

Original Articles.

PROVISION FOR THE CARE OF ADULT PAUPER EPILEPTICS IN MASSACHUSETTS.¹

BY WM. N. BULLARD, M.D., BOSTON.

OUT of the many thousand pauper patients who, in the course of a year, seek treatment in our large hospitals and charitable medical institutions, there is no class for whose proper care and protection the means at our disposal are so utterly inadequate as for adult pauper epileptics. Beyond certain mild palliative therapeutic measures, we have no resource until the patients become fit subjects to be legally committed to institutions for the insane. The only exceptions are those cases where surgical interference is deemed desirable. In the whole range of medical practice in Massachusetts, there is no class of patients whose interests have been so thoroughly neglected.

The cause of this is not wholly clear. It has, no doubt, been due in part to the inherent difficulties in making such provision, and largely, also, to the ignorance and indifference of the public at large, caused by the want of energy of the medical profession in drawing attention in this direction. There seems to be at present in the minds of many persons, a lazy notion in regard to epileptics, that when the attacks are frequent and severe, the patients are insane, and when they are not so obtrusive, they should be treated as if well, look after themselves, be cared for by their friends, or be sent to almshouses, or other regular pauper institutions. It is scarcely necessary for me to state that these views are wholly false. There is probably no considerable class of the physically or mentally afflicted, which contains so large a proportion of persons demanding our deepest pity, or which entails so large an amount of suffering for each person, as that comprising the chronic epileptics. They are, as a whole, much worse off than the chronic insane, worse off even than the acute insane, for the condition of the latter is but temporary. The chronic epileptic is, however, in a condition which may be described as one of recurrent insanity. The attacks are not so suffering in themselves. During them, the patient is unconscious, but the condition preceding is often one of much mental pain and it is the constant dread of the attack, always impending, occurring at any time without notice, which causes the greatest strain. There is also, the mental condition of depression, and of uncontrollable fear and terror produced by the disease itself which adds to its horrors. These facts are well known to the medical profession, and I should hardly have deemed it worth while to have mentioned them here, were it not that we have too long been inclined to treat them with apathy and indifference. This condition of suffering seems to have been too often passed over as one of those things which, alas, exist, and which we must admit as belonging to the inevitable, but which, with our imperfect means, it is useless to attempt to combat or control.

That, possibly, at one time, with the means then at our command, this view may have had a real foundation, I am quite willing to admit, but I deny that at the present time this view is tenable, or in any way justifiable. It is neither true in fact, nor is it just to

the sufferers, that it should longer be held. We can, if the proper means be provided us, do much to alleviate the sufferings of these patients, and if, in many cases, we cannot wholly cure them, we can render their life infinitely more comfortable and more bearable. To aid in doing this, seems to me to be the duty of all who know and pity these unfortunates.

Thus far I have spoken only from the point of view of the welfare of the patients and their freedom from suffering, but this subject must also be considered as regards the welfare of the public. Many epileptics are dangerous, both to themselves and to others. I do not in this statement refer to those who are insane in the legal sense, and can properly be committed to asylums for the insane. Every alienist, and all others skilled in dealing with such insane patients, will admit that they form, perhaps the most dangerous class of all insane. But of them, I do not speak. I mean, on the contrary, in this statement to include those epileptics who are subject to frequent severe attacks, but who, in the intervals between these attacks are in a condition of comparative sanity. Only a short time ago, I saw in company with Dr. Jelly, a patient of this character, who had a few days previously attempted to drown himself, apparently while in a so-called post-epileptic condition, that is, in an abnormal condition immediately following an attack. He seemed to have had a perfectly clear idea of what he wanted to do, but his reasons for doing it seemed to have been indistinct and vague. Between the attacks, including in this word certain temporary epileptic conditions as well as the actual convulsions, this person was sane, and we thoroughly agreed that it would be impossible to commit him to any medical institution. Yet such a patient is subject to conditions in which he may do violence to others, either under temporary delusions or without knowledge thereof. The patient mentioned is liable, for example, to lose consciousness of his actions for varying periods, and frequently recovers his senses to find that he has walked a distance of from twenty minutes to half an hour from the place where he was when he last recollects anything. There is no evidence that when in these conditions he appears otherwise than sane to those whom he meets. He is, however, apparently unaccountable for his actions at these times. It is in these conditions that non-insane epileptics become extremely dangerous. Such a person may attack, assault, rob, murder, or commit almost any other crime. Cases of this character are too well-known among medical men for me to relate them here. As an example, I will refer to the one related by Voisin, where an epileptic, without any cause, violently attacked a shopkeeper with whom he had previously had no acquaintance.

After an epileptic has committed a serious or savage crime, if it can be rendered probable that this was done under the influence of the disease, and that he was, therefore, morally irresponsible, he will generally be sent to some institution for the insane, at least for a time, and not improbably later set free, while still a source of danger to those about him. The release of the patient before he is apparently safe is, from the nature of our institutions, not altogether avoidable. The patient may be practically unsafe, and yet technically not insane. What, however, I would insist on, as most important to the community, is that those epileptics who are very liable to be dangerous, should be placed in a position where they can harm neither

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themselves nor others involuntarily. This is only justice to the patients themselves; for their own sake they should be prevented from committing crimes even unconsciously. The mental suffering which may be caused by the unconscious or involuntary commission of a crime, is much greater than the annoyance and discomfort of carefully systematized protection. *Epileptics*, like the insane, must be protected from themselves.

These persons are as much members of the community as any others. They stand in the same relation as regards personal protection. Of mental suffering, although much more serious, the community cannot, as a rule, take cognizance, but from physical injury or danger, it is, within certain limits, its duty to protect all its members. It is its duty to protect epileptics from themselves. We must restrain them from suicide, and prevent them from injuring themselves as far as possible. The community also should be spared the shock of sudden accidents or deaths. It is only a few months since that an epileptic who had, from time to time been under my care, was drowned in the Public Garden Pond during an attack. I had searched in vain for a place where this man could be put in safety; there was no such in existence in the State. He was not insane, and was not a proper subject for an almshouse.

Such accidents as this are avoidable, and we all become more or less culpably negligent unless we consider what are the proper remedies, and take active measures to apply them.

Epileptics must be divided into classes as regards treatment. Many of the lighter cases do well under proper diet, exercise and drugs. Other cases, especially the traumatic ones, are helped by surgical means, and the secondary cases, which are hardly to be considered here, are often best treated by treating the primary cause. But when all these have been eliminated, there still remain those for whom some home is necessary, who are unsafe either for themselves or others, or are liable to be so. The best method of dealing with this class — of course I am speaking now only of the pauper and semi-pauper cases — is the institutional, but they must have an institution of their own. They should not be placed in an asylum for the insane, nor are they fit subjects for any almshouses or institutions for the poor, such as at present exist. This has long been admitted by all specialists and other physicians who have knowledge of this subject, and is too plain to admit of discussion.

But the best form of institution for these unfortunates is less settled. Various schemes have been proposed for their care. The first point to be determined and perhaps the most important, is the question of independence. These patients may be cared for in connection with patients of some other kind; they may form a portion of some other institution, preferably an asylum for the insane, and though entirely separated and forming a distinct ward or division, be under the same management and direction. This method has certain great advantages over any other, and has been advocated by some of the soundest experts in Europe. In the first place, it is cheaper. The larger the number of persons cared for, other things being equal, the less is the average cost; it, to a certain extent, according to the degree of dependence, avoids the necessity of separate establishments and thus in many ways, labor and expense are avoided.

The food for the whole institution may be cooked in one kitchen, the washing done in one laundry and the number of employees be less than would otherwise be the case. The superintendent of a large institution has more opportunity for observation and, if he has time, he can profit by his larger experience.

But, on the other hand, we are confronted here by a real difficulty and, as I believe, a well-founded objection to this method. Passing by the fact that our ordinary asylums and other institutions are already so large that the superintendents, even aided as they are by a corps of skilled and competent assistants, have as great a responsibility as they can bear, and more weight should not be put upon their already overburdened shoulders, it seems scarcely advisable that these men should be called to treat a class of patients whose management must be extremely different and, in some cases, diametrically opposite to that which they ordinarily use. The management of the insane needs a special training to which a man should devote his whole energies and faculty, and it is a loss whenever these are diverted in another direction. The management of epileptics in an institution, also needs a special training, and the two are not of a character likely to be combined. If the medical care and arrangements for the insane and non-insane epileptics are combined under one management, neither class is likely to be so well cared for, as if they are kept wholly distinct.

For these reasons, I should certainly not feel it wise that both insane and non-insane patients should be confined in the same medical institution, even in separate parts thereof, unless these parts should be practically distinct with different superintendents, medical officers and, as a whole, form separate establishments. In such cases all the advantages above mentioned are absent, and such establishments belong less to the class of dependent than to that of independent and unconnected institutions.

Believing for the above reasons, that separate institutions are advisable for the best care and treatment of chronic pauper epileptics, the next question to be considered is, what form of establishment or settlement for such persons is the best. Three arrangements have been advocated, and all have been in actual use. These are:

(1) A large building or institution of the same general character as our ordinary hospitals or asylums, to be used solely for epileptics. This may be one large building, or several large buildings, the essential factor being that a number of patients are congregated together under one roof.

(2) A series of small buildings — cottage hospitals — each containing only one or, at most, a very small number of patients. These buildings are all under one management.

(3) A colony resembling that of Gheel in Belgium, where the epileptics may be boarded out in families with whom they live and by whom they are cared for.

The value of these methods must be determined both by the experience of others and by special considerations. From the very nature of their affliction, special remedies and special conditions are demanded for these patients. They are in a different position from the ordinary sick and also from the insane, and cannot be placed in a common category with either. Until within late years — and even at the present time in this country — epileptics were treated exclusively either in hospitals with the ordinary sick, or in asy-

lums for the insane. The effect, therefore, of the treatment of epileptics in connection with other patients and with other epileptics, has been for a long time a matter of experience. The latter question, which alone concerns us now, has also been tested in special wards and hospitals. We find that the influence of epileptics upon each other is not as bad as might be *prima facie* supposed, that a certain number can be well cared for in a large building devoted to them, but that the majority cannot be so well managed when they form part of a community as when they live more separated. It is not found that the sight of epileptic attacks in another epileptic, is specially likely to induce them in the non-hysterical looker-on and the argument that this was the case which at one time obtained widely, is not valid. None the less, we ought to spare these afflicted as far as possible the mental shocks of such scenes, so much worse when they know that they are later to go through the same themselves. Very important, too, from a practical, medical point of view, is the danger which one patient labors under of being attacked by another. As before stated, non-insane epileptics when the epilepsy is severe are liable at any time to attack others, or injure themselves and often without any notice. This is the most weighty reason for their separation. Secondly and derived from this, is the reason that in large institutions, when many patients are brought together, the number of attendants is liable to be scant and scrimped and, on the whole, not such as the most cautious would desire. On this account serious accidents may occur. Again, *open-air* employment is almost necessary for epileptics and this can usually be better arranged when they are not all herded into one institution.

For these reasons and also because a routine treatment is, except within certain narrow limits, unadvisable in these cases, there is no doubt but the cottage hospital system, or that of colonization, is preferable to that of one large building (the community system).

The respective merits of colonization and of cottage hospitals may vary somewhat under various circumstances. In certain countries, the cottage hospital system appears to offer decided advantages. In this system, the sick are under constant trained care, which under the colonization scheme, is well-nigh impossible. Such care not only lessens their liability to injury, but the security for their proper treatment and protection is much greater, no matter how careful the inspection under the colonization plan. In the latter plan, too, the danger from epileptics to others cannot be disregarded.

On these grounds, therefore, I have concluded that the cottage hospital system offers, at the present time, the best means for the proper care and treatment of chronic epileptics. But whatever means are used for this purpose, they cannot be properly cared for without the free expenditure of money. The primary requirement in forming any institution of this class, is that there should be no stinting of means. If such an institution cannot be carried on so as to fulfil its purpose, it had better not be undertaken at all. Waste of money is not clarity, and that money is wasted, which being too small in amount, does not accomplish its purpose. No half-way measures should be attempted; they are liable to be worse than useless, as being not only ineffective, but obstructive to true progress in this direction.

TWO CASES OF LAPAROTOMY FOR INTRA-ABDOMINAL HÆMORRHAGE.¹

BY JOHN HOMANS, M.D.,
Surgeon to Massachusetts General Hospital, and Harvard University
Lecturer on Ovarian Tumors.

CASE I. In November, 1888, I was asked by Dr. W. T. Carolin, of Lowell, to see a married lady, twenty-three years old, who had been flowing almost constantly since the 14th of October.

The patient was a bright, intelligent woman, who stated that her weight had formerly been one hundred and fifty pounds, and was now but one hundred and fifteen. She had been married three years, and had never been pregnant. Before her marriage she was accustomed for many years to suffer from backache and headache. In 1883, she consulted Dr. O. W. Doe for dyspepsia and hysteria. In 1885, she was treated locally and generally for six months by Dr. Irwin, of New York, and also by Dr. Wood. In 1887, she consulted Dr. W. H. Baker, and also Dr. Gillette. During these years she had backache and soreness in the left iliac region, and was unable to walk any distance for two years on account of pain and soreness in the abdomen.

January 1, 1888, she entered St. John's Hospital, in Lowell, and remained there six months, under the care of Dr. Carolin. She felt somewhat improved when she left the hospital, and went to Martha's Vineyard, but she soon became tired and feeble. Later in the summer she went to the northern part of Vermont, and gained flesh and strength. In the autumn she came to Boston, and, after walking about a good deal, had a return of her former debility and suffering. About this time she began to wear a pessary, and on October 10th, went to Holliston, Mass., and walked a mile. The next morning she could hardly stand; and after hobbling about with pain in her left side and in her foot at every step she took, she removed the pessary and flowing at once began. This had continued ever since, with short intervals of cessation and pain. The color of the blood was mostly bright, and about four ounces a day by estimation.

I saw her on November 7th, with Dr. Carolin. I found the hæmorrhage going on. On examination the abdomen looked normal. It was somewhat tender, particularly in the pubic and iliac regions, especially on the left side, where the percussion note was duller than elsewhere. Both lumbar regions were rather dull. There was great tenderness in Douglas's pouch. The os was virginal and healthy. A bunch, the size of an elongated Seckel pear, was felt in the left iliac region. She was suffering considerable pain, and for this she was given McMumm's elixir of opium; she also took aromatic spirits of ammonia and ergot. She had fainted away the morning I saw her; and I was told that she had fainted several times previously. Her pulse was 108, and her evening temperature 101°. She had been and was now having profuse night sweats. She fainted again on the morning of November 8th. I learned that her father was living at sixty-three, and her mother had died, at thirty, of typhoid fever; but her paternal grandfather and grandmother and uncles and aunts were reported to have died of consumption. Taking all these facts into consideration, the hæmorrhage, fainting, tenderness, the pallor, the tumor, and more or less dullness on percussion in

¹ Read before the Obstetrical Society of Boston, November 8, 1890.