SIR,—Is it not proper for the British Medical Association to take action with reference to the proposed tax on the breathing spaces of towns—those, at least, that are in private hands? The proposal reminds one of the old window tax, in that it inflicts a penalty on the supply of fresh air.—I am, etc.,

Tunbridge Wells, May 10th. P. C. SMITH.

SIR,—May I ask, Is it fair that doctors owning motor cars should pay only half the tax on their cars, while doctors using horse carriages should continue to pay the whole tax, as if they were used for pleasure and not as a means of earning a "mere living"?—I am, etc.,

May 10th. AN M.D. WHO DRIVES A CARRIAGE.

SIR,—In regard to Dr. O'Connor's suggestion of making the increased Budget duties a ground for agitating for increased capitation rates for sick clubs, there are, I think, grave objections. That the average rates are too low is undeniable, but surely we have surer and firmer grounds for a higher remuneration than the occurrence of a temporary increase in the drug bill. The prices of drugs vary from time to time and Budgets are soon altered, and if we adopt Dr. O'Connor's suggestion we are forging a two-edged sword that may be used against us later on when the spirit duties are taken off or reduced and the price of drugs fall. To be logical we should then accept proportionately smaller club rates. Does Dr. O'Connor urge this? Such an arrangement can be of no benefit to the doctor, but only lead to friction and confusion.

Were we mere retailers of drugs there might be some justification of this course. But I think there is no occasion for the profession to emulate the practice of the "trade," who appear to be making increased charges on spirits absurdly out of proportion to the proposed increased duty, and who (at present at any rate) are doing rather a profitable trade on the Budget.—I am, etc.,

May 9th. CLUB DOCTOR.

PROFESSIONAL UNION AND THE BRITISH MEDICAL ASSOCIATION.

SIR,—I was interested to see Dr. Horseman's letter publicly acknowledging his debt of gratitude to the Association for what it had done in raising contract fees in his district.

As an incentive and encouragement for other Divisions to co-operate for their own internal and possibly eternal welfare, I should also like to mention what has been accomplished in my Division in that direction.

Some five years ago I was asked to organize, under the auspices of the Division, the union of practitioners in my district by calling upon and securing the signature of every medical man to a bond not to accept any *new* club without first consulting a committee that was appointed. In this way every man became a candidate on equal terms. The excellent results of this personal canvass are shown in the medical rates of three clubs being raised to 6s., in one case the former scale being just doubled. We have had one failure, a newcomer and non-member of the Association, who first agreed to act in concord with the other applicants for the higher rate, and then accepted the lower.

Last year a meeting was held in conjunction with a neighbouring Division, notice of which was sent to sixty-five general practitioners, and succeeded in obtaining their agreement to a minimum 6s. new club rate, and at our own last annual meeting a resolution was unanimously adopted, making it compulsory for no *new* club appointment to be accepted at a less rate.

I hope that other Divisions throughout the country will see their way to adopt such a scheme when clubs fall into the market, either by the decease or retiral of their medical officers. Six shillings may not perhaps be termed an ideal minimum at which to rest content, but it is in the right direction, and is certainly preferable to remaining for ever at the 3s. or 4s. rate which spells either slavery or quackery.—I am, etc.,

G. H. GRANT DAVIE,
May 10th. Hon. Secretary, Manchester (South) Division.

HOME CONDITIONS AND EYESIGHT.

SIR,—With reference to Dr. L. F. Richardson's remarks upon the conclusions of Miss Barrington and Professor Pearson that "there is no evidence whatever that overcrowded, poverty-stricken homes are markedly detrimental to the children's eyesight," it may be pointed out that generally when the homes are overcrowded the districts in which those homes are situated are also overcrowded, and that these conditions are distinctly detrimental to the children's vision—that is to say, to the acuity of vision.

Some time ago I examined the vision of 1,000 country-town children for the Board of Education and of 50,000 children for the London School Board, the London children being taken from every variety of district. These children for purposes of comparison have been divided into six classes or divisions, in whom the following variations in the quality of eyesight have been noted. (The figures denote percentages of defects):

I. Jewish children residing in the East End and mostly of Russian nationality, 37.16.
II. Children of poor working-class parents living in crowded neighbourhoods where there are no wide thoroughfares, 29.04.
III. Same class as II, but not so much walled in and wide thoroughfares available, 27.0.
IV. Country-town children, but mostly of poorer class than V or VI, 21.0.
V. Children living in more or less semi-suburban localities, 19.01.
VI. Children residing in more outlying suburbs and those attending higher-grade schools, 18.0.

With regard to the East End Jewish children, the organic defects are not greater than in the other children, but they are incapable of being corrected to the same extent as other children. Various theories have been put forward to account for this, but so far none has been found to explain the fact.

It may be mentioned that when children of Classes II and III are sent into the country at holiday times, many of them at a distance of 500 yards cannot distinguish a cow from a cottage, but their vision improves daily.—I am, etc.,

London, W., May 10th. H. CRITCHLEY, M.D.

SIR,—Mr. Richardson quotes and seeks to explain Miss Barrington's and Professor Pearson's paradoxical statement that there is "no evidence whatever that overcrowded, poverty-stricken homes, or physically ill-conditioned or immoral parentages are *markedly* detrimental to the children's eyesight." The statement is not only paradoxical, but directly contrary to the experience of any one who has had much to do with an ophthalmic out-patient clinic. Apart from errors of refraction, by far the most common cause of defective vision is the presence of corneal nebulae, resulting from phlyctenular keratitis, and this disease is undoubtedly associated with bad food, bad air, and parental neglect. How, then, does it happen that the total number of those with defective vision is not (if it is not) greater among these neglected children than among those who are better cared for? The explanation that I would suggest is that among the latter class the proportion of studious children is so much greater than among the former that they are more subject to school myopia, and that this factor, as far as the acuity of distant vision goes, is sufficient to balance the greater prevalence of corneal disease among the less cared for children.—I am, etc.,

London, W. A. HUGH THOMPSON.

TETANUS OCCURRING AFTER SURGICAL OPERATIONS.

SIR,—I read with interest Mr. Richardson's communication[1] on post-operative tetanus, and enclose a brief note of two cases occurring in my own practice.

H. M., male, aged 10, was admitted to the General Hospital, Birmingham, April 20th, 1898, for tuberculous glands along the carotid sheath on the left side. These were excised on April 22nd, and a satisfactory convalescence followed until May 4th, on which day the boy was to be discharged from hospital. The sister of the ward then mentioned that the patient complained of a stiff neck, and on examination I found the head in a position due to spasm of the left sterno-mastoid. The patient swallowed with difficulty, but there was no stiffness of the jaw or pain on opening it, no definite twitchings of the muscles; the wound was healed except for a tiny place at the point of insertion of the drainage tube. The subsequent daily history showed a constant increase in the gravity of the symptoms, which became typically those of ordinary tetanus, and on May 7th breathing was very difficult, owing apparently to spasm of the

[1] BRITISH MEDICAL JOURNAL, April 17th, 1909, p. 948.

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