having aural school clinics within the school and under the supervision of specialists. The present system of taking such cases to hospital dispensaries was wasteful. Summing up, Dr. Kerr Love indicated the immediate steps to be taken for the prevention of acquired deafness to be: (1) The management of the ear-complications of the infectious diseases by otologists. (2) The notification for the purpose of study and treatment of all forms of meningitis. (3) The medical inspection and treatment of the ear diseases of school-children by otologists.

Passing on to the classification of deafness for the purposes of prevention, the lecturer divided deafness into: (1) Cases in which the deafness is undoubtedly acquired after birth. (2) Cases of sporadic congenital or infantile deafness. In these there were no cases of deafness either in the direct line or in the collateral branches of the family, although a brother or sister might be deaf. Many of these cases were, of course, congenital. (3) Cases of true hereditary deafness. These were all congenital, and the deafness was present in other branches of the family. There were two fallacies to be got rid of: (1) That the possession of a deaf brother or sister was by itself any proof of the heredity of the deafness of a deaf-mute child. (2) That slight deafness amongst the relatives of a deaf-mute child was any proof of the heredity of the deafness. There was no disease which commonly appeared in one generation as hardness of hearing and in another generation as deaf-mutism. If these restrictions were applied it would be found that the hereditarily deaf were a very small class. The conclusion might be drawn, however, that backwardness was commoner amongst those whose deafness was congenital without being hereditary, and that true hereditary deafness was seldom associated with mental backwardness or physical inferiority.

As a correct classification must be the basis of any serious attempt to prevent deafness, Dr. Kerr Love said: "We must make the pathology of deafness, and not the date of its occurrence, the basis of classification; we must have a strictly scientific definition of what the term hereditary as applied to deafness means; we must have a much better admission schedule, giving not only a careful record of the personal and family history, but containing the results of a careful clinical examination of every deaf child." Concluding, the lecturer contended that the institutions must extend their scope. The institutions for the deaf began as asylums for the deaf; now they were well-conducted educational establishments, but they must help to prevent deafness. The spirit of research must fill the institutions.

The remaining lectures will deal with syphilis and deafness and with hereditary deafness.—J. K. Love.

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