of prevention.

Dr. MACPHERSON, Honorary Secretary to the Section, read an abstract of a communication from Professor Morselli, of Genoa, dealing principally with the classification of suicide.

INSANITIES OF INEBRIETY.

Dr. J. F. SUTHERLAND, Deputy Commissioner in Lunacy for Scotland, read a paper on "The Insanities of Inebriety from the Legislative and Medico-legal Standpoint." Dr. Sutherland counts inebriety high as a producer of insanity, placing it second, and that by a short way, to heredity. Probably, however, those who attribute most weight to heredity would place the latter in an entirely different category from any cause acting in a sense externally. Dr. Sutherland seems to consider alcohol responsible for as many as 25 per cent. of all cases of insanity and imbecility which pass into asylums. He reviewed previous legislation on the subject of the prevention of habitual inebriety, and held that the Bill of last Session could be improved by a clause prohibiting vendors from supplying alcohol (1) to certified inebriates who are put under recognisances, and not yet deprived of liberty; (2) to certified inebriates on probation; (3) to certified inebriates, whether discharged on probation or not, for a period of three years thereafter. He believes that such legislation could be worked successfully in Scotland, yet he sees considerable difficulty in making it operate successfully in large towns. It appears to us that these difficulties would be very serious, taking into account the numbers that would need to be dealt with, and the extreme unwillingness of those charged with the administration of the law to go even within statutory limits beyond the demands of public opinion. Arguing on the remarkable difference between the prevalence of inebriety in towns, and its comparative rarity in country districts, a patent fact,

Dr. Sutherland plainly affirms that inebriety, whether criminal or non-criminal, is a disease or vice, or both, for the vice long indulged ultimately ends in disease, and is in the main, like insomnia, neurasthenia, neuralgia, and hysteria, met with in large centres of population, and in great measure due to unhygienic and uncomfortable surroundings, to the facilities for illicit sale, to vicious and contaminating environments, to customs and habits long practised in certain strata of society, and so forth. But if this way of looking at inebriety be correct, surely the duty of society should begin by endeavouring to get at the causes, and not by punitive measures or measures tending to restrict vice or disease already established. The liberty of the subject, says Dr. Sutherland, has become a fetish. A law to lessen the degradation and disgrace both of the individual and the community cannot be considered an invasion of liberty. So far, most modern thinkers whose eyes have been opened to the miseries produced by alcohol will agree with him. But he goes further, and in this probably few of us will follow him. He tells us that the criminal law in this country is far astray in regard to its attitude towards the authors of homicide, assaults, &c., committed by persons in a state of intoxication. Intoxication, he says, is insanity, fleeting it may be, but from the disorder of the senses and faculties producing as perfect a picture of insanity as is to be met with in the wide and diversified range of lunacy. His feeling is that the plea of insane at the time is a proper special defence, or failing the acceptance of that, that the crime, after medical and other evidence has been received, should be reduced from murder to culpable homicide.

At the conclusion of the discussion a resolution was moved by Dr. Sutherland, seconded by Dr. Yellowlees, and unanimously adopted, calling upon the Council of the Association to press the need of further legislation, and stating the opinion of the Section that no such legislation would be effectual unless it provides compulsory care for habitual inebriates from all classes of society, and unless it prohibits the sale of intoxicants to known and certified inebriates. We have not heard how this last clause of the resolution is to be rendered effective in actual working.

The Phenomena of Hypnotism and the Theories of its Nature.

Dr. Milne Bramwell discussed the general bearing of the question of hypnotism at some length, and detailed a series of cases of his own illustrating its useful therapeutic effects. These cases were of great interest, but seemed to show nothing absolutely new. Dr. Bramwell has clearly been an assiduous worker in the field, and has had some results which are extremely encouraging and successful. What is new is his claim to have proved that the hypnotised subject is not at the mercy of the operator. This he says he himself at first believed, but finding that individual patients varied very much in their susceptibility to suggestion during hypnosis, he initiated a series of experiments on the volition in hypnosis. The plan he adopted was to question profound somnambules during hypnosis as to their own mental condition. Their replies showed that when in the hypnotic state they knew that they were hypnotised, but retained completely the sense of their personal identity and relationship with the outer world. They could reason as logically as in the waking state, and were confident that they could resist any suggestion that was displeasing to them. He gave some remarkable examples of persons refusing to adopt a suggestion made to them, whilst in the hypnotic state, to commit crime or even the semblance of crime. His conclusion was that not only is the volition unimpaired in hypnosis, but hypnotic experiments or treatment exercise no weakening effect upon the volition in the waking state. Judging from his experience, Dr. Bramwell is of opinion that the employment of hypnosis by medical men who are acquainted with the subject is absolutely devoid of danger. Dr. Bramwell dwelt at length upon the various theories of hypnotism propounded since the time of Braid. He contested Bernheim's notion that suggestion explains hypnotism, whereas suggestion is merely the machinery by which the phenomena of hypnotism are excited. He also strongly contended against the views prevalent in the Nancy school that automatism and weakened will characterise the hypnotic state.

Mr. F. W. H. Myers, in a very polished discourse, dealt with what might be called the theoretic aspects of hypnotism. Though we must admire this author's skill in exposition, we cannot see that the idea conveyed in his elegant phrases

treating of "supraliminal" and "subliminal" spheres of mental activity bring us much more forward than did the "unconscious cerebration" of the school of Carpenter. Contrasting hypnotism and hysteria, he tells us that in hysteria we lose from supraliminal control portions of faculty which we do not wish to lose, and we cannot recover them at will. In hypnotism we lose from supraliminal control portions of faculty which we wish to lose or are indifferent to losing, and we can recover them the moment that we will. Comparing hypnotism and genius ("products of subliminal mentation uprushing into ordinary consciousness with actual benefit to the waking life") he discusses the question whether hypnotism succeeds in bringing up faculty from submerged strata into conscious control and enjoyment, and answers that to do this very thing is the essence of hypnotism. Again, in sleep we have a condition of shutting off of the supraliminal life of relation, of external attention, and the concentration of subliminal attention upon the profounder organic life. The first obvious effect of hypnotism is to bring sleep more fully under control. After glancing at sleeping-waking states, Mr. Myers said that the essential meaning of hypnotism is always the same—a fuller control over subliminal plasticity. Attributing the therapeutic effects of hypnotism to this fuller control over subliminal plasticity (the activities which are busy with organic as distinguished from intellectual life), and recognising that the phenomena of hypnotism are in the main due to suggestion, he tells us we need to ask what suggestion really is. It is not ordinary persuasion, that is clear. Mr. Myers believes that subliminal relations between man and man play a real part in the production of hypnotic phenomena.

Other Papers.

An instructive case of *Hæmatoporphyrinuria* was reported by Dr. Hotchkiss, of Gartnavel.

Drs. Kerr and Bois, of Hartwood, related the results of their trials of spleen and thyroid extract in the treatment. Twenty-two patients were treated with spleen extract. Mental recovery occurred in eight, physical improvement in seventeen. The most favourable cases appear to be adolescent males suffering from stupor. The mode of use recommended is by capsules of fresh liquid extract, twenty grains in each.

Dr. W. Bernard read a paper on the need of recognising weakmindedness early in children, and pointed out that more distinct criteria of this condition at the earliest period of life were needed.

Drs. Dawson and Rambaut read a valuable paper analysing the ocular phenomena in forty cases of general paralysis.

Dr. Hogben read a paper on pauper lunatics in private dwellings in Scotland.

Dr. Marie, of Dun-sur-Auron (Cher.), presented a brief report on the family care of the insane in France, and distributed a report on the colony at Dun, from which it appears that from the time that the colony was founded, at the end of 1892, up to the end of 1897, 673 patients have been admitted. The admissions during the year 1897 were 175, and at the end of the year there were 555 patients in residence. These figures alone show that the institution of family care at Dun has been a success. The colony had existed six years without an accident. The system was not alone economical, but was beneficial to the patients, who preferred it as being a more natural life than that of asylums. The town of Dun contains 6000 inhabitants, among whom the patients are boarded. The patients are by no means all dements, many being melancholics. There is a special hospital. The average cost is half of that in the Asylums of Department of Seine, whence the colony is fed.

Aphasia in Relation to Testamentary Capacity.

On July 28th a conjoint meeting of the Sections of Psychology and State Medicine was held to consider this subject.

A discussion on this subject was introduced by Sir William Gairdner, who, having indulged in a brief retrospect and shortly glanced at the anatomical bearings of the question, said that he was willing to concede that a man who had always been aphasic, who was deficient in anything that went to make the speech faculty, never could become a reasoning animal, or rise above the level of the dog, the elephant, or the horse. But when they came to the case of a man who by accident was lamed as regarded the mechanism of that particular faculty, having had all his

reasoning powers beforehand, he was not willing to admit that he necessarily suffered any derogation from the higher faculties. The point there was how far did that laming of one faculty interfere with a man's capacity to make a will? That question could not be answered in any general sense.

Referring to a recent decision in a will case (not of an aphasic, however) tried before the Scottish Court of Session, Sir William Gairdner quoted Lord President Robertson's ruling (premising that the Scotch law, founded on the old Roman civil law, was superior to the English judge-made law—a thing of shreds and patches). (Laughter.) The Lord President said this:—"He must remind them that they had not got to try the question whether in the general sense she was sane or insane. The question was much more narrow and limited. It had reference to this particular will—had she enough mind to understand it, and did she understand it?—because there were many people in this world who had got what might be called a crack in them, and were really eccentric, and yet whose wills were perfectly good. Therefore in this case they had no abstract question to determine as to whether this woman was sane or insane, but they had to consider first the will and say whether she was able to understand it. They might think that it was too complicated for her, and if so, then they would find against the will. On the other hand, they might think, although they had heard a good deal of trash about the woman's eccentricities"—(let them observe with what contempt he brushed aside the attempt to prove theoretical insanity)—"that still she had enough sense to make a will if it was a will that she could understand. . . . It was to be observed in favour of the will that it was not very complicated, if they thought the woman really wanted it. They then would have to consider whether there was satisfactory evidence that her mind was applied to it. But in the meantime, as regards the woman herself, he dared to say that they had no doubt she was a person of rather low intelligence. She had not been well educated, and there was in the family a strain of eccentricity." He concluded that "they were left a good deal in the dark as to what share this woman had in the making of the will at all. But it was for the jury to say whether this will was her own will. They must not break the will unless they really thought either that she was unfit to make it, that she had not sufficiency of mind to make it, or else that she was weak and was led into making it by other people." That was very much in accordance with the way he himself put it. (Applause.) It threw the *onus probandi* entirely upon those who dispute its validity to show that the testator was not fully cognisant of what he was doing when he made it, or was misguided by interested parties. That was the position in law. How was it that the position was altered by aphasia? The fact of aphasia shifted the *onus probandi* upon those who considered the will genuine. It made a difficulty in the way of the testator giving expression to his true desires and true will, and those who supported the will had to prove that that difficulty was successfully overcome. He held that a person completely aphasic had, as regarded his inner mind, the capacity to make a will quite sufficient to meet these legal conditions in all probability. He exemplified the case of Pasteur, who for the last few years of his life suffered from left hemiplegia. Was there the least reason to suppose that if, instead of being on the right side of his brain that lesion had been on the left side, Pasteur would not have been able to form that will in his own mind, would not have been able to make a valid will, providing that he could have positively impressed everyone that that was his will? He held that there was no doubt whatever that his testamentary capacity might have been totally unaffected, except that which they might regard as outward mechanism. The difficulty they placed in the way was an additional obstacle to be got over, and the multiplication of these obstacles might incidentally preclude the possibility of giving effect to the intention, which nevertheless might have been quite clear in the testator's mind if he could only have got it out. The question of whether an aphasic could make a will was a question of detail entirely. It was a question that must be submitted to a jury upon the individual case. The principle was, did the man know what he wanted, did he form a clear conception of what he wanted, and did he succeed in giving effect to that conception?

Dr. WILLIAM ELDER said that every case of aphasia was mentally and intellectually on a lower level than the patient was before he was affected. Between that condition, however, of slight degradation of the mental and intellectual altitude of an individual and the other condition of actual mental incapacity there was a vast

difference, and there were many steps, so that it must necessarily always be a difficult question to answer where sanity ended and insanity began, where testamentary capacity ended and incapacity began. It must be laid down as a general principle that no one could make a will who did not possess the power of understanding and producing language of some sort. It would not be held to be a will if a person simply indicated by signs before he died that he wanted such and such a thing to be done, nor would it be held to be a will if a person gave directions by word of mouth. A person must be capable of understanding language, so that he knew either what he said or what was read to him. That implied that he could hear and understand words if he could not read or understand pantomimic language; but if he could read and understand what he read, then it was not necessary for him to hear or understand pantomimic language. Given that a person understood what was in a document, it was not necessary that he should be able to speak in order that he might execute a testamentary deed. He might indicate what he wished by means of writing, or by pantomime, or in other ways. A complete case of auditory aphasia, which implied word deafness and word blindness, would be incapable of making a will, because, not being able to understand any form of language, he would, in all probability, not be able to communicate his wishes by producing any form of language. From a consideration of the whole subject he had come to the conclusion that some forms of aphasia might render a patient incapable of will-making, such as auditory aphasia, pictorial word blindness, pictorial motor aphasia, and graphic aphasia, although he was not necessarily mentally incapable.

Dr. CLOUSTON (Edinburgh) said there were two points which he insisted every man must attend to. The first was the test question whether it was the will of the individual or whether it had been suggested to him. The second was that in making the will of any aphasic patient it was the duty of every medical man to put the contrary case. A man had left, say, £100 to his wife and £100 to his daughter—to A and B. They were bound to ask him if it was for B and C or for D and E that he intended the money. No will of an aphasic could be a legal and proper will unless the contrary case had been thus put, because an aphasic would assent to anything if put to him in a certain way.

INSANITY IN CRIMINAL CASES.

(Also considered by the Conjoint Meeting.)

Dr. MERCIER opened a discussion on the Plea of Insanity in Criminal Cases. He asked the assent of the meeting to three propositions. In the first place he asked them to say that no insane person should for any act be punished with the same severity as a sane person would be punished for the same act. Every institution for the insane was conducted in accordance with that principle. The second proposition was that there was for every insane person a certain sphere of conduct for which he ought to be entirely immune from punishment. Every insane person might commit certain deeds for which he should not be punished at all—misdeeds which, if they were done by sane persons would be rightly punishable, but which in the case of insane persons it would be clearly and manifestly wrong to punish at all. His third proposition was that very few indeed of the insane were wholly irresponsible. He meant by that that there were very few indeed of the insane who ought never to be punished. With a full appreciation and expectation of the misunderstanding and obloquy and odium he would incur by the statement, he affirmed that for very many of their wrong acts the majority of lunatics ought to receive some punishment; further, he affirmed that explicitly or implicitly that was the opinion of every practitioner who had experience of the insane, and, furthermore, he affirmed that punishment of the insane in some form or other was in practice in every institution for lunatics. Let them clear their minds of cant in this matter. Who was there among them who, if a patient on parole came in drunk, would not refuse him his parole next time, and time after time when he applied for it? Who was there that, when a woman had been fighting or smashing, would not forbid her to attend the weekly dance? Who was there among them that would not stop the tobacco of a man who was discovered pilfering or bullying? It might perhaps be denied on other grounds that this was punishment. It might be said that a woman who was so violently maniacal as to be fighting and smashing was unfit to attend a dance, and was forbidden for that reason, and not

for punishment. But he declared that in a patient who had been smashing or tearing up her clothes not in an excess of acute mania, but in an outbreak of temper, she would be excluded from the dance, not because she was unfit to be present, but as a punishment. They relied upon the temporary withdrawal of privileges to act as a check in preventing abuse in future; that was to say they withdrew it as a punishment.

The practical importance of these propositions with regard to the plea of insanity was that while there were some cases in which they might rightly ask the court to refrain altogether from punishing the criminal, there were many more cases in which they could not justly demand such immunity, but in which they could fairly argue that the criminal was responsible to some extent, but was not wholly responsible, and that therefore, while he ought to be punished, he ought not to be punished with the same severity as an ordinary offender. While it was common for a crime to be committed under the promptings of delusion, it was extremely rare for the delusion to be of such a character that if it represented the actual facts of the case it would completely justify the act. He exemplified the case of Prince, the murderer of Mr. Terriss.

In conclusion, the speaker laid down the following propositions:

(1) All lunatics should be partially immune for all their misdeeds; (2) Every lunatic should be wholly immune for certain misdeeds; (3) Very few lunatics should be wholly immune for all misdeeds—corollary—the plea of insanity, if established, did not necessarily involve the total immunity of the accused from punishment; it did necessarily involve his partial immunity; and (4) That in order to establish the plea it was necessary to prove the existence in the accused of one or more of the following mental conditions:—(*a*) exonerating delusion; (*b*) such confusion of mind that the accused was incapable of appreciating in their true relations the circumstances under which the act was committed or the consequences of his act; (*c*) extreme inadequacy of motive; (*d*) extreme imprudence in the act; and (*e*) the non-concurrence in the act of the volitional self.

QUEBEC MEDICO-PSYCHOLOGICAL SOCIETY.

The physicians attached to the asylums of the Province of Quebec—Arthur Vallée, medical superintendent of the Quebec Lunatic Asylum, T. J. W. Burgess, medical superintendent of the Protestant Hospital for the Insane, E. J. Bourque, physician-in-chief, George Villeneuve, medical superintendent, F. E. Devlin, assistant superintendent, F. X. Perreault, A. J. Prieur, C. Laviolette, and E. P. Chagnon, assistant physicians of the St. Jean de Dieu Lunatic Asylum, Longue-Pointe,—held a preliminary meeting on the 16th February last, at Longue-Pointe, for the purpose of organising themselves into a society for the advancement of the specialty.

It was resolved that the association should be known as the "Quebec Medico-Psychological Society," and that meetings should be held in turn at the different asylums of the province. The following officers were elected for the years 1898–9:

President.—Arthur Vallée, M.D., medical superintendent of the Quebec Lunatic Asylum. *Vice-President.*—T. J. W. Burgess, M.D., medical superintendent of the Protestant Hospital for the Insane, Verdun. *Secretary.*—E. P. Chagnon, M.D., assistant physician of the St. Jean de Dieu Asylum, Longue-Pointe.

Pursuant to this organisation the first meeting of the Society took place at St. Jean de Dieu Asylum, on July 14th, 1898, Dr. Vallée, president, in the chair.

Election of New Members.

A. Marois, assistant superintendent, A. Bélanger and C. S. Roy, assistant physicians to Quebec Asylum, L. J. O. Sirois, physician to St. Ferdinand d'Halifax Asylum, and J. V. Anglin, assistant physician to the Protestant Hospital for the Insane, Verdun, were elected members of the Association.

Resolutions.

Mr. Villeneuve moved that Honourable Mr. J. E. Robidoux be elected Patron of the Society. Mr. Burgess seconded the motion. Carried unanimously.