

# RUTHIN CASTLE: A PRIVATE HOSPITAL FOR THE INVESTIGATION AND TREATMENT OF OBSCURE MEDICAL DISEASES (1923-1950)

by

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A LESSER-KNOWN development in medicine in Great Britain was the opening in 1923 of Ruthin Castle, North Wales, the first private hospital for the investigation and treatment of obscure internal diseases. Apart from the inevitable publicity it evoked, and although the clinic acquired a wide reputation, it remained unadvertised except for a regular notice in the Quarterly Journal of Medicine. This announced simply that patients could be received for investigation and treatment on the authority of their doctor and that mental cases would not be accepted. It also commented briefly on the historic setting of the Castle and the beauty of its environment.

The clinical director was Doctor, later Sir Edmund Ivens Spriggs, K.C.V.O., M.D., F.R.C.P., J.P., who for years had been a consultant physician on the staff of St. George's Hospital, London, following an academic career in which his training in physiology had played a major part. His withdrawal from practice in London in 1910 was brought about by a severe illness: pleurisy with effusion, after which in due course he was persuaded not to return to London but



to take on the clinical directorship of a small private hospital at Duff House, Banff, designed for medical cases rather than tuberculosis, which was managed and financed by a group of doctors, notably Dr. David Lawson of the Torna Dee Sanatorium Group who had invested money in the project. In this setting during the First World War, Spriggs and his assistant, Dr. Dennison Veith Pickering, contributed some papers of note and Spriggs did work on diet for the Ministry of Food. But soon it became evident that Banff was too far removed as a suitable centre and the Company decided to move and acquired Ruthin Castle, North Wales, transferring their patients and staff thence in 1922-1923. Other considerations were the unwillingness of Banff and Macduff Councils to allow additional building at Duff House and also the tragic death by drowning of Dr. Spriggs' two daughters, which had a pronounced influence on him, especially as it was pure chance that dictated his walking on the beach at Banff and being responsible for identifying the bodies of the two children. Ruthin had been the home of a famous family, the Cornwallis-Wests, who had been closely associated with royalty and with the Prince of Wales in the latter years of the previous century.

The adoption of the ancient 13th century feudal castle, complete with its walls and moat and standing in its own grounds on a commanding eminence just beyond the small town of Ruthin, Denbighshire, entailed much capital expenditure. Discreet and becoming extensions were made to its southerly aspect to provide extra rooms for patients, but the original pile was untouched. Spriggs and his family lived in the Castle, occupying part of the original building, and great care was taken to preserve its historical features and maintain continuity with the former establishment of Duff House. No patient was received without a doctor's recommendation. The journey from Chester, 20 miles distant, was made by private car provided by the Castle. Arrangements for their admission were made by Mr. Arthur Watson, B.A., the secretary. Patients came from all over England, Scotland, Wales and Ireland, the chief proportion from London. There was also a steady trickle from the Dominions, especially Australia and India, and from the United States of America, where the advantages offered by Ruthin were soon appreciated.

The new clinic contained enough separate rooms to take 64 patients, these being distributed between the "Castle Wing", the "Moat" and "South" Wings. Charges were high, ranging in 1925 from 30 guineas a week for a room in the Castle Wing to from 19 to 25 guineas in the Moat and South Wings. In effect, when it is remembered that all investigations and treatment were included in this cost they were moderate, no additional expenses being incurred by the patient and no expense being spared over the extent of the investigations made, when necessary, or the treatment given. This, of course, was in 1925 when prices in general were moderate and few people realised just how difficult it was to formulate an "umbrella" type of treatment, and it was probably for this reason primarily that the clinic was so restrained in the form of its advertising.

#### NURSING, AUXILIARY AND MEDICAL STAFF

The clinic had an expert radiographer on its staff in the person of Mr. O. A. Marxer, a Swiss, a most experienced technician, many of whose original gastrointestinal radiographs were reproduced in British text-books of medicine. In addition,

the clinic had a fully trained staff of bacteriologists and biochemists under Mr. A. J. Leigh, B.Sc., working under the direction of the medical staff, and a number of masseurs and physiotherapists, capable of administering all the well-tryed and acknowledged form of physiotherapy available at the time. Most of the patients were ambulatory and capable of taking advantage of the many opportunities offered for out-of-doors pursuits such as croquet, tennis, fishing, and shooting, the last-named activity being under the direction of a gamekeeper and well-known Scottish ghillie named Mr. Donald Conacher.

The nursing staff was carefully chosen, many of them having previously been at Duff House. They were under the direction of the Matron, Miss Jane Dewar. In charge of the dietetic arrangements was a Miss Davidson.

On his medical staff Spriggs had three assistant physicians, each of whom had charge of a proportion of the patients, the underlying responsibility for all, however, devolving on Dr. Spriggs. First there was Dr. Sydney Wentworth Patterson, deputy to the Director, who had charge of patients in the Castle Wing. Australian by birth, he had before coming on the staff of the Castle been Director of the Walter and Eliza Hall Institute for Medical Research in Melbourne, and before that engaged in physiological research with E. H. Starling, with whom he had already made a contribution on regulation of the stroke volume of the heart (1914), which became well-known.\* He had served during the war as a major with the Australian Forces at the famous base hospital at Wimerieux, where he had worked with Sir Almroth Wright, Harvey Cushing, the famous American neurosurgeon, and the equally famous Gordon Holmes. The second assistant physician, formerly Acting Professor of Anatomy at Melbourne, also an Australian, was Dr. John Hubback Anderson, C.M.G., C.B.E. Anderson attained the position of Medical Director of the Australian Land Forces during the war. He was a remarkable man and of the three seniors the most gifted in his practical experience and sympathy with the sick, and in his devotion to their care. In 1925 a third Assistant Physician was added to the staff, Dr. R. S. Allison, previously medical registrar to the West London Hospital Post-Graduate College, after house appointments at the Royal Victoria Hospital, Belfast. The house physician, Dr. Cyril D. Shapland, subsequently took up a career in London in ophthalmology and succeeded to the staff of Moorfields Hospital, becoming famous in his time for his work on detachment of the retina.

Sir Edmund Spriggs retired in 1944, but continued as a member of the Board and Chairman for several years until his death in 1949. His son, Anthony, came on as Assistant Physician from 1951-53 and the Clinical Director became S. W. Patterson, the original company going into liquidation. On Patterson's retirement in 1959 a third company took over with Dr. Picton Davies as Senior Physician. This arrangement continued into the early sixties when, owing to its gradual decline and the introduction of the National Health Service earlier in 1948, it ceased to be a hospital and was taken over by a new concern as a first-class private hotel.

It is now just over 50 years since the writer joined the staff and in retrospect he is still convinced that the qualities which Sir Edmund Spriggs displayed were unique. A big man, with sandy-coloured, greying hair, he was formal in his manner and restrained in his speech, but always thoughtful and patient in listening to what

\* Quoted by Singer in F. H. Garrison's "History of Medicine", Vol. IV 1929.

others had to say. He was a purist in his use of language and speech and could be quite sharp in his unequivocal objection to some of our statements which were non-exact or based on unjustifiable physiological conclusions. In the writing of case notes he insisted on understatement and ample proof of one's claims. Further, he encouraged all of us not to look upon our jobs merely as routine matters but in the afternoons to turn our minds to related subjects and to be ever in the position of working on such in addition to our regular clinical duties.

In this sense as a mentor one never found his authority oppressive and one gradually fell into line with routine and could appreciate one's good fortune in having such a man for chief. Thus, I recall many informal dinner parties held in his house and one in particular when Sir Arthur Hurst was also a guest, Spriggs remarking on how good were the opportunities we enjoyed, being privileged to work in such an atmosphere. These were surely the ideal conditions for advancing the science of medicine. Arthur Hurst, also a Guy's man, had begun his career as a neurologist and slipped imperceptibly into internal medicine. He was director of the New Lodge Clinic, Windsor Forest, which had begun work on the same lines as at the Castle.

#### ORGANISATION OF THE CLINIC

Whilst giving his staff every opportunity to display their originality and effacing as much as possible his qualities as Director, Spriggs was nevertheless a firm disciplinarian, and brought immense care and attention to the running of the Castle. He himself was dubbed "The Chief" by everyone and although autocratic was scrupulously fair. He insisted on a degree of perfection in the work of members of the staff, both medical and nursing, which brooked no carelessness or slovenliness. There was an adequate number of clinical secretaries, and this at a time when such help was scarce in Britain. Each assistant physician was responsible for preparing the case notes which he made, first in longhand, before turning them over to the typist and having them bound in a folder. When a new patient arrived he was promptly seen and his notes written up. The assistant physician had then to make arrangements for all tests required, whether they involved the services of the biochemical, bacteriological, or radiological laboratories. Dr. Patterson was responsible for electrocardiography. All directions relating to these preliminary investigations were made out by the assistant physician on coloured paper slips which were filed in the patient's folder, and duplicate copies sent to all the departments concerned, as well as to the nursing staff and dietician. This meant that at any moment the folder contained an up-to-date statement of the patient's position and avoided errors of omission or reduplication. As regards barium meals, the assistant physicians were encouraged by Mr. Marxer to go down to his department and observe the screening process and progress of the meals, and he himself, being an artist of some talent, made black and white sketches of the relevant appearances at different stages in the investigation, these being included in the notes. When the facts had been assembled the folder was then placed in Dr. Spriggs' consulting room and a consultation with him arranged.

Part of the daily routine also on every week-day was for the assistant physicians to gather at 9 a.m. in Dr. Spriggs' consulting room where, seated around his desk,

they would in turn give progress statements and discuss points of doubt about difficult cases, looking up books of reference, if need be, for assistance. Patterson was always brief, whereas Anderson took trouble to mention any relevant points in detail and "The Chief" brought us up to date with any correspondence that had been received about individual patients, details concerning non-medical matters being kept for discussion with the secretary, Donald Conacher, or Miss Dewar, the matron. These daily conferences we grew to enjoy, although Spriggs rarely permitted himself to relax or to become expansive, the conferences usually lasting not longer than 20-30 minutes before we dispersed to visit our individual patients.

In the afternoons one could usually find something to do in the biochemical or bacteriological laboratories and there was time to make a nine-hole round of golf at Pwllglas with Mr. Marxer, who vainly tried to gain my interest in the game, he himself being a devotee.

Twice a week one was "duty doctor" and remained in the Castle all day, but otherwise one was expected to make an evening round of the patients and whenever one was very ill or required additional help, to stay the night in the castle so as to be on hand in the emergency.

Another informal activity in which the staff as a whole engaged and which Spriggs approved of, although he himself took no regular part in it but would drop in occasionally, was the custom of holding monthly evening meetings at the Castle at which not only the physicians but the radiographer, biochemists and bacteriologists attended regularly. Their purpose was to review current medical literature, and each member of the staff made himself responsible for two or three journals. After citing a list of their contents he would discuss articles of special interest and this was followed by a general discussion. Patterson, who read and spoke German fluently, took on the "Archives für Pathologie", "Deutsche medizinische Wochenschrift" and the "Quarterly Journal of Medicine". Anderson took charge of the "Lancet" and "British Medical Journal" and Allison made himself responsible for "Brain" and the "Journal of Neuropathology and Psychiatry". Meetings were conducted in the big dining room at the Castle and afterwards we were given a cup of tea and biscuits before dispersing. This was one of the best of the many bright ideas emanating from the Castle and on return to Belfast in 1930 one instituted the same practice among the auxiliary and younger consultants at the Royal, and we succeeded in making an arrangement with C. P. G. Wakeley, the editor of the "Medical Press and Circular" to publish a weekly review of the proceedings, Dr. Evelyn Allen acting as secretary and convenor of the meetings.

## ORIGINAL WORK

Before the opening of Ruthin Castle, at Duff House Spriggs had published seventeen papers, including one on examination of the stomach with X-rays, another on duodenal diverticula, and a study of sixty-five patients after short-circuiting operations. During my time at Ruthin, being keenly interested in shooting, especially driven pheasants and partridges, he studied the problem of the "towering bird", seeking to find an explanation as to why on being shot some birds did not plummet straight to the ground but instead continued in flight for a few seconds,

rising on outstretched wings rather than falling directly to the ground. Mr. Marxer took X-rays of these dead birds and they were carefully dissected to show where the shot was distributed in the feathers and in their bodies. It was found that the thoracic cavity had usually been penetrated and that a massive haemothorax had resulted. In his subsequent article on the subject, which appeared in the "Field", Spriggs and Patterson presented evidence to suggest that the towering flight had been brought about by cerebral anoxia, triggered off by extensive loss of blood, giving rise to a transient decerebrate rigidity.

In 1930 Spriggs went on a lecture tour of the United States. He gave the Oliver-Sharpey Lectures in 1906 and the Croonian Lectures in 1935, his subject then being "The Clinical Study of Headaches". As his bibliographer in Munk's Roll states "Ever ready to examine fresh ideas, he was cautious in arriving at his own conclusions, although quick to defend them once established. But he was always willing to withdraw from an untenable position. Thus, his work created an impression of far-sightedness and thoroughness". In his assembly of illustrative cases of headaches from his personal files, he worked late into the small hours of the night and for a time could think of little else, all his staff becoming involved so that for each of the points he made adequate support was available.

Patterson interested himself for a time in the history of the Castle and wrote a good account of its development from the earliest days, tracing the various sieges and misfortunes it had sustained before and after England and Wales came under a common monarch. Spriggs continued to interest himself in the study of diverticulosis and with Marxer was the first to draw attention to the characteristic "saw-tooth" appearance of the colon as an early sign of the condition or a manifestation of the pre-diverticular state.

Shapland wrote an M.D. thesis whilst house physician at Ruthin on the subject of diurnal variations in the hourly levels of the human blood sugar, which won him the approval of the University of London. It was at Ruthin, too, between 1927 and 1930 I had permission to conduct a survey in North Wales of patients suffering from disseminated or multiple sclerosis.

### SOME CLINICAL RECOLLECTIONS

Spriggs was also especially interested in diabetes mellitus and before the introduction of insulin practised the traditional methods of treatment as outlined by Allen on the basis of the latter's work on feeding of low carbohydrate diets in depancreatized dogs. Thus, in pre-insulin days his patients were given diets ranging from 1,500 to 2,500 calories to which the carbohydrate content contributed only a small proportion—20-30 grams daily or less. Twice daily urine tests were made for the presence of ketones as well as sugar, and by attention to the water requirements he managed to keep patients alive, although balanced precariously often on the verge of diabetic coma. Such a patient I well remember was a Dr. Day, whose home was in the Midlands. For years he had been coming to Ruthin and when insulin was first used it was truly remarkable to note the beneficial effect even small doses had on his metabolism. His breath became free of acetone, and he put on weight; his limbs, which formerly consisted almost entirely of skin and bone,

expanding to their normal proportions, and he himself feeling a return of his former energy. It was this patient who changed radically Spriggs' attitude to the treatment of diabetes mellitus. Instead of limiting the carbohydrate intake, patients were now given moderate amounts of carbohydrate, at first being allowed 250-300 grams daily, although the overall caloric value of the diet was still restricted to 2,000-3,000 calories. To become familiar with the details of this radical departure from standard treatment Spriggs sent Allison for a time to the clinic of Professor von Noorden in Frankfurt, Germany, to study the new methods. One of the principal lessons learned was that larger amounts of insulin were not required, as had been supposed, when more carbohydrate was given. The insulin requirements indeed improved and whereas without insulin the ratio between insulin and carbohydrate had been approximately 1 gram per unit of insulin, with more carbohydrate and the diet still being restricted the ratio improved to 3-5:1.

A certain number of patients were received for treatment of their obesity. Spriggs was opposed to harsh dietetic restrictions or to dietetic "gimmicks," pointing out that loss of weight was largely a matter of individual intake and output of energy, especially of the former. Dietitians prepared appropriate and adequate diets consisting of normal foodstuffs in the usual proportions, the total intake of which was restricted to 1,500 calories, this amount being gradually reduced until the patient was living on a dietary of 800 calories daily. He had no time for most patent foods used as substitutes for bread, and was never tired of pointing out to patients the fallacy underlying the supposition that toast was preferable to ordinary bread. If patients insisted on having the former, less could be allowed than of ordinary bread, and this applied to bread made with white, brown or wholemeal flour. In relation to potatoes he had less objections and usually allowed them to have one with their dinner. These fulfilled a need in many subjects, and in any case they had only a low carbohydrate content. It was the prevailing method of preparation by creaming or adding butter which, of course, put up their caloric value to unacceptable levels. Another point: although most patients were regarded as making satisfactory progress on diet when they lost 2-3 pounds per week, if they kept the same weight despite a strict diet, he made no change and neither thyroid nor other medicament was prescribed. Usually, it was found that having remained static for a week their weight began to fall again, persistent failure to lose weight not being a feature of uncomplicated obesity under reduction. The usual explanation was that the patient had been eating on the sly and it says much for his influence over them that such cases were few and far between. Genuine hunger was also uncommon, even on a restricted diet, and Spriggs permitted patients occasionally to have a good meal, i.e. two or three slices of roast beef with plenty of vegetables as a compensation for their strict dieting at other times. We had one patient, a young man in his twenties, whose weight was reduced progressively from over 14 stone down to 9-10 stone in weight and whose photographs before and after treatment he used to display proudly.

A large number of patients suffering from gastric and duodenal ulcer were received, these being treated with few exceptions on bed rest and a modification of the Sippey or Lenhartz diet, whereby they were fed at frequent intervals and were given repeated doses of alkali over a period of one month. I do not remember seeing any ill-consequences follow this regime in the way of alkalosis or milk

intolerance. Patients who failed to respond, in whom pain kept on recurring, or who had a haematemesis, were always reviewed, a consultation being sought with an experienced surgeon such as Professor Kelly or Mr. Montserrat of Liverpool, or Mr. Burgess of Manchester.

Chronic cholecystitis and gallstones also presented an occasional problem in management and one recalls a consultation between Spriggs and Sir Berkely Moynihan over the case of a famous peer who had been coming to Ruthin for years with intractable dyspepsia due to gallstones and chronic cholecystitis. Sir Berkely Moynihan approached the subject boldly. In his opinion there was only one thing to be done—to have the gallbladder excised at operation, and he quoted statistics which gave the risk involved and the percentage of cures. This advice, however, the reluctant peer decided not to accept and insisted on continuing on his dietetic regime and post hoc or propter hoc he survived for years afterwards.

The mayor of a seaside resort, a man in his fifties, and a bon viveur, with a pronounced hypochondriacal tendency, also presented with a difficult problem. There were no physical signs, the blood pressure was only a little increased and electrocardiography showed only slight ischaemic changes, his heartbeat being regular. For three weeks he was kept on strict rest in bed, and despite this he continued to complain daily of recurring anginal-like bouts of pain. Immediate relief followed the inhalation of a capsule of amyl nitrate, although the introduction of this drug did nothing to lessen the recurrence of his pain. Our minds divided between regarding him as a potential coronary thrombosis and a hypochondriac, we permitted him gradually to resume his physical activities, walking a little more each day and finally reaching the stage when he could play a round of gentle golf on the 9-hole course joining the Castle. His pain continued to recur so that within a matter of weeks the whole of the golf course became strewn with broken used ampules of amyl nitrate. His weight had been reduced and he was on a strict dietetic regime and not permitted rich foods. And then, one day he was discovered lying in a corner of the golf course dead! The post-mortem examination disclosed advanced atheroma of the coronary arteries and the presence of a massive infarct in the myocardium.

Altogether some 4,796 patients were admitted to Ruthin Castle over the 10-year period, 1925-1935 and there was a rapid turnover, the majority leaving within three weeks of their arrival and only a few remaining for a month or longer under treatment. We had several cases of ulcerative colitis and a few of idiopathic steatorrhoea and sprue, with other examples of defective fat absorption and presenting with a picture of coeliac disease, their investigation and treatment involving careful analysis of the faeces and the patient being placed on a Kjeldahl diet because Spriggs was only satisfied to make the diagnosis when repeated laboratory tests showed defective absorption of fat to some 50 per cent and the patient was on a known diet. Even more common types of case complaining of obstinate constipation had to be kept under observation for a week, during which no aperients were allowed and the rate of passage through the bowel was checked by charcoal, the first appearance of the drug in the faeces being taken against the time of its final disappearance. Usually when this was done it was found that delays in the rate of passage for longer than the normal, up to 72 hours, were usual, the complaint arising from the patient's almost invariable habituation to the use of aperients.



Simple cessation of their use produced no ill-effects and was all the treatment they usually required. But one young woman who already had submitted herself to an operation for partial colectomy without success, turned out to be a case of Münchhausen's Syndrome. It is unnecessary to go into the strategy employed to establish proof of this without causing loss of face to the patient but the result was most satisfactory and we received a warm letter of appreciation from her own doctor, a Glaswegian practitioner. He sent a copy of a paper he had written some years before when the young woman had presented herself with an incurable dermatitis which he had resolved by demonstrating that the skin lesions were artefacts or self-inflicted.

We had one case of Addison's Disease which proved fatal. Another spontaneous polycythaemia in which the patient's unusually slate-coloured complexion was much at variance with his high number of red cells. There was, too, a planter from the Malay States who was brought into the Castle on a stretcher suffering from a severe polyneuritis and Korsakoff type of syndrome. This latter, which was due to his big consumption of alcohol, was found to have created in his case a syndrome of diabetes insipidus. This would explain his position when, on alcohol being withheld, he continued to drink large quantities of mineral water alone daily. A remarkably pleasant fellow, he retained his spirits and capacity for looking on the bright side of things throughout the long period he remained at the Castle. On his discharge finally on maintenance doses of pitressin and his promise to avoid alcohol in the future, he did so for some 10 years, during which he corresponded with us regularly.

As can be seen, a wide variety of patients were admitted to Ruthin and this was a great advantage to a young physician on the threshold of his practice. Despite the exclusion of frank mental cases, many patients exhibited neurotic or frankly hysterical symptoms and it was always a problem to decide how much this was contributing to their complaint. This was in the days before the appointment of psychiatrists to the staff of hospitals and in the working out of the mental aspects of a patient Spriggs never took much interest, being content to make a full evaluation of the organic aspects and leaving any elucidation of the purely mental side to one of his assistants. Before concluding I should like to mention a young woman, which illustrates this point. She was admitted on account of a so-called idiopathic narcolepsy, her referral being due to the fact that no improvement whatever had followed appropriate drug treatment. "Sleep" attacks came on without warning when she would slump in a chair or on a couch and remain apparently asleep for periods ranging from 1-24 hours.

The patient had not been more than three days in Ruthin before she had an attack. One day, standing talking to her, she broke off in the middle of a sentence and without changing colour, fell back on the bed and lay there breathing naturally. Attempts to rouse her by speaking in a loud or commanding voice; giving her a little ammonia to inhale; tickling her throat with a feather; stimulating the soles of her feet with a sharp pin; or employing a galvanic current had no effect, the patient appearing to be still asleep and utterly unmoved by these procedures. When I called upon the Danish nurse, who had accompanied the patient to Ruthin, and invited her to "bring her round", within a few seconds she responded, opening her eyes again and exhibiting no signs of emotion. So far as I could detect, all the nurse had done was to speak in a low voice into the patient's ear. This was, of course,

in the days before electroencephalography but we did blood sugars, examined the pulse, the cardiogram, and the pupils for any changes, but finding none agreed that the sleep attacks were not genuine but purposeful in their character.

The first step was to get rid of the Danish nurse and isolate the patient from her relatives, our own nursing staff being taken into our confidence. Then, ignoring the patient's conscious state and the fact that she was "sleeping" most of the time, she was treated as if she was fully awake, it being suggested to her that she would have no further inclination to fall asleep by day and as soon as the attacks had disappeared she could be discharged home. Throughout the prolonged period of "sleep" that resulted there was no incontinence of urine or faeces, but during the night the patient would suddenly sit up in bed and mutter to herself in a distraught fashion, like a sleepwalker, before resuming her former state. On the fifth day, as she was not taking food it was decided to introduce tube feeding, the patient suffering a large rubber tube to be passed down her oesophagus without demur, after which an egg and milk mixture, fortified with glucose and vitamins, was poured down, and thus she was fed for three days without there being any alteration in her condition. Indeed, one was becoming worried that we had taken on more than had been anticipated and the nursing staff were beginning to lose faith, although Spriggs kept calm and advised me to carry on as before. The only alteration I made was in getting the nurses to give more particular attention to the state of the skin and to ensure that the patient still was passing urine and faeces, and was in water balance.

One morning when I visited her as usual, she suddenly to my surprise sat up in bed and asked for her clothes so that she might dress and go out of doors. This sudden volte face was totally unexpected so, concealing my surprise, I assumed a nonchalant attitude and had her clothes brought to her so that she could sit out on the terrace and have her meals as usual for a week before her parents were summoned and she was permitted to return home. The patient herself was not submitted to any criticism but reassured that her illness was now a thing of the past and that within a little time she could expect to behave and feel like a normal person, which she undoubtedly was.

This concluded a memorable case, the like of which I was not to see again. Whatever the diagnosis it certainly was not idiopathic narcolepsy but I was satisfied that dissociation of the personality had genuinely taken place and been responsible for her symptoms. If I had ever doubted the possibility of such occurring, this provided adequate proof. We kept in touch with her parents for three months and over this period there was no further recurrence of symptoms.