

tion of the nation's duty in the prevention and control of disease.

The state or municipality can establish free dispensaries and is already doing so. It has its laboratories for the free examination of sputum. It indirectly aids in the early detection of the disease by providing sanatoria for incipient cases and thus encourages the individual who fears he may be suffering from tuberculosis to apply for an examination, knowing that if he is found to be tuberculous an opportunity is afforded him for treatment. The nation can require that all its employees in the army, navy or civil service shall be periodically examined. The state can go farther and insist upon the examination of all operatives in workshops and factories before referred to. Massachusetts, for example, now requires that all factories shall be well lighted, well ventilated and kept clean; that cuspidors shall be provided; that there shall be proper sanitary arrangements; that medical and surgical appliances should be kept in all factories; and that proper egresses, fire escapes and fire extinguishers shall be provided. Why not extend this paternal care of its working people and require a periodic examination of the lungs of each operative, perhaps of equal value with these other requirements, when one considers the frequency of tuberculosis among workers? Moreover, such a requirement might, with equal reason, be extended to large department stores where many young women are employed.

Again, the state, by exhibitions and the dissemination of literature upon tuberculosis and other educative measures, can impress upon the public the importance of the early recognition of tuberculosis, with especial reference to the favorable results of treatment in the early stages of the disease. Thus it will be seen that official action can, and in many countries does, accomplish very much toward securing to its citizens an examination as regards tuberculosis, and can, by these various measures, cause it, in many cases, to be discovered in its incipiency, when cure is easy and the infection of others impossible.

The above are some of the difficulties, as I conceive them, in the early detection of tuberculosis, and I have endeavored to suggest some of the remedies.

MEDICAL INSPECTION OF SCHOOLS FROM THE STANDPOINT OF THE MEDICAL INSPECTOR.*

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THE first system of medical inspection of school children in this country was inaugurated in Boston, in 1894, under the direction of the Board of Health, and to Dr. Samuel H. Durgin, Chairman of the Board, the pioneer in this work, is due all credit. After several years of patient endeavor, Dr. Durgin's wishes were finally realized, when, in 1894, under the administration of Mayor Mat-

thews, an appropriation of \$10,000 was granted for instituting the work. The city was divided into districts, and 50 physicians were appointed as medical inspectors of schools, at an annual salary of \$200 each. The system was as follows:

A daily bulletin of all cases of scarlet fever, diphtheria and measles reported to the Board of Health was mailed to each inspector. His duty was to visit each case of scarlet fever and diphtheria not sent to the hospital and report upon the isolation. Upon receiving notice from the attending physician of the completion of desquamation, the medical inspector again made a visit and examined the patient and, if satisfied that desquamation had ceased, notified the Board of Health of the fact, recommended that the patient be released from quarantine and that the premises be disinfected. In the beginning, in cases of diphtheria, the medical inspector took cultures for release only when the attending physician refused to do so or abandoned the case. Later on, two consecutive negative cultures were required for the release of the patient and the medical inspector was required to take the final culture. Two years ago, visitation and report on the isolation of typhoid fever, tuberculosis and cerebrospinal meningitis were required, and these diseases were included in the daily bulletin.

The primary object of the school work was the detection of communicable diseases among the pupils. The teachers selected such children as seemed to them indisposed or showed some external sign of disease. The medical inspector examined these children, gave to the teacher his opinion and advice as to what should be done. The medical inspector has no authority in the schools, his position being merely advisory. Dr. Durgin was emphatic that no treatment be given to any pupil and that the medical inspector should in no way attempt to enlarge his private practice through his connection with the schools. One exception to the rule of no treatment exists, and will be mentioned later. In addition, the medical inspector was expected to be particularly cautious lest any action on his part should give offense to any practising physician. The actual work at present comprises:

1. Examination of all children entering the schools without certificates of successful vaccination.

2. Examination of and advice regarding all children referred by the teachers for any evidence of ill-health.

3. Contagious diseases. If a child is found in a schoolroom suffering from a contagious disease, the medical inspector closely observes the other children of that room for the next two or three weeks for the appearance of this disease; or, should it be discovered that several children attending a certain room are absent at the same time with the same contagious disease, an examination of all the children of that room becomes necessary. Should the medical inspector feel that disinfection of the room is necessary, the Board of Health is notified and proper action taken. Again, the chief medical officer of the

* Read at the regular meeting of the Boston School Physicians' Association, Nov. 20, 1908.

Board of Health, Dr. Shea, may note an unusual number of contagious diseases in a certain locality; the school physician is then called upon to ascertain the distribution of these cases among the different schools in that district. That the system in this respect has been efficient is shown by the fact that while we hear of many schools, public and private, outside the city which are obliged to close on account of an epidemic of scarlet fever or diphtheria, such a condition has not occurred in Boston since medical inspection was inaugurated.

The exclusion and return of pupils is in the hands of the medical inspector, who is constantly consulted upon these points by the teachers. He can readily advise upon this question, since a part of his work consists in visiting the patient at home. Even though children in his school may reside outside his district, he can, if necessary, readily secure information from his associate who covers the territory in question. The law says:

"A child who is a member of a household in which a person is ill with smallpox, diphtheria, scarlet fever, measles or any other infectious or contagious disease, or of a household exposed to such contagion from another household as aforesaid, shall not attend any public school during such illness until the teacher of the school has been furnished with a certificate from the board of health of the city or town, or from the attending physician of such person, stating that danger of conveying such disease by such child has passed."

It might be mentioned in this connection that about 60% of all the cases of scarlet fever and diphtheria occurring in Boston are treated in the hospitals.

Upon receipt of the first mail at the office of the Board of Health, the chief medical officer is advised of all contagious diseases reported in that mail. Through long experience he can readily decide from the locality of the diseases reported whether they can be cared for and properly isolated at home or not. If from his knowledge he deems they cannot, the Board of Health machinery is put in motion and these cases are placed in the hospital and the premises disinfected before nightfall.

Therefore it would seem from the above that children attending schools, visited by one medical inspector and residing in the territory covered by another, present no great difficulty as regards the question of exclusion from or return to school.

One exception to the rule of no treatment by the medical inspector exists in cases of pediculicapitis. In 1896 the Board of Health ordered the medical inspectors to make a general inspection of all school children for this condition. A printed card was furnished by the Board of Health to be filled out by the master or teacher. It informed the parents that their child had been found by the medical inspector to be infected with pediculosis, full directions for treatment following. With this card was sent a prescription for crude petroleum. This card and prescription, by the way, have been omitted in the "Special Report on Board of Health Medical Inspection of

Schools" in the annual report of the Superintendent of Schools for the year 1907 and 1908.

The following letter, taken from the annual report of the Board of Health for 1897, is of interest as showing how this action was appreciated.

"One master endorsing the work states:

"Now that we are through with the pedicular examinations in our district, I wish to say a word: Dr. —, who examined our children, did his work faithfully, patiently and with tact. . . . The examination proved very popular with the parents. About 1,200 children were examined in my district. Not more than 25 or 30 parents made any objections. The children of these parents had infected heads and I have not found one parent who did not think it wise to have all children's heads examined except their own. My general judgment is that all parents, except a minority, so small in number as to have little or no weight, want the examinations continued at proper intervals. While many children have felt mortified when found infected, the movement has been considered one of education. The next time the plan is tried there will be but a minimum of friction. The children are very much cleaner in other ways, and look and feel better. They cannot help enjoying more physical comfort. My object in writing is to strengthen the hands of your Board in creating what I hope will prove a permanent plan which, from my observation and experience and in the judgment of nearly all parents, has been too long delayed. As a teacher, parent and citizen I hope the good work so well begun will be continued.

"Very respectfully yours,

"Principal, — School."

The attention of the medical inspector is sometimes called to poor sanitary and other bad hygienic conditions in the schools. The Board of Health is notified, investigates and reports its findings and recommendations to the school authorities.

At the outset the medical inspector was an unwelcome visitor in the schools in many instances. Masters and teachers regarded him as an unnecessary intruder. Persistence and patience on the part of the medical inspector, however, finally convinced the teachers of the necessity and value of the work, so that the system originally instituted to detect contagious diseases has so broadened in its scope as to include all matters pertaining to the physical well-being of the pupils. * Hence the work originated by Dr. Durgin and carried out by his appointees at an inadequate salary has proved its necessity and by its results attracted widespread attention both among hygienists and educators.

Notwithstanding the good work done by the original system, it was recognized on all sides, and particularly by the medical inspectors themselves, that the system was not complete in all its details. Pupils were examined and advice given to the teachers, who notified the parents of the diagnosis and of the measures to be adopted for

relief. In many instances the parents took no notice of the suggestions made. As a result of this, and by reason of the fact that no treatment was allowed, it was felt some time ago that the medical inspectors' duties should be broadened and that nurses subordinate to and under the control of the medical inspectors should be employed.

Nurses in the public schools were first utilized in New York and proved a success. In Boston the health appropriation did not allow of their introduction by that department, though advocated by Dr. Durgin. A few years ago, to demonstrate the value of such assistance, the Instructive District Nursing Association placed two nurses in the schools, one in the West End and one in the South End. Their work was such that the commission appointed by the Boston School Committee in June, 1906, to report on matters relating to the health of school children, endorsed it highly and recommended their general introduction. In 1907 the Boston School Committee obtained authority from the legislature to expend annually the sum of \$30,000 in the employment of nurses, who were placed under the direction of the Department of School Hygiene, created in the same year.

We now come to the considerations of the results of the first year of medical inspection of school children by the combined method of physicians, under the Board of Health, and nurses, under the Department of School Hygiene. The original idea of having nurses in the schools to supplement and render more efficacious the work of the physicians has not been wholly realized because each division, subject to a different head, has worked along divergent lines, only acting together in isolated instances. By virtue of this disconnected state of affairs the present system of medical inspection in the Boston schools is faulty and inefficient on account of its duality and divided responsibility. The rules of the School Committee state: "It shall be the special duty of the assistant nurses to assist the medical inspectors assigned to the public schools and to see that the directions given by the inspectors are carried out."

If there was a strict observance of this rule, with nurse and doctor subject to the same authority, it is easy to see that we would have a system of school inspection of the first order. Unfortunately, however, such is not the case. The medical inspector receives no report on cases referred by him to the nurse for some particular object. The nurse may carry out the suggestion of the medical inspector, but her report is made to the supervising nurse at school headquarters. The medical inspector only hears of these cases through his accidental meetings with the nurse or through the teachers. Furthermore, in many instances, the nurse goes into the schools, steps into the domain of the physician, makes diagnoses, advises treatment and excludes pupils without even referring the cases to the medical inspector.

In addition, a new responsibility hitherto nowhere allowed has been given to the school

nurse: while the medical inspectors are not allowed to treat any child, the nurses are supplied with a complete armamentarium for doing minor surgical dressings, and, according to the report, during the last year, 29,017 dressings were done by the nurses. This would be all very well if the nurses were immediately directed by physicians, as they should be, when they apply treatment.

In the superintendent's annual report for the past school year, it says of the nurses' work: "The work accomplished during the year 1907-1908 is set forth in detail in Table B." Table B is entitled: "Nurses' Statistical Record of Boston Public Schools." We shall consider a few of the statistics contained therein. "Pupils inspected for pediculosis, 43,036; number found, 12,909." The number found by the medical inspectors was 4,181. As previously mentioned, this work has been done by the medical inspectors. Now it would appear that the nursing division is to assume that responsibility, which we consider unwise, since it is not the province of a nurse to make a diagnosis, no matter how simple or easy of recognition the condition may be.

Nurses are not trained in the making of diagnoses, physicians are, and to them should be assigned the responsibility. In almost every disease in the nurses' record, the number reported is far in excess of that reported by the medical inspectors. As we are obliged to draw our own conclusions, since no explanation is given, we must infer that either the nurses themselves made a very large number of diagnoses of tuberculosis, typhoid fever, syphilis, scabies, impetigo contagiosa and other diseases, or for some unexplainable reason these cases were taken to hospitals or dispensaries for diagnosis. If the first conclusion is correct, the nurses have overstepped their province; if the latter is the case, it should not be, since the medical inspectors always stand ready to examine all pupils. Two hundred and thirty-two cases of tuberculosis appear on the table. It would be interesting to know what was done with these cases. The medical inspectors report 32. Twenty-four cases of rachitis are reported in the nurses' record; the medical inspectors saw none. We were unaware that rachitis as an active disease existed much after the age of two years.

Seven hundred and eighty-seven cases of diphtheria and 1,000 cases of scarlet fever are recorded in this table, while the medical inspectors saw but 28 and 45 cases respectively. Just what these figures mean we are unable even to conjecture.

The following from an article in the *Boston Transcript* of July 28, 1908, entitled "Healthy School Children" is apropos. It says:

"In no one year since 1894 had the medical inspectors of the Board of Health reported more than 77 cases of diphtheria among school children, or 31 cases of scarlet fever; in less than five months following Sept. 11, 1907, the nursing division discovered 392 and 407 cases respectively." Inquiry at the office of the Board of Health shows no record of such a number of cases of contagious diseases found in the public schools of Boston during that time. Furthermore, how could the

nurses have any connection with so many cases of diphtheria and scarlet fever, since one of their rules reads as follows: "The nurses shall visit excluded pupils at their homes, provided that such visits shall not be made in cases of smallpox, scarlet fever, diphtheria, measles, whooping cough or mumps."

The nurses' report says 8,542 pupils were excluded. The medical inspectors advised that 4,905 pupils be excluded. We must infer, then, that upon their own responsibility the nurses excluded some 3,607 children. Cases referred to family physicians and hospitals are 9,648 and 9,715 respectively. Here also is another instance of nurses exercising the rôle of a physician, since it does not state that the referring of these cases was authorized by any physician. Pupils inspected for pediculosis, dressings, pupils escorted to hospitals and visits to homes are the only things specifically stated as having been done by the nurses.

The balance of the report, comprising a long list of diseases, with the number of each, is without explanation as to the authority for recording them. In the nurses' record no mention is made of cases referred to them by the medical inspectors or of work done at their suggestion. The medical inspector as a factor in the nurses' work is entirely ignored, other than the following statement: "The co-operation of the Department of Medical Inspection under the Board of Health and the nursing division under the Department of School Hygiene has been cordial and effective." The foregoing analysis of the nurses' report has been rendered necessary on account of the newspaper articles which have appeared from time to time during the past year extolling the more thorough and effective school inspection under the nursing division as compared with the past work of the physicians, as also on account of the figures presented in the annual report of the nurses' work, which leaves it to be inferred that the old corps of medical inspectors is of no importance in the new régime. That the work of the nurses has not been of value, far be it from us to imply, but undirected by physicians in the field we have grave doubts as to its reaching its fullest degree of efficiency.

Dr. Luther Halsey Gulick, Director of Physical Training, New York Public Schools, and Leonard F. Ayres, General Superintendent of the Schools of Porto Rico, 1907-1908, have recently published a book on "Medical Inspection of Schools," which contains all the available information on the subject. Of interest to us is the following account of the work of the school nurse in Philadelphia by Dr. Cornell:

"The efficiency of these nurses depends largely upon their personality. As a rule, in foreign poverty-stricken sections, they are invaluable. It does not appear that their sphere would extend beyond the home visiting for the purpose of urging treatment in the other sections of the city." We feel that this statement holds good for Boston.

In addition, Dr. Cornell says: "In those schools visited by both the medical inspector and the

nurse, the nurse is subordinate to the medical inspector. The method of action and record in these schools is for the medical inspector to leave the small blue cards, each containing the record of some child's physical defect, for the nurse's enlightenment. The nurse sends for the children by means of these cards and either treats them at the time or makes a note of home visits required."

In *Charities and the Commons* for Nov. 7, 1908, is a review of Gulick's and Ayres' work by L. L. Dock, who says: "The nurse is the proper person to observe symptoms and report them to the physicians. It is for this that she has been trained. Although the authors report favorably upon the work of the public school nurse, where it exists, and quote Dr. Newmayer, of Philadelphia, as calling her 'the most important adjunct to medical inspection,' they yet do not make it sufficiently clear that a complete or model organization of medical inspection is impossible unless it includes the nurse. There are ample proofs that it was the practical personal work of the nurse that drew public attention and sympathy to the medical work in the public school and vitalized the hitherto perfunctory routine of medical inspection and exclusion of infectious cases. This being true, the authors might well have given a little more carefully the history of the establishment of public school nurses in New York City, where their successful demonstration was first made and whence the impulse has radiated to other places, and it would have seemed fitting to record in this first general history of medical inspection the distinguished part taken by Dr. Lederle, then commissioner of health, in this movement, and the useful service of Miss Lena L. Rogers, who after making a successful experiment enjoyed the honor of being the first municipally appointed public school nurse, not only in this country, but in the world."

CONTROLLING AUTHORITIES.

Gulick and Ayres, in a chapter under this heading, discuss this question as to whether medical inspection should be under the control of the board of health or under the school authorities. Their conclusions in brief are:

(a) Medical inspection for the detection of contagious diseases may well be a function of the board of health.

(b) Physical examination for the detection of non-contagious defects should be conducted by the educational authorities or at least with their full co-operation, because they are made for educational purposes.

(c) The records of physical examinations must be constantly and intimately connected with school records and archives.

(d) They do not need to be connected with other work of the board of health.

All the school authorities whose opinions are quoted in this book advocate school control and consider medical inspection should be a part of the school economy, thereby avoiding divided authority, dual responsibility and friction, which

they hold must ensue from a system under the control of the board of health.

When we consider that the board of health is the supreme authority and sole arbiter in all things pertaining to the health of the community, this contention does not appear well founded. Even if the system should be under school department control there might arise conditions, when, because of its supreme authority, the board of health must step in and assume control.

School department control over the child is limited to the school, whereas the board of health has surveillance over the physical well-being of all, wherever they may go in the municipality, whether in the home, the street, the store, the factory or workshop, the public conveyance, the places of public assembly, including the schools.

Medical inspection under school department control cannot supply the so-called hiatus in the present system and enforce medical care upon children found to have physical defects as effectively as can the department of health. In the *Transcript* articles, we find the following: "The period of unrecognized convalescence after the contagious diseases and the consequent neglect of these children are busy supplying candidates for the Perkins' Institution for the Blind and furthermore are the cause of many of the heart and kidney complications so commonly found." This assertion is not in accord with facts, since the above-mentioned complications of the contagious diseases occur, if at all, during the height of these diseases and not some time later. As previously stated, over 60% of all cases of scarlet fever and diphtheria occurring in Boston are treated at the South Department of the Boston City Hospital. In scarlet fever, every patient remains in the hospital at least fifty days, at the end of which time the possibility of all complication has passed. If any complication has occurred during the course of the disease, information of the fact is given to the parents when it occurs and also at the time of discharge, when advice as to further treatment is given and the request made that the patient return at a certain time for further examination and advice. Heart complications in diphtheria are carefully watched for in this hospital and every patient is kept in bed a sufficient length of time to allow for their appearance. In the severe cases these complications occur very shortly after the disappearance of the membrane. In the milder cases, after two weeks or thereabouts in bed, if no heart complication appears, it is safe to allow the patient to sit up. In cases of post-diphtheritic paralysis, heart complications do occur, but in this event the patient is in no condition to attend school. As to contagious diseases treated at home, it is safe to say that both parents and attending physicians do their duty by the patient and no unrecognized convalescence can exist. No case of scarlet fever will be released from quarantine in less than four weeks; the majority stay longer. In diphtheria, two negative cultures for release are a sufficient safeguard.

The board of health must continue its medical inspectors for the purpose of overlooking contagion in the home or elsewhere and it does not seem practical in that event for the school authority to maintain another independent set of inspectors for the school work.

The prevention and care of contagion in the school or in the community at large cannot be divorced from the department of health, and since any system of school inspection must include this feature, it is obvious that the search and remedy for non-contagious defects are closely related to the former and should logically be under the direction of the department of health. Daily clinics in the schools seem to us unnecessary and objectionable, since schools are for education and should not have the semblance of a dispensary.

Dock, in his review of Gulick's and Ayres' book, says, in this connection, "In dealing with the question of control, the authors display a certain impatience with health boards. The arguments for control by the educational authorities are given much more fully than those in support of health boards, and yet the natural advantages of the latter bodies in promoting sound systems of medical inspection are great, as was pointed out in a set of memoranda presented to the committee for the study of the physical welfare of school children in New York City in 1908. The memoranda referred to advised divided control to this extent: For educational departments, everything relating to hygiene, both as to the child and his environment, rooms, seats, light, etc.; for medical boards, everything relating to curative and corrective treatment, not only so far as contagious diseases were concerned, but also to the ultimate extent of complete physical examination. This would seem to be the most rational division of responsibility."

Therefore it is evident that a system of medical inspection under the control of the school department would be somewhat limited and could not be so far reaching and effective as that conducted by the board of health. Consequently, it is clear that, viewed from the standpoint of preventive medicine, medical inspection of school children is essentially the work of a department of health.

A word as to some matters concerning the physical well-being of school children which have received but scant notice during the agitation for an improved medical inspection. The schools are overcrowded and "the portable," a small wooden building, has been placed in many school yards. It is to be regretted that all the children attending the schools cannot be housed in suitable buildings. Classrooms exist in many basements, where light is poor and ventilation bad, and where, very often after the recess, the odor from the toilets permeates the atmosphere. Classes are placed in some instances in corridors. If for any reason the thousands of children now attending sectarian schools should demand admittance to public schools, it is easy to see what confusion would ensue.

Many schools are oftentimes overheated, and in others there is no proper system of ventilation. Lighting is poor in many schools and causes eye strain to prevail, as shown by the recent sight tests. Gas as a means of illumination is bad, as it uses up much oxygen. There is a rule which calls for washing of windows only twice a year, in April, and in the early fall. It would be better hygiene to have the windows washed whenever necessary, as clean surroundings are essential to good health. Since the eradication of causes is sought, why not begin with the fundamental causes, viz., the conditions just mentioned, which concern the pupils' physical well-being, particularly in the primary grades. Signs of fatigue among children, as shown by yawning, nervousness and lolling on desks, are due in all probability more to faulty heating and poor ventilation than to physical defects in the children themselves.

Since the aim and object of any system of medical inspection of schools is to discover and remove all causes tending to lessen the full mental and physical development of our youth, then why should not the services of the nursing division, as well as the board of health inspection, be extended to include all schools, public and private. The health of the community and the physical upbuilding of the whole population is the concern of the state, and any movement to improve the welfare of school children should be made to include parochial and other private schools as well as the public schools, as a strong mental and physical development of the individual contributes to the strength of the state.

Although Boston is the pioneer city in the establishment of medical inspection of school children, it is obvious to all concerned that its system has many defects. To remedy the inefficiency of the present system we would recommend:

1. That the whole system of medical inspection, including physicians and nurses, be placed under the control of the Board of Health.
2. That a chief medical inspector be appointed, with deputies, if necessary, to have full authority over all, his function being to direct and control the work of the district inspectors and to see that each performs the duties required; also, through a supervising nurse, to direct the work of the nurses.
3. That the medical inspectors' powers be definitely determined and specifically set forth and that a proper compensation be given.
4. That the nurses be subordinate to the district medical inspectors and work only under their direction.
5. That a card system of records be devised, to be filled out by both physicians and nurses, one set to be kept at the schools and another set at the office of the chief medical inspector.
6. That the Board of Health and the School Committee co-operate in bringing about such needed reforms.

We feel confident that a system carefully prepared along these lines would prove ideal.

OBSERVATIONS ON EPILEPSY.*

BY EVERETT FLOOD, M.D.,

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THIS paper comprises observations resulting from the care of nearly 1,500 cases of epilepsy at the Massachusetts Hospital for Epileptics during a period of nine years. Results are noted and compared with those of observers elsewhere, for example: Deathrate, blood pressure, diagnosis of mental diseases, diagnosis of nervous diseases, age at onset of epilepsy, heredity in epilepsy, predisposing causes, estimation of number of epileptics in Massachusetts, number of persons who can help themselves, kind and amount of work, trauma, diet, etc., and some general remarks.

The main question of the need of the epileptic (what care is best for him, the general plan of separation from the insane, work, school, play, etc.) has been broadly discussed and was practically settled some years ago. We have still, however, a multitude of details to arrange.

The good done by such a place of retreat as the state hospitals furnish is illustrated by individual cases. It often happens that persons are free from attacks while residents in the hospital. Parents are at their wit's end to know how to care for a spoiled or refractory epileptic child. All calm and quiet is out of the question. Even the entire neighborhood is disturbed. The hospital takes this patient and at once all is calm. The person does not try to impose upon the more experienced caretakers here and is a little awed by the new surroundings, while the home settles down to quiet. An instance of a girl who had been the sole care of her entire family for years recently came up. She was more or less spoiled, though possessing a naturally mild and lovable disposition. If any noise occurred in the vicinity the family had thought only of a possible fall of this girl. There was a strained and careworn attitude all the time. The whole situation was improved by the removal of this patient to a hospital for the epileptic. She was herself far better off, was not discontented, but was hopeful of recovery and helped by her associations. She could attend religious services, entertainments, even dances, and soon formed a number of congenial associations. The family simply relaxed and would on no account return to the former pressure. We may also note the good done to the patient himself by regularity of life, work, diet, etc., the discipline, the freedom from fits, contentment (which is the rule), appreciation (which is often met) and many other advantages.

It is well to keep in mind, however, that a large number of epileptic persons are suitably cared for at home, and there is no doubt in many instances that a family properly situated, with judgment and right medical advice, can do better for their own afflicted member than any sanitarium. When the patient comes to the hospital facts are sought by written and verbal questions from the patient and family, both on admission and subsequently, as to all the points so far as we recognize

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