THE CONTROL OF VENEREAL DISEASES AT THEIR SOURCE IN CIVIL COMMUNITIES.

BY

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It may be pointed out that there are two essentially different modes of State intervention which may be adopted with a view to checking the spread of these maladies. The system at present in force in the principal countries of Europe regards persons of a particular class and sex as the chief agents in the diffusion of disease, and seeks to prevent it by keeping these persons under constant sanitary supervision, the supervision consisting of periodical medical inspections, in order to ascertain whether the disease is present or not, and by compulsory detention and treatment in hospital in case it is found to exist. In order to ensure the regular attendance of the women, they are required to enter their names and addresses on a register kept by the police, and those who fail to attend the inspection are liable to be arrested and imprisoned. This is the system commonly known as "regulation." The difficulty of enforcing registration and attendance is, however, very great; and in many countries the police encourage, as far possible, the aggregation of the women in houses of ill-fame, which are tolerated or licensed by the State on the understanding that the mistress of the house insists on the observance of the regulations by her inmates.

These *maisons tolérées* are regarded by many regulationists as the very core of the system.

The other mode of possible State intervention is to require doctors and others to notify all cases of actually existing disease of this kind, in persons of whatever class or sex, to the health authority, who is to inquire into the means of segregation and treatment (as in the case of other infectious diseases), and is empowered to remove the patient to hospital if necessary. It has been urged in favour of the latter method that it is not open to the objections brought against the former, as being unequal between men and women, or as encouraging immorality by superintending, in its interests, the health of those who minister to it.

A letter on the Majority Report on the Poor Law, in reference to venereal diseases in the United Kingdom, appeared on page 52 of the BRITISH MEDICAL JOURNAL of January 1st, 1910. The writer, Dr. H. T. Gillett, thought that some of the recommendations, if followed, must inevitably do harm. He also takes exception to the fact that the Poor Law Commissioners, in vol. i, p. 354, suggest that certain types of sick cases should be compulsorily detained; amongst these are:

1. Persons suffering from phthisis;
2. Persons suffering from venereal diseases.

For phthisis the Commissioners recommend "a diffusion of knowledge of its dangers."

For venereal diseases they recommend *compulsory detention*.

I would suggest, however, that both remedies be applied in the most thorough manner possible for the adequate control of venereal diseases. An international conference on the prophylaxis of venereal diseases which met at Brussels in 1899 recommended:

That since a thorough knowledge (*connaissance approfondie*) of venereology is one of the most important means of effectually combating the spread of disease, complete and compulsory courses of instruction in the subjects for all medical students should be instituted in every university so as to ensure the training of really competent practitioners.

They also recommended that the Governments should use their utmost powers to suppress the prostitution of girls under age, and that the utmost rigour of the law should be enforced against *souteneurs*—that is, men who live upon the earnings of prostitutes. Also,

That the statistics of venereal diseases should be drawn up in all countries on a common basis.

These, amongst other resolutions, were carried unanimously. Four of them aim at the prevention of vice as the root of the whole evil. The remainder seek to increase the efficacy and accessibility of medical aid, to apply a

stimulus to research, and to bring all results into a common treasury. There is no reason to fear the light, if only there is light enough.

Inquiries extending over twenty years in Brussels, and having for their object the discovery of the cause which led women to adopt a life of prostitution, elicited the fact that in 1,523 out of 3,505 cases it was poverty.

The foregoing facts, therefore, would appear to show the very real value of the suggested action on the part of the Poor Law Commissioners to control venereal diseases, since poverty cannot be controlled by them. Dr. Gillett also takes exception to the fact that the Commissioners urge "infringement of the liberty of the subject" by detaining such cases until cured, and he further expresses the opinion that:

Such would lead to concealment of disease and detention for very long periods.

What, however, is meant by the liberty of the subject? According to Mr. Conway Scott, in the *Sanitary Record*, 1894,

Liberty to be as drunken as you like,
Liberty to be as immoral as you like,
Liberty to propagate as much disease as you like.

As long as the public opinion of Christian Britain endorses such ideas no great improvement can be looked for in our national health, but the moment public opinion determines that the highest liberty is to live according to the laws of God . . . then, and not until then, can we have a marked improvement in the national health.

It is, however, quite an error on Dr. Gillett's part to suppose that it is necessary to detain persons for long periods in hospital; four to eight weeks amply suffice in probably 90 per cent. of cases in order to cure the more contagious earlier periods when disease is spread broadcast. I speak from seventeen years' special experience of this particular class of work, in many parts of the world, both amongst men and women.

The State of Massachusetts, U.S.A., in 1891, passed a law for the detention of certain persons affected with syphilis. In this law it enacted:

That persons suffering from syphilis and being inmates of any correctional or administrative institution, such as a house of correction, a penitentiary, or a workhouse, shall be placed under medical treatment and be isolated until the medical attendant shall consider further isolation unnecessary. And if, at the date of discharge of a person, syphilitic symptoms are still present and likely to prove a public danger, compulsory detention may be put in force to detain the infected person until such time as dangerous symptoms have been pronounced to be no longer present.

Concealment of disease to some extent tends to correct itself, as the person is commonly unable to walk, owing to gonorrhoeal orchitis, or to buboes supervening, and consequently is obliged to seek medical aid. In the army such aid is given in hospital. In civil life, however, such cases are often treated as out-patients, which is wrong but inevitable, as there is no law to control them and no beds to accommodate them.

Concealment can also be largely obviated by fine, or by notification from medical men, as is the case with any other contagious or infectious disorders which are dangerous to the public health. Such a system of notification now exists in India, and is of great value.

The communication of venereal disease to other persons is an offence punishable by fine or imprisonment in some countries—and very properly so.

It is the duty, I consider, not only of Poor Law Commissioners, but of the State, to interfere with the individual liberty of diseased persons, in the public interest, on financial apart from purely medical grounds.

The late Dr. Parkes said:

In the case of venereal diseases the State must as much protect its citizens as from the danger of foul water, or the chances of gunpowder explosives, or the risks of any other perilous and unhealthy trade.

I do not, therefore, endorse Dr. Gillett's view:

That it would seem more reasonable to endeavour to diminish venereal disease by lectures dealing with normal sexual physiological processes, or by parents speaking of these things to their children when they reach the age of puberty.

I think Dr. Gillett overlooks the fact of the innocence of the majority of children at puberty, and the utter impossibility of their being able to grasp the facts. The majority

of medical men and fathers would probably consider that, rather than speak to a young child of 14 or 15 years of age on this very delicate subject, it must run the risk of contracting disease, and, if necessary, that its liberty should be curtailed whilst it was being detained and adequately treated in order to prevent disease being transmitted.

By directing public opinion to this subject, which possibly constitutes the most important social problem of the day, and by obtaining the requisite legislation, fathers and medical men, if they do not succeed in benefiting their own children, may confer an everlasting benefit on the progeny of the next generation.

I would recommend the establishment of voluntary hospitals for those women who have not sunk too deeply in the mire, where they can seek medical advice and be reclaimed.

This particularly applies to clandestine rather than to irreclaimable prostitutes, who require more thorough supervision both in and out of hospital.

I would also recommend the compulsory notification of venereal disease, occurring both amongst men and women, by means of a confidential certificate, as now exists in the case of the medical examination of school children, and punishment by fine or imprisonment when it is reasonable to suppose that venereal disease has been spread by a person with a probable knowledge of the facts.

I would not accept ignorance as an excuse, if that person previous to transmitting the disease, had applied for aid to a private medical practitioner or to a public institution, such as a hospital or dispensary.

Solicitation by women, or by men who may finance the situation and live on the earnings of women, and all open scandal in the streets should be rigorously suppressed under the Town Clauses Act, 1847; and prostitution by alien women in London be much more adequately controlled by the police.

England, in regard to the control of prostitution, is fifty years behind the Continent of Europe. In Brussels the worst forms of syphilis are known as *English syphilis*.

Diseased women find their way from the Continent to England. They enjoy uninterrupted personal liberty and freely exercise it at the expense of the country of their adoption.

If we look back into ancient history we find that this problem has been faced before.

Moses, in many respects, anticipated modern sanitary science by about thirty centuries.

Prostitution, and all its attendant diseases, which destroy humanity, was abolished *in toto*; no daughter of Israel to follow such a business under the penalty of death.

Stranger still, nearly all the diseased, the syphilitic, the scrofulous, the epileptic, and other sufferers from the diseases of civilization, were isolated beyond the camp. Under such regulations, rigorously enforced, the national health was found to rise year after year, and at the end of forty a new race appeared, as strong and hardy and self-reliant as their predecessors were diseased, degraded, and cowardly.

In the camp of Moses the scrofulous could not produce again all his diseases in his wretched children, the syphilitic could not destroy and poison the very line of humanity by propagation of his fearful diseases, and the epileptic could not transmit his disease to his innocent offspring.¹

All Jewish children are circumcised in infancy. This extensively protects against syphilis but not against gonorrhoea. This is supported not only by Mohammedan practice, in India, in which class syphilis is much less than in Hindus, according to statistics from the police force in Bombay, but, as pointed out by Dr. G. Elliot Smith, it is also supported by Egyptian experience, before Rameses II, B.C. 1310-1243.² Tarnowsky quotes the case of three families with twenty-two children with syphilitic taint, from whom only one healthy adult survived. This was in the *intelligent class* of society.

Professor Fournier (Paris) records the case of a man who gave his mother syphilis by kissing her.

Mr. Buckley (New York) has tabulated 110 epidemics of innocently contracted syphilis, culled from literature, with a total of 3,000 victims. The common causes of conveyance, apart from heredity, are nursing, hand raising of infants, breast drawing, accouchements, vaccination, tattooing, household utensils, dental, barbers', and other instruments, kissing, pipes, etc.

He further states:

We approach the matter from the higher ground of "innocent" communication. The time has now come to place syphilis under the control of the proper health officers and to make it quite as criminal to transmit syphilis wittingly as it is to transmit small-pox, scarlatina, or diphtheria.

An attempt was made in England in 1870 to repeal the Contagious Disease Acts of 1864-66-69.

A Royal Commission reported in 1870:

That the worst forms of disease had been much reduced amongst the lower class of prostitutes, and that the women had benefited in an indirect manner. We are satisfied from the evidence that the frequent examination of women is the most efficacious means of controlling the disease.

On April 20th, 1883, however, by a chance vote of the House of Commons, the Acts were not repealed, but a resolution was carried:

That this House disapproves of the compulsory examination of women under the Contagious Disease Act.

The Judge-Advocate-General declared:

That though his vote might jeopardize his seat at another election, he must protest against any attempt to impair the efficacy of a system which had done much to check the progress and alleviate the severity of one of the most terrible scourges of humanity, and had also done something to mitigate one of the most prevalent vices of modern society.

There was an entire divergence of opinion between different members of the Government on the question of the Acts. This, in my opinion, arises from conflicting evidence and a lack of cohesion on the part of the medical faculty.

A voluntary system of control existed in England in 1884-5, and the Acts were totally suspended in 1886.

Mr. Parker Wilson, surgeon to Brixton Prison, London, states that:

Amongst 700 prisoners in 1882 the percentage suffering from venereal disease was only 2.9; in 1883, 4.5; and in 1884, 23.9 per 100.

There are no reliable statistics at present kept of the relative incidence of venereal diseases in civil communities in England, and we are obliged, therefore, to fall back on British army statistics, which are now thoroughly collected.

In England the Contagious Disease Acts were suspended in 1886.

In India the Lock Hospital system was temporarily suspended in 1886, and finally abolished in 1888.

Taking the average annual ratios for the years 1886-90, the admission ratios to hospital per 1,000 of strength for all forms of venereal diseases were, in the various foreign armies:

27	in the German,
51	in the French,
65	in the Austrian,
94	in the Italian,
202	in the British.

As far as my experience is concerned, where British troops are stationed and where no control exists over prostitute or diseased women, the average annual incidence of freshly contracted syphilis amongst soldiers is about 2 per cent.; gonorrhoea is three times as frequent. The relative incidence is probably less than this in civil life, allowing for the beneficial influence of marriage and other factors.

In London, therefore, with a population of 5,000,000 people, about 75,000 to 100,000 persons contract syphilis each year. In New York City, 50,000 persons are infected in each year, but the population is much less than London. Three times the above number probably contract gonorrhoea in these cities. Under one hundred beds exist in the civil hospitals in London for the treatment of these diseases, one of which—syphilis—may be perpetuated even to the fourth generation, in various forms, such as lunacy, epilepsy, etc.

In Paris 2,000 beds exist for treating syphilitic disease; and, as London is five times the size of Paris, the provision of 10,000 beds would be inadequate.

In France and Germany control is exercised over prostitute women of all classes and over venereal cases. In France, according to *Le Noir*, "amongst the adult males of Paris the proportion of known syphilitics was not less than 13 per cent."

Fournier, working on the statistics of general hospitals, gives 13 to 18 per cent. Working on analogy, London must be higher, since no control exists.

Dr. Holland, in 1854, estimated that in the United Kingdom at least a million and half persons were infected with syphilis every year.

In New York 300,000 cases of skin disease gave a percentage of 11.5 due to syphilis.

At the Moscow Hospital, Russia, from 1850 to 1870, there were 2,002 births from syphilized parents, and of these 1,425 (71 per cent.) died.

Fournier, in Paris, found:

That fully 25 per cent. of all females whom he had seen in private practice had contracted the disease innocently and undeservedly. Of the married females, in 75 per cent. of cases the disease was unmistakably traced to the husband.

In India we have results which, in my opinion, as a demonstration of the possibility of control, will never be surpassed in any country. The native population of India is 300,000,000, and there has been in the past fifty years a garrison of about 70,000 British soldiers.

In 1888, the Lock Hospital control over women was finally abolished, and venereal diseases rose year by year until, in 1895, the admissions to hospital for all forms of these diseases reached the enormous total of 537 per 1,000 of strength.

Further, in 1897, 661 invalids for venereal diseases were sent to England in one year. Control, by means of the Cantonment Code, October, 1897, again commenced in 1898. In 1908, ten years later, the admissions to hospital for all forms of venereal disease were reduced to 70 per 1,000 of strength, and 59 invalids sent to England. How did this occur?

The following will briefly explain. Under the Cantonment Code, 1897, and other measures:

- (a) Notification exists.
- (b) Diseased men and women are isolated and controlled in hospital, or otherwise, for four to eight weeks, as is the case with any other contagious disorders.
- (c) Prophylaxis by in-patient and later out-patient treatment is rigorously and systematically enforced.

The financial saving in regard to India has thus been enormous. In 1895 there were over 3,000 soldiers constantly sick in hospital with venereal disease, and in 1908 about 500. In 1897 there were 661 invalids sent to England for venereal disease, and in 1908 only 59.

A trained soldier landed in India costs the State £100, so if 661 invalids from venereal disease leave India in one year the loss represents many thousands of pounds—this quite apart from the fact that a soldier's food costs the State 1s. to 1s. 3d. per diem in hospital. The food of a diseased native woman in hospital costs 4d. I leave the details to actuaries, but the actual saving to the State would possibly pay the interest at 5 per cent. on capital sufficient to build several Dreadnoughts.

Taking the civil aspects in England, a corresponding reduction in the maintenance of lunatics, epileptics, and persons with paralysis or locomotor ataxia due to syphilis, as well as a reduction in the number of blind infants and sterile men and women who have had gonorrhoea, quite apart from lessened poor rates, etc., would probably repay in a few years the capital outlay that these Dreadnoughts cost.

"The Royal Commission on the Blind, the Deaf, and the Dumb, which reported to both Houses of Parliament in the year 1889, estimated that about 7,000 persons in the United Kingdom had lost their sight from ophthalmia neonatorum, and assess the cost to the State of each of them at £50 a year, on the basis of £25 for keep and £25 for loss of useful work. That is, the cost to the State for these cases of preventable blindness is £350,000 a year."

This disease within the last year, however, is notifiable in England.

It is to be hoped, therefore, from a financial, apart from a public health point of view that preventable diseases like syphilis and gonorrhoea will also be notifiable before the millennium.

This problem goes far beyond the purely medical aspects, and is well worthy of the consideration of those statesmen who have their country's welfare at heart, as in many instances venereal diseases are so largely dependent

on poverty and spread by the poor in a dying effort to exist.

In conclusion, we may add with Professor Fournier of Paris, in imitation of another proverb, that "the fear of syphilis is the beginning of wisdom."

We are also with him in quoting Pasteur's fine thought that "Where good is to be done duty only ceases when there is no longer power to do more, or to do better."

REFERENCES.

¹ Conway Scott, *Sanitary Record*, 1894. ² BRITISH MEDICAL JOURNAL, January 29th, 1910, p. 294. ³ A. Stanley Parkinson, *ibid.*, August 28th, 1909, p. 577.

A NOTE ON THE COMBINED USE OF SPINAL AND GENERAL ANAESTHESIA.

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IN spite of the advocacy of enthusiasts for spinal anaesthesia it must be realized that this method of rendering the lower part of the body anaesthetic is not yet free from danger, and it is extremely doubtful whether it will ever replace general anaesthesia for routine work. In selected cases, however, spinal anaesthesia presents such great advantages over general anaesthesia that it is certainly the method of choice. With patients who have a dread of being rendered unconscious, in cases of emergency where the operator is single-handed, in some acute abdominal conditions, and in cases of disease of the heart and lungs, spinal anaesthesia is certainly to be preferred to a general anaesthetic. Also, as I have pointed out in an article on amputation for diabetic gangrene,¹ in conditions associated with fatty changes in the liver and other organs—as, for example, diabetes, rickets, alcoholism, starvation, malnutrition, and the cyclical vomiting of children—a deep degree of general anaesthesia is to be avoided from fear of bringing on acid intoxication, which may lead in diabetes to coma and in the other conditions to "delayed anaesthetic poisoning."

But by far the most important and interesting question in considering the advantages of spinal anaesthesia, is its action in the prevention of shock. It is now generally admitted that if all impulses from the area of operation or injury be prevented from reaching the central nervous system by the employment of this method, shock from this source is either absolutely prevented or at any rate minimized. It must, however, be remembered that psychic influences may bear no small part in the production of shock, and impulses from the highest centres may affect the vital centres just as seriously as the effects of trauma at the periphery.

Crile^{2,3} has always insisted on this element in the production of shock, and has lately published⁴ the results of experiments, which show that definite changes occur in the cells of the brain as the result of fear. He has clearly proved that trauma, anaemia, infection, and fear, not only produce very definite symptoms, but that singly or in combination they damage the brain cells, and so influence the immediate results of surgical operations. In Graves's disease, when the patients are especially susceptible to fear, he has seen death occur from fear alone. Working on these lines Crile has often advocated the combination of general anaesthesia with local and regional anaesthesia, and his plan has been followed by many in cases of emergency. I have reported⁵ a successful case of amputation for diabetic gangrene in which nitrous oxide anaesthesia was used in conjunction with nerve blocking, and Crile⁶ states that since following this plan he has amputated twelve times for gangrene of the leg without a fatality. "Indeed, there is usually no noticeable operative effect."

In reporting my own case and also elsewhere⁷ I expressed the opinion that many advantages might be gained by the use of a combination of spinal anaesthesia with a light degree of general anaesthesia. By the spinal injection the vital centres will be protected from injurious impulses from below, while by general anaesthesia the effects of fear will be prevented. There are three ways in which spinal anaesthesia may be used in conjunction with a general anaesthetic. The solution of stovaine or