

THE PROBLEM OF HOME ISOLATION OF LEPERS IN THE PHILIPPINES

BY THE LEPROSY ADVISORY COMMITTEE
OF THE DIRECTOR OF HEALTH¹

TOPICAL SUMMARY

Introduction

Purpose of the proposed change of law

Status under the existing law

Medical aspects of the question

Course of the disease; special treatment; general medical management; availability of facilities.

Conditions and implications of home isolation

Conditions; implications

Past experience and present opinions

Past experience: Norway; Rumania; South Africa; Brazil; Java.

Present opinions

Earlier leprosy conference; Philippine Leprosy Commission; Cairo Conference; Philippine Council of Hygiene

Is home isolation practicable in the Philippines?

Conclusions

INTRODUCTION

During the recent (1940-41) session of the Philippine Assembly there was introduced, as has been done repeatedly in recent years, a bill intended to modify the present law with regard to isolation of the leprosy patients who, under present regulations, are confined in leprosaria. The essential difference between this bill and the present law is that it would provide specifically for the practice of home isolation. At a public hearing held on March 14, 1941, by the Committee on Health, attended among others by government officials, it was asserted that in view of the discretionary powers vested

¹Memorandum to the Director of Health, prepared in June, 1941. Chairman, Dr. Jose Guidote, Chief, Division of Epidemiology; Members, Drs. Casimiro B. Lara, Chief Physician, Culion Leper Colony; Cristobal Manalang, Chief Pathologist; Jose N. Rodriguez, Supervising Physician, Regional Treatment Stations; Jose G. Samson, Chief, Section on Leprosy Control (Secretary); Felix Velasco, Physician in Charge, Leper Department, San Lazaro Hospital; and H. W. Wade, Medical Director, Leonard Wood Memorial and Consulting Pathologist, Culion Leper Colony.

in the Director of Health it was not necessary to change the law in order to attain the proposed end. Action on the bill was suspended.

Subsequently, three inmates of the San Lazaro Hospital formally requested that, in accordance with that interpretation of the law, they be immediately released and allowed to be treated in their homes by private physicians. With the persistence of the agitation the Director of Health requested the opinions of certain members of the staff of the Bureau on technical questions which bear on the subject of home segregation. The present memorandum, which represents a synthesis of the opinions of those individuals, was prepared in a meeting which was later convened in Manila.

PURPOSE OF THE PROPOSED CHANGE OF LAW

It seems clear that there is no intention, in any authoritative quarter, to abandon the effort of control of leprosy in the Philippines by segregation or isolation of infectious cases to prevent contact with healthy persons. The impetus of the proposal to modify the existing law is humane sympathy for the unfortunate persons who because of their disease have been confined in leprosaria, and the objective is to lessen the disabilities and distress of those who have thus been separated from their families and friends. The question of how well that particular objective would be attained by home isolation under conditions necessary to avoid danger to others is one of the most important points to be considered. Other questions include that of how enforcement of those conditions could be secured, and—not unimportant—what the effect would be on the general welfare of their families.

Fundamental to the question of maintenance of isolation in the home is the fact that the persons with leprosy who clamor to be permitted to live at home believe that in this way they would be relieved of the onus of the restraints to which they are now subjected; they expect that in that way they would gain relative freedom. There is reason to believe that they have little if any concept of the limitations to which they would be subjected—to say nothing of the expense—by the conditions that it would be necessary to establish in order to protect those around them.

STATUS UNDER THE EXISTING LAW

Leprosy is a peculiar disease, vastly different in many respects from other known infectious ones, and the measures for its control must take these peculiarities into account. The measures employed in the Philippines are predicated on the generally accepted facts that the disease is infectious and transmitted mainly by contact. Its fundamental epidemiological characteristics are, first, that

the bacteriologically positive case is the principal source of infection, and, second, that the infection is transmitted by such cases to susceptible persons—the most susceptible, it is generally believed, being infants and children. It must be stated, however, that there are other possible means of transmission besides contact which cannot yet be entirely excluded, and these possibilities have to be considered and provided for in instituting any form of isolation.

The law establishes the bacteriological examination as the basic criterion for determining which individuals are to be isolated. Those found positive for *Mycobacterium leprae* are required to be isolated, irrespective of the type and advancement of the disease in them, whereas no individual can be permanently segregated if the bacteriological findings are negative. Suspicious cases may be placed temporarily in isolation for proper study in order to arrive at a definite diagnosis, but in no instance can such suspects be detained for more than three months.

At the time the leprosy law was promulgated, it was evidently considered that the bacteriological examination was the crucial factor in the establishment of the diagnosis. Since that time, however, considerable progress has been made with regard to the early, clinical recognition of the disease, and it is now possible in many cases to arrive at a definite diagnosis long before the bacteriological examination becomes positive. Furthermore, most cases of the neural type remain bacteriologically negative indefinitely, and in this country such cases are not isolated. It is therefore a fact that many persons definitely known to be leprosy but who are not bacteriologically positive and are consequently called "clinical lepers," are not segregated but are permitted to live in their homes.

In spite of these advances in diagnosis, no change in the law with regard to the bacteriological examination is considered necessary for the present, in view of the generally—though not universally—accepted opinion that the bacteriologically negative cases are only slightly contagious if at all.

The fact that there are persons with clinically recognizable leprosy lesions who are allowed to live in their homes is not generally known by the public. Furthermore, many of those who are aware of their existence do not realize the large number of them. There are already recorded by the Bureau of Health about 3,000 such persons. Actual field surveys have shown that, in every locality surveyed, there are as many such "clinical" cases as there are bacteriologically positive ones. The results of treatment in early cases of this kind are very encouraging. The existence of such large numbers of persons with leprosy in its early and other supposedly

noninfectious forms permitted to remain in their homes should be extensively publicized, in order to encourage early presentation of individuals suspecting themselves of having the disease.

Another group of bacteriologically negative cases consists of the paroled "negatives." These, however, will merely be mentioned in passing since they are of no particular concern in connection with the present discussion.

In the early period of application of the segregation policy in this country there was almost universal opposition to it on account of the fact that, at that time, segregation in a distant leprosarium meant virtually the separation of the leprosy person from his family for life. Subsequently, public cooperation was at least partially secured through the introduction of measures designed to alleviate the condition of the segregated lepers. Three of them may be mentioned:

1. Paroling of negatives, started about 1922, made possible by improvements in treatment.
2. Establishment of regional treatment stations, beginning in 1928, which permitted the isolation of patients nearer their homes.
3. Granting of pass privileges, also introduced in 1928, to segregated patients in case of need under conditions covered by regulations.

Such modifications tending to humanize the practice of leprosy segregation have been introduced by the Bureau of Health as rapidly as increasing knowledge of the disease has permitted. The question now under discussion is whether or not a further attempt in that direction can be made through the introduction of the policy of home segregation. A correlative question is whether or not it can be permitted under the law as it stands at present.²

MEDICAL ASPECTS OF THE QUESTION

Course of the disease.—Leprosy runs a very chronic course, the disease or its sequelae affecting the individual in whom it becomes well established practically for life. In some cases—the proportion has not even approximately been determined—the disease is arrested and undergoes spontaneous resolution during the incipient or fairly early stages and may not again become clinically active. In the Philippines possibly 25 to 30 per cent of cases which have been discovered, or which can be recognized with the usual

²The report as submitted contains at this point a discussion of the question: Is home isolation allowable under the present law? Being of purely local interest, it is not included here.

methods of examination, are susceptible to lasting clinical cure. The majority, however, are of the more serious, more intractable forms. Such cases undergo periods of quiescence or arrest, alternating with periods of increased activity, but in these the disease tends to become progressively worse and incapacitating. In many cases there develop festering ulcers, eye involvement, and more or less serious sensory and motor disturbances. If in some cases the disease in this severe form eventually dies out before the patient succumbs, he is usually left largely helpless—crippled, deformed, and perhaps blind.

Many patients in the course of their illness also undergo acute phases, characterized by periods of fever, painful eruptions, and various other disturbing manifestations. These attacks may last from a week to months, and a series of such reactions may extend over a period of years. Whenever such reactions are sufficiently severe, which is not rarely, the patient is necessarily confined to bed and requires almost constant medical and nursing care.

Patients with leprosy seldom die of leprosy. For many years, as a rule, practically normal physical and intellectual energy and mental and emotional reactions are conserved. Sooner or later, however, progressive deterioration supervenes, at least in the physical sense, and this is further aggravated by an increasing susceptibility to intercurrent illness. Tuberculosis, nephritis, the pneumonias, septicemias, and gastro-intestinal disorders are the most frequent direct causes of death.

Special treatment.—Treatment (chaulmoogra, etc.) is of great help in most of the cases with the benign forms of the disease, as well as in many of the earlier cases with the more severe forms. Nevertheless, complete or lasting cure cannot as yet be positively assured in individual cases, with any known form of therapy. Yet there is need for constant and adequate medical care, primarily to obtain a cure whenever possible, and always to alleviate the suffering and promote the comfort of the patient, as the disease becomes more and more intractable and the patient more and more incapacitated. The very advanced cases, also, invariably require more or less constant general and nursing care.

General medical management.—From what has been stated above, it follows that the medical management of a case of leprosy requires specialized training and familiarity with the disease on the part of both the medical and the nursing attendants. It is not sufficient that the physician possess a general idea of the course and clinical manifestations of the disease; he must have had enough practical experience—i.e., he must have observed and treated an

adequate number of cases—to enable him to recognize the different forms of the disease and the peculiarities of the course of each of them. Such experience is necessary, particularly with respect to the employment of therapeutic measures, not only that the patient may derive the greatest benefit, but also in order that possible injury may be avoided and that a judicious appraisal of the treatment as well as the prognosis may be made. The ability of the attending physician to recognize and manage the more common complications and intercurrent affections is of course essential.

Availability of facilities.—All or nearly all of the necessary medical and nursing care that a patient with leprosy, in the majority of the cases, would sooner or later require are actually either directly available or can be made readily available in any of the organized institutions for the care of leprosy patients in this country. Special antileprosy treatment, constant observation, and hospitalization—with all the benefits this affords, as regards general therapeutic, nursing and dietetic care, together with laboratory and other diagnostic facilities and surgical and other special therapeutic services—can indeed be provided for only in such institutions, except at great expense. The same is true with regard to opportunities for occupational therapy, vocational training, recreation, and even some sort of gainful occupation. For his proper care, such facilities and opportunities as those mentioned should be available to the patient for the entire period of his isolation, wherever that might be carried out. Without them his care would be far from adequate. It may be safely asserted that in the long run the individual patient, if isolated at home, would in the majority of instances find that the advantages which might be gained thereby would be greatly outweighed by the disadvantages.

CONDITIONS AND IMPLICATIONS OF HOME ISOLATION

Judging from conversations with leprosy patients themselves, as well as with others, it would appear that most people have a vague if not an altogether mistaken conception of the meaning of home isolation. It is generally agreed that, in order to control leprosy, isolation of infectious cases is necessary, whether it be in a leprosarium or elsewhere. If this should be attempted in the home it would not suffice merely that the patient refrain from contact with persons outside his home—i.e., that he merely be confined to the home. He would have to be isolated *within* the home, from contact with other members of the family, and that would involve conditions so severe that normal home life would be impossible—constantly, over the long period of the duration of the disease.

Conditions.—For home isolation to be at all effective, the patient, first of all, would have to be provided with separate quarters for his comfort and sanitary needs, whether within the family domicile or separate from it. He would have to avoid contact with all healthy persons—especially children, including his own—except, perhaps, an approved attendant; consequently, he would have to be self-sufficient in most of his necessities. He would not necessarily have to prepare his own food, but the washing of his tableware—which would have to be kept apart—and the other household chores, if not all done by himself, would have to be done by an adult person sufficiently intelligent and instructed to avoid danger of infection of him- or herself and of others; his laundry would have to be disinfected before removal from his quarters, if not washed there. He could not join his family in their ordinary daily activities and pleasures, nor could he frequent public places or participate in the public gatherings common to community life; he could not attend church services or go to the theater, nor could he eat in restaurants. He would have to arrange, himself, for the necessary medical care, and for nursing care in case of intercurrent illness and when incapacitated by the disease.

It will be apparent that home isolation in its real sense—avoiding exposure of others to infection—would not really be “freedom,” as is believed by many of the segregated patients; actually it would lead to even a more restricted life than in a leprosarium. The individual’s opportunities for recreation and entertainment would be limited in the extreme, and the possibilities of gainful occupation would be practically nil; whereas in the leprosaria the inmates do have some kind of community life, may enjoy close friendships and companionships, and can often engage in beneficial and even gainful occupations. The expense that would be involved in home isolation, properly established and maintained, would obviously be heavy.

Implications.—Under the necessary conditions of home isolation indicated above, it is obvious that the patient and his family would have to be under the closest and most constant supervision by the authorities in order to prevent violation of regulations. Otherwise, with only perfunctory supervision, there is little probability that real isolation would be achieved. Those concerned would of course facily agree to the conditions imposed, in order to attain their immediate purpose—release of the patient from the leprosarium. So do patients who are being paroled agree facily to report for continued treatment and observation thereafter—and rarely do they honor their promises afterward.

Human nature is not changed in persons who acquire leprosy. Many leprous parents at Culion are very reluctant to allow their infants to be removed to the nursery, an extreme manifestation of selfishness in view of the grave danger of infection to which they submit their children in keeping them. Experience in the leprosaria affords many examples of repeated fondling of young children brought to visit their leprous parents, in spite of admonition and advice; and instances could be cited of more intimate relations between inmates and visiting spouses. Could it seriously be expected that an adult married leprosy patient, supposedly isolated at home but of course not under guard, would through the long, unoccupied days and nights of many months and years remain apart from his wife, or refrain from playing with his children? Could the leprous child, who in the leprosarium would find playmates and opportunities for play, be expected to remain alone in a separate room or behind a confining fence and not join in the play of his brothers and sisters and of the neighbors' children?

PAST EXPERIENCES WITH AND PRESENT OPINIONS
CONCERNING HOME ISOLATION

PAST EXPERIENCES

The intimation of doubt of the effectiveness of home isolation expressed above is not based on personal opinion so much as on experience elsewhere in the past, which cannot be ignored. The one example that is always mentioned by advocates of this system is Norway, but as will be seen the conditions there are peculiar and the example is unique. On the other hand attempts in this direction made in Rumania and South Africa proved unsuccessful, leading to home propagation of the disease rather than its control. What is known of this matter, from the literature or personal observation, will be reviewed briefly. The subject was discussed at some length several years ago by one of us.³

Norway.—As stated, Norway is the sole outstanding example of a country in which home isolation has been employed apparently to advantage, but in a review of the control of leprosy there Lie has stated that they had always tried to isolate in institutions the cases in which the danger of infection was presumably greatest, "whether the danger lay in the form of the disease itself or the conditions prevailing in the homes."⁴

³ RODRIGUEZ, J. N. *Month. Bull. Bur. Health* 16 (1936) 161.

⁴ LIE, H. P. *Trans. Roy. Soc. Trop. Med. & Hyg.* 22 (1929) 357; reprinted in *Internat. J. Leprosy* 1 (1933) 205.

In that country "home isolation" meant real isolation in the home. The regulations required, among other things, that the leprosy patient have his own room:

" . . . where he eats by himself with his own table utensils, etc., and where he must remain when he is not out in the open air."

Lie asserted his belief that this measure, though admittedly not always adhered to, was significant in the decline of leprosy in the country, for in general the regulations seem to have been enforced. The public was made health-minded, and it insisted on complete isolation of the leprosy patient. This attitude was developed chiefly by persistent activity carried on in the leprous districts, beginning as early as 1850. In them there were established health committees which were enjoined to see to it, by close observation, that all individual patients isolated in their homes complied with the regulations, and they held periodical meetings at which their wards were discussed in detail. Under the district physicians they carried on educational work of detailed character. Although these supervisory committees were composed of the patients' own townmates, the system worked very well. The reason probably lies chiefly in the temperament and discipline of the Norwegians.

In evaluating the factors which led ultimately (in some ninety years) to the virtual disappearance of leprosy from Norway, Lie attaches great weight to improvement in the economic and general hygienic condition of the people. In conclusion he states, in part:

The course of leprosy in Norway must be regarded in connection with the whole economic and cultural history of the country. The increase and decline of the malady seem to follow, at some distance, periods of depression and prosperity in the country. . . . The great decrease in the prevalence of the disease since 1856 must therefore be regarded in the light of the great progress the country has made during that time in all respects, and not least in hygiene and sanitation.

Rumania.—In this country, according to Babes,⁵ the law providing for home isolation was passed in 1897 but not applied in full force until 1903. In the intervening period, 245 leprosy patients isolated in their homes gave rise to 83 new cases, an incidence of 33 new infections for every 100 patients so isolated. During the next five-year period (1904-1908), when the law was fully enforced, 123 cases studied by Babes gave rise to 61 new infections. This rate, 50 new cases for 100 leprosy patients, represented a marked increase in the infectivity rate, precisely during the period when home isolation was employed with maximum force. This led to the abandonment of the method.

⁵ BABES, V. *Lepra* 10 (1910) 152.

South Africa.—Though little could be quoted from the literature regarding home segregation in South Africa, one member of this conference, in visiting that country, was informed by the health authorities that the system was introduced many years ago but proved unsuccessful. Only members of the Boer element of the population were in a position to enjoy the privilege, and of them only property owners who built separate quarters in which the leprosy patients were supposed to live apart. In actual practice, however, they did not comply with requirements and new cases arose around them. (In one instance, it was said, 20 new cases were traced to one person so “isolated.”) The law was not modified, but new control regulations were imposed—including one which required full-time service of a trained nurse—which made home isolation prohibitively expensive.

Brazil.—Information was obtained by one of us, when visiting Brazil in 1938, that home isolation is permitted under the regulations, but that few persons are in a position to avail themselves of the privileges and that it is not encouraged by the health authorities.⁶

Java.—Home isolation in some of the villages of Java has been mentioned in reports, and its application in one village was demonstrated in 1938 to a party of which one of us was a member. The situation as observed was obviously a travesty on “isolation”; if the leprosy patients concerned actually lived apart from their families and neighbors, it was only to a limited extent.

PRESENT OPINIONS

The question of home isolation of patients with leprosy has been considered seriously by more than one authoritative group in recent years. Their opinions are noted here.

1. *The earlier leprosy conferences.*—The first three international conferences, between 1907 and 1923, were held in Europe and were composed mainly of Europeans, few of whom had had any experience with leprosy in the field or with conditions in other regions that affect the matter of control. Consequently, they were influenced overwhelmingly by the experience in Norway; and it is but natural that the conference held in that country (Bergen, 1909) recommended isolation of patients either in institutions or in

⁶ Speaking at the Fifty-fifth Annual Meeting of the Conference of State and Provincial Health Authorities of North America, May 8-11, 1940, held in joint session with the Pan-American Conference of National Directors of Health, Dr. de Barros Barreto, formerly director of health of Brazil, stated that in that country “home isolation, always to be suspected of inefficiency, is reserved for special cases.”—EDITOR

their own homes. The same conditions prevailed in the third conference (Strasbourg, 1923), and it concluded, in part, that:

1. The legislative measures concerning the fight against leprosy should differ according to the countries where they are to be applied. . . .
2. In countries where leprosy is not widespread, isolation as it is being done in Norway, in a hospital or in the home, is recommended if such an arrangement is possible.
3. In endemic foci of leprosy, isolation is necessary.
 - (a) This isolation . . . should allow the patients to remain near their families, if this measure is compatible with effective treatment.

The first international meeting in which the viewpoint of the practical field worker predominated was that of the Leprosy Commission of the League of Nations, which met in Bangkok in December, 1930. It dealt primarily with the problem of prophylaxis. The Leonard Wood Memorial conference, held in Manila shortly afterward (February, 1931) its personnel including the members of the League Commission, did not discuss that subject but approved in principle the report of the latter group. It is a noticeable fact that the report avoids mention of home isolation. Its essential feature relative to the present problem is as follows:

The isolation of infectious leprosy patients, on a proper basis, still remains one of the essential measures in the prophylaxis of the disease. . . . *The isolation of patients with leprosy should be carried out in accordance with the circumstances prevailing in the countries involved.*

2. *Philippine Leprosy Commission.*—In 1935 this matter, among many others, was dealt with by a commission appointed by Governor-General Frank Murphy, who on July 23 had vetoed a bill which provided for radical changes in the system of leprosy control in the Philippines. The sections of their conclusions and recommendations which are pertinent to this question are as follows:

Conclusions: (d) Under conditions as they exist in the Philippine Islands the segregation of bacteriologically positive patients with leprosy is and must continue to be the basic measure for the control of leprosy. The form of segregation employed should be that which will afford the necessary protection for the public and interfere as little as possible with the rights of the patient.

(e) The segregation of the individual leprosy patient in his own home is impracticable as a control measure in the Philippines. Home segregation, theoretically, would permit the individual to remain with the adult members of his family, but this single advantage would be far outweighed and nullified by the many disadvantages. In practice it would not protect the family, especially the children, or the community. The environment created by home segregation would not be for the best interests of the individual segregated, and it would tend to have an adverse effect on the progress of the disease under treatment.

(Recommendations) : 1. That group segregation be continued as a basis of leprosy control in the Philippine Islands.

3. *Cairo Conference.*—The Technical Committee* on Epidemiology and Control of the International Leprosy Conference held in Cairo in March, 1938, reported as follows on this subject:⁷

(1) *Isolation of open cases.*—The present view is that the open case constitutes the greatest danger to the public health, and therefore such cases should be prevented from contact with healthy persons, especially children. This has been attempted in the following ways: (a) isolation in institutions, (b) isolation in the patients' own homes, (c) isolation in villages.

(b) *Isolation in the patients' homes:* Isolation of a person with leprosy on his own premises may be designed to separate him from the public and from members of his own household, or from the public only. In neither case do we consider home isolation to be a generally effective method. This applies especially to isolation from the patient's own family. Exceptionally, under favorable circumstances (for example, in the case of a wealthy patient), home isolation may be possible. Home isolation is not recommended as an alternative to institutional isolation.

4. *Philippine Council of Hygiene.*—Later in the same year, in a report on "the present status of leprosy based on Dr. Manalang's plan of leprosy control"⁸ the (Philippine) Council of Hygiene concluded that the principle of control laid down by the committee of the Cairo conference just cited coincides with those to which it, itself, subscribed; and it ended as follows:

The Council of Hygiene believes that the method of prevention and control of leprosy as laid down by the International Congress on Leprosy held in Cairo, March 21 to 27, 1938, conforms to the system already adopted in the Philippines since 1906 as modified from time to time, and this Body recommends that further studies on the leprosy problem be continued with a view to introducing such improvements as may be warranted by the facts and local peculiar conditions prevailing in this country.

IS HOME ISOLATION PRACTICABLE IN THE PHILIPPINES?

The considerations which lead this conference to a negative opinion on this question, quite aside from experience in other countries, are as follows:

⁷ *Internat. J. Leprosy* 6 (1938) 389-417.

* The personnel of this committee was as follows: Dr. R. (now Sir Rupert) Briercliffe, from Nigeria; Drs. R. G. Cochrane, from India; E. Agricola of Brazil; A. V. Bernard of Malta; Et. Burnet, from Tunis; M. Dalgamouni of Egypt; T. F. Davey, from Nigeria; J. A. Doull of the United States; G. Gushue-Taylor, from Formosa; P. H. J. Lampe, from Java; E. Marchoux of Paris; J. N. Rodriguez of the Philippines; (Col.) A. J. H. Russell, from India; I. Santra of India; G. M. Saunders of the United States; D. S. de Simon of Ceylon; H. C. de Souza-Araujo of Brazil; and J. B. Sitanala of Java; also Mr. Perry Burgess, of the Leonard Wood Memorial, and Mr. A. D. Miller, of the Mission to Lepers, India.

⁸ *Month. Bull. Bur. Health* 18 (1938) 545-551.

(1) It must be emphasized that, since there is no known method of immunizing against leprosy, or any other relatively simple measure of preventing transmission of the infection, it would be necessary in order to protect the families of the patients isolated at home to impose conditions that would limit severely the freedom of action of the person so isolated. Because of the exceptional chronicity of the disease, these measures would have to be maintained over periods of years or even decades.

(2) Unlike the victims of other contagious diseases, the person with leprosy remains for years strong and active, capable of participating in most of the activities, recreational and otherwise, of the normal persons around him. The restraint that would be necessary to prevent his endangering his family, and others over a larger territory, would soon become and long remain onerous in the extreme.

(3) Factors that need not be enlarged upon here are the force of sentimental attachment within the family, and the as yet not high development of hygiene-consciousness of the people as a whole. The latter factor might perhaps be modified in time by some such measure as the system of local health committees employed in Norway to help in supervising the patients isolated at home, and to instruct them in matters of hygiene—the latter being probably the best feature of their work. However, since our circumstances and customs are very different from those of the Norwegians, even that method would not be sure of success. The first factor mentioned is an outstanding one in connection with this disease because of its peculiarities. The fact that the manner of its transmission is not obvious (or, in fact, known with certainty), that the infection rate is variable, and that the appearance of manifestations of infection are as a rule greatly delayed, make the situation vastly different from that with respect to the acute infectious diseases which strike quickly and frequently are attended by high mortality. The leprosy patient may mingle with his family and play with his children freely perhaps for years before any harm may become evident. Through such long periods it would require almost superhuman self-control—to say nothing of an unusual appreciation of the principles of hygiene—to impel him, of his own volition, to hold himself rigidly and constantly apart.

(4) Under all of these circumstances it would be obvious, if experience elsewhere had not long since shown it to be so, that patients with leprosy granted the privilege of home isolation would have to be kept under close and continuous observation by the health authorities. Special provision would have to be made for

this supervision if it were not to be merely perfunctory and utterly ineffectual.

(5) Only a very small proportion of the families of leprous persons in segregation would be financially able to meet the necessary conditions of home isolation. As a result, many of the patients might feel that they were being discriminated against ("class legislation"). The possibility must be considered that there might follow more vociferous and widespread protestations than at present.

(6) Since so few patients could take advantage of the privilege, it cannot be seen that this modification of the present practice would modify the present situation with respect to the expense to the government of segregation of leprous persons. On the contrary, we have to consider a probable increase of expense if proper supervision of the patients allowed home isolation were to be carried on.

(7) From the social point of view, there should be taken into account certain considerations that would effect the families of the patients, quite aside from the expense involved. The existence of a leprous person in the family is, however wrongly and unfortunately, a stigma. After the patient has been sent to a leprosarium, in the course of years the fact that a case had developed in the family may be forgotten, or at least quite overlooked, especially if realization of his misfortune had not become deeply implanted in the minds of the community. Thus the social handicap may be overcome; the unmarried members of the family may then find opportunities to marry. But if the patient should be isolated in the house he would remain an ever-present reminder of the misfortune of the family, an incubus that could not be shaken off so long as he lived, or for long afterward. He would constantly serve as a potential source of friction with the neighbors and others in the community, a fact that might give trouble to the authorities. The business of the family would very likely suffer, through hesitancy to buy anything they might produce or otherwise acquire to sell.

CONCLUSIONS

In the foregoing memorandum this conference has discussed the necessary requirements of effective home isolation and treatment of persons with leprosy; we have indicated the experience with that measure in certain countries of widely differing characteristics; and we have cited the opinions of authoritative groups which have considered the subject, these citations showing that the trend of opinion has been toward the negative as it has come to

reflect the experience of practical workers in highly endemic countries. Having given due consideration to the scientific, economic, and social aspects of the problem with special reference to the Philippines, we are of the opinion that it would not be practicable or wise to adopt this measure in this country at the present time.

We do not hold that there has been no improvement in the situation with regard to leprosy and those affected by it, but it must be recognized that such advances as have been made are not of such kind or degree as to justify radical change in the system now employed in the effort to control the disease.