DIPLOMA IN PHYSICAL MEDICINE

Regulations by English Conjoint Board

Paragraph 7 of E.M.S. Memorandum No. 6, on "The Organization of a Hospital Rehabilitation Department," issued by the Ministry of Health, reads: "Wherever possible, it is desirable that the various activities connected with rehabilitation should be under the personal supervision of a single member of the medical staff, whose duties include the maintenance of general oversight of the exercises, etc., given to patients, the prompt examination of anyone complaining of pain or other unfavourable reaction, and the holding of regular conferences with members of the rehabilitation staff. Such supervision is essential to success, and in no sense interferes with the continuity of control exercised over the individual patient by the original physician, surgeon, or obstetrician who orders rehabilitation therapy, and with whom the medical supervisor works in close association."

In this connexion it may be noted that the Conjoint Board in England has recently published the regulations for a Diploma in Physical Medicine granted jointly by the Royal College of Physicians of London and the Royal College of Surgeons of England (D.Phys. Med., R.C.P.&S.Eng.). These regulations, copies of which may be had post free from the Secretary, Examination Hall, 8, Queen Square, W.C.1, provide that (*a*) the examination is open to practitioners of not less than three years' standing who have held recognized hospital appointments and have completed a course of full-time special study extending over twelve months; and (*b*) the whole examination, which is divided into two parts, must be taken in the first instance, and subsequent admission to Part II is, of course, dependent on success in Part I. A syllabus indicating the scope of the examination is published in the regulations.

Since there may be some candidates whose experience, either in one of the Services or in the E.M.S., during the last three or four years may have been sufficient to justify their admission to the examination under the provisions of Regulation 6, arrangements are being made to conduct the examination for the first time in July next. Applications for admission to the examination under these provisions must be accompanied by original certificates (which will be returned), setting out the experience on which the application is based, and must reach the Secretary not later than Friday, June 16. The fee should not be forwarded until notification is received that the application has been approved and admission to the examination granted.

AFTER-CARE OF SERVICE PSYCHIATRIC PATIENTS

A scheme of after-care for men and women invalided out of the Services on account of psychiatric disabilities is announced by the Board of Control. The Service Departments and the Ministries of Health, Pensions, and Labour have co-operated in drawing up the scheme, and the organization of the work in England and Wales is to be undertaken by the Provisional National Council for Mental Health in collaboration with the Mental After-Care Association. The scheme will cover neurotics, psychoneurotics, and psychotics who no longer require in-patient treatment but who need further medical treatment and advice or help in finding employment or in adjusting themselves to civilian life. Officers commanding Service psychiatric hospitals and establishments and the medical superintendents of E.M.S. Neurosis Centres will notify the Board of any patient about to be discharged from the Services and returning to an address in England or Wales who needs after-care and is willing to receive it. This notification, accompanied by a report from a trained social worker allocated to each of the hospitals and centres by the Provisional National Council, will be forwarded by the Board to the P.N.C. to be dealt with by the latter's regional social worker. This officer will visit the patient at home and take any further steps necessary, acting in co-operation with the patient's own doctor and the local authorities and Government Departments concerned. A scheme on similar lines is being organized by the General Board of Control in Scotland, and one is under consideration for Northern Ireland.

The first series of scholarships for nurses which the Hospital Saving Association is providing out of its 21st birthday funds (July 31, 1943, p. 147) will consist of two scholarships for nurse dietitians of approximately £250 each; four for nurse teachers of £200 each; four for health visitors of £105 each; twelve for industrial nurses of £65 each; and four for midwife teachers of £75 each. They will be awarded annually over the next four years, will be open to nurses who are on the general part of the State register and have trained in hospitals within the area of King Edward's Hospital Fund, and will be available at any of the recognized training centres. Candidates will be required to sit for a competitive examination. Application forms may be obtained from the Royal College of Nursing, 1A, Henrietta Place, Cavendish Square, W.1.

Reports of Societies

PHYSIOLOGY OF FAINTING

At a meeting of the Section of Anatomy and Physiology of the Royal Academy of Medicine in Ireland in Dublin last November, with the president of the section, Prof. E. J. CONWAY, in the chair, H. BARCROFT, O. G. EDHOLM, J. MCMICHAEL, and E. P. SHARPEY-SCHAFER presented a paper on changes in the circulation during fainting.

At the onset of fainting, it was observed, the heart slowed and the blood pressure fell steeply to a low level. Measurement of the cardiac output by the direct Fick method in seven subjects showed that during fainting cardiac output was not further diminished and might increase. The fall of blood pressure was therefore not of cardiac origin, but was due to vasodilatation. In a further investigation of the effects of a controlled haemorrhage of approximately three-quarters of a litre, three subjects fainted while the forearm blood flow was being recorded by the Lewis Grant plethysmographic method. In all cases forearm flow increased during fainting. The combination of increased forearm flow and fall in blood pressure signified marked vasodilatation in the forearm during fainting. In view of the intense pallor of the skin the site of the vasodilatation was likely to be in the skeletal muscle.

In another series of experiments the effect of sympathectomy was produced by anaesthetizing the deep nerves to the forearm musculature. There was a high initial blood flow, as all vasoconstrictor impulses were removed. During fainting the blood flow fell steeply with the descent of the blood pressure, and recovered as the blood pressure rose. It was concluded that the fall of blood pressure in fainting was due to a peripheral vasodilatation of muscle vessels, and that the dilatation was of nervous origin.

Nerves in Joints

Prof. M. A. MACCONAILL, in a paper on nerves in joints, said that the following conclusions appeared to be justified by the results of the methylene-blue techinque of G. Weddell:

1. The synovial membrane is everywhere a sensitive membrane, but not one with so high a degree of localization as the skin.
2. Both pain and phasic sensations are subserved by the intra-articular structures, including the menisci.
3. The fatty pads (Haversian glands) are structurally fit to act as manometers of intra-articular pressure, in addition to their function as stream-lining elements of the joint cavity.
4. The arterial vessels, especially those of the fatty pads, have a liberal nerve supply, including adventitial nerves; this supply ceases at the capillary level.
5. The nerve-endings observed were of the non-encapsulated type only, even those on the special ligaments. Musculo-tendinous endings of the Golgi-Mazzoni kind were, on the contrary, seen at the musculo-capsular junctions of the extensor genu muscles.

SQUINT

At a meeting of the Maternity and Child Welfare Group of the Society of Medical Officers of Health in January, with the President, Dr. MARJORIE BACK, in the chair, Mr. C. L. GIMBLETT spoke on squint, and Miss IRVINE, senior orthoptist, R.A.F., demonstrated the synoptophore.

Mr. Gimblett showed how the various theories concerning the cause of squint could not be made to fit in with the facts until binocular vision was taken into consideration. Mr. Claude Worth had discovered three stages of binocular vision in the squinting child: (1) simultaneous perception; (2) fusion; (3) stereoscopic vision. In answer to questions Mr. Gimblett said that all cases of squint were not suitable for orthoptic treatment. Rest periods were given at suitable intervals, but the young child was not discharged from the orthoptic department until he could read and be trained to accommodate properly. The ideal age for orthoptic treatment was 5 to 8 years, but a child should be sent for examination as soon as the squint was noticed. Any error of refraction should be corrected and amblyopia prevented. If the squint was neglected for two or three years, then much of the time spent in the orthoptic department would be taken up in improving vision in the amblyopic eye. Vision in the worse eye must be at least 6/12 before orthoptic treatment could be started.

Br Med J: first published as 10.1136/bmj.1.4336.228 on 12 February 1944. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.