Ireland.

TRAVELLING EXPENSES OF REGISTRARS OF BIRTHS, DEATHS, AND MARRIAGES.

WITH very few exceptions dispensary doctors are the registrars of births, deaths, and marriages in Ireland. The Treasury has issued for these officials a revised scale of travelling expenses when making their visits to the superintendent registrars with their quarterly returns. Notwithstanding the great increase in travelling expenses in recent times, the Treasury has reduced the rate of mileage from 6d. to 5d. a mile in the case of doctors using two or three seated motor cars. The proprietors of motor cars for hire in Ireland will not undertake to drive a fare for less than eighteen pence a mile. The obvious remedy for the registrars is to inform the Treasury that they will only take their books to the superintendent registrar when the Treasury, by its own negotiations, supplies them with a conveyance for the purpose.

Correspondence.

POST-GRADUATE TEACHING AND THE UNIVERSITY OF LONDON.

SIR,—The recent discussion at the Medical Society of London on reconstruction in medical education was marked by two significant statements. Professor Adami, speaking apparently from intimate knowledge, stated that Paris would probably become the chief centre of post-graduate teaching in Europe, since the French were making every preparation to capture the position hitherto held by Vienna and Berlin, adding that it moved him almost to "anger" that the claims of London should go by default. Also, Colonel Waring, speaking as a member of the Senate, and presumably better informed than other people, stated that in his opinion little could be expected from the University of London—that is, to improve from the imperial point of view the situation which Professor Adami deplored.

Most of us must surely feel that in comparison with the serious fact that the centre of gravity of medical learning and teaching is about to be shifted and that our country is to have no part in the new order, the other matters under discussion, such as whether applied anatomy should be taught by anatomists or surgeons, and the exact relationship of midwifery and gynaecology, are of almost trivial importance.

The case for the establishment of a real centre of post-graduate teaching in London needs no argument. I understand that proposals are on foot for this purpose. What I should wish to urge is: (1) That no scheme can be satisfactory that does not make special provision for instruction in certain branches of medicine which at present find no place in medical teaching; (2) that systematic teaching in these subjects must be combined with facilities for and encouragement in research; (3) that in order to give sufficient authority and attractiveness to post graduate teaching in London the teachers in these subjects must be university professors.

To particularize: the action and uses of physical remedies—light, heat, cold, mechanical impressions, movements, electrical currents, and rays of every kind—are either not taught at all or in an entirely inadequate and occasional manner. These physical agencies are embraced in a group of allied sciences—hydrology, climatology, mechanotherapy, electrotherapy, radiology—all of them of absorbing interest, which have now become, especially since the war, of immediate practical medical and public importance. How far it is consistent with the public interest or with the dignity of the medical profession that branches of medicine should be practised without being taught your readers can judge.

The case for research is equally clear, for our experimental knowledge of the intimate action of these agencies upon the body is only now beginning, and research must go hand in hand with clinical study and teaching.

I believe that the Universiy of London professes to concern itself to supply teaching in special subjects of importance for which no room has been found in the formal curriculum. Since the boundaries of medicine are always extending there must always be these unoccupied territories. Undoubtedly the recognition of these provinces of learning by the university and the provision of university teaching therein confers upon the subjects taught a certain authority and status not otherwise obtainable, which in a medical subject will ensure in time a higher standard of qualification and practice.

If happily now a great centre of post-graduate teaching and research is set up in London, I venture to think that the university will do a great public service by placing the various branches of teaching under university professors; and, *pace* Colonel Waring, I hope that the university may in this way play a leading part in the reconstruction of medical education.—I am, etc.,

London, W., Dec. 10th. R. FORTESCUE FOX, M.D.Lond.

TEMPORARY PEG LEGS.

SIR,—I have read with much interest the report by Major Chapple, R.A.M.C. (November 30th) on temporary pegs for amputation of the lower limb. I have recently been making a number of plaster pylons, but before trying to put them on I consulted Mr. Woodland, a maker of artificial limbs in Southampton, and the following were the chief points he urged:

1. That in leg stumps, as well as in thigh stumps, the bucket should be around the thigh, as the main point of support of the body weight should be at the tuber ischii, the patient, as it were, sitting on the upper edge of the bucket, and that in the case of plaster pylons, to avoid friction, it would be as well to incorporate a felt pad between the layers of the plaster bandage where the edge of the bucket would press against the tuber ischii.
2. That in leg stumps the part of the leg below the knee is simply of use as a lever for bending the knee-joint. He had never seen a successful artificial leg where the bucket was around the leg instead of around the thigh, even when hinged to a corset around the thigh.
3. That there should be no pressure at all on the end of the stump from any part of the apparatus.

By following this advice, I have now made a number of plaster pylons which patients wear without discomfort; after a few days' practice they can walk several miles. The tendency for the plaster-of-Paris to crumble can be to some extent obviated by coating the inside as well as the outside of the bucket with No. 7 paraffin.

Mr. Woodland's principles appear to differ very much from those of Major Chapple, who in his report writes:

An ideal bucket will therefore have a smooth and almost shiny inside surface, with a diaphragm so placed as to carry a maximum portion of the weight of the body on the end of the stump, and a rim so contrived and shaped as to carry the remaining portion of the body weight by coaptation to the appropriate bony surfaces, near the adjacent joint.

He also describes and figures various auxiliary pegs where the bucket is applied to the leg stump in amputations below the knee, instead of to the thigh.—I am, etc.,

Southampton, Dec. 3rd. G. D. FREER, M.B.Lond.

BOOT HEELS AS A CAUSE OF FLAT-FOOT.

SIR,—With reference to Dr. Samways's remarks, let me say that I mentioned that with heelless boots the weight falls mostly on the heels, with low heels entirely on the arch and with high heels mostly on the metatarso-phalangeal joints, in the latter case being transmitted lengthwise along the tarsal and metatarsal bones and not falling on the arch. Consequently, with high heels the arch is preserved. Owing, however, to spastic peronei and idle tibialis anticus the crown of the arch rotates somewhat downwards and inwards around the long axis of the foot, power and elasticity being thus sacrificed and the arch becoming practically rigid. A five mile walk with 3 in. heels would convince Dr. Samways that high heels make corsets necessary. The weight of mountaineers descending steep slopes falls mostly on the heels. If it fell on the arch (that is, at right angles) they would descend head first. Walking on the heels when descending and plentiful exercise of the tibialis anticus when ascending account for their erect carriage (without corsets). Boot heels raise only the posterior narrow parts of the feet, which are not very sensitive to cold. The boot described is as elegant and warm as ordinary boots. The bare feet of men lying on their sides are at a more obtuse angle than when standing with boots on. Spastic calf muscles and undeveloped

tibialis anticus explain this; Dr. Samways's theory does not.

The hip-joint being further from the toes than from the ground the advancing foot (walking) must be dorsiflexed or the knee bent in passing the other foot. When barefooted dorsiflexion takes place. With heels on both boots, the spastic calf muscles prevent dorsiflexion, and the knee is flexed. This flexion prevents gravity carrying the knee past the other, and it has to be raised. Observation confirms this.

The foot of a man who has always worn heeled boots is not normal. His heels project further behind, and his balance falls further forwards than Nature intended. Standing tiptoe exercises unfortunately strengthen the powerful gastrocnemius and soleus, whose action flattens the arch when the weight is on the ankle-joint. Plantar flexion, sitting, strengthens the other calf muscles and the arch without exercising the gastrocnemius and soleus.

Using boot heels is equivalent to jacking up one end of an inverted motor car spring with a solid block, thereby reducing its resilience to that of a half spring. The tibialis anticus represents the shackle that keeps the spring in the right plane and holds it up to its work, like the bow-hand in archery. The foot in infantile paralysis should be put up fully dorsiflexed and inverted.

When heelless boots are used the feet should be kept parallel and a pendulum gliding movement of legs and feet adopted, the steam-hammer method of putting the feet on the ground being abandoned. The knee need scarcely be flexed, but the foot must be dorsiflexed in passing the other. The development the tibialis anticus then undergoes and the rapid improvement in the arch are "startling."—I am, etc.,

S. D. FAIRWEATHER,
Captain R.A.M.C.

Kenmore, Nov. 26th.

THE CONTROL OF VENEREAL DISEASES.

SIR,—The paragraph (p. 608) on the control of venereal diseases deals ably with a subject of vital importance, but fails, in my opinion, on one point—namely, in not emphasizing enough the necessity of treating gonorrhoea correctly. In the lay and medical press attention seems to be focussed chiefly on syphilis. Health authorities strive to instruct medical men in the administration of the salvarsan remedies, strive eagerly to get patients to undergo treatment, yet the ravages of the gonococcus are touched upon lightly.

While admitting the great value of the newer remedies in treating syphilis and the importance of the general practitioner being capable of administering these remedies himself, yet I would hesitate to assert—and he would be a brave man who did so—that the patient having undergone this treatment is cured of the syphilitic taint for ever; for who with experience of these remedies has not had the misfortune to get a return of a positive reaction after months and years of absence?

But with gonorrhoea it is different; untold harm is done through bad, or rather incomplete, treatment. Every venereologist has listened to the wailings of the man with chronic urethritis, every gynaecologist knows how restricted his field would be if there were no gonococci, and every medical officer of health has something to say about ophthalmia neonatorum, yet millions of men and women are allowed to go about potential agents of infection, supposed to have had treatment and supposed to be cured. This should not occur. No case should be discharged as cured until a careful examination of all the organs connected with the urethra is made, including patient microscopical search for the germ; yet it is not uncommon to hear medical men assert that they can cure gonorrhoea within a week; their criterion of cure is the cessation of the purulent discharge. What a fallacy! I fear to encroach further upon your space, otherwise I would have something more to say on the subject of chronic urethritis. I conclude with a hope that whoever has the power to make arrangements for the treatment of venereal diseases will emphasize the importance of facilities for treating gonorrhoea, and will take as much trouble in educating the general practitioner how to treat this disease as he has taken in teaching him how to insert a needle in a vein.—I am, etc.,

M. W. BROWDY, M.B.

Manchester, Nov. 30th.

THE BOARD OF CONTROL ON EARLY TREATMENT OF MENTAL DISORDERS.

SIR,—I have read with much interest your leading article in the JOURNAL of November 30th, p. 607, on the report of the Board of Control on lunacy. Valuable suggestions are made as to the treatment and diagnosis of cases of mental disorder incipient in character or of recent origin. But these suggestions entail the removal of the patient from his home for the purpose both of diagnosis and of treatment. In this particular disease I cannot help thinking that this procedure is not the best. I should have thought that it was better, certainly for diagnosis, and probably for considering treatment, to see the patient in his natural surroundings, so as to be able to form a proper opinion of the influence of his home, his home life, his way of living, and his surroundings generally, and so as to get a more accurate idea of his family history.

To meet this point I suggested, in a letter to your contemporary the *Lancet* on November 16th, that in any case of suspected mental disease the practitioner in attendance should have the right of calling in an appointed specialist, just in the same way as he can now do in the case of suspected tuberculous disease. If this was done—and it could be arranged that the medical attendant should meet the specialist in consultation—not only would it be of advantage to the patient, but the general practitioner would have the advantage of what would in fact be a clinical lecture, and the consultant would have the advantage not only of seeing the patient in his ordinary surroundings, but of learning his previous history from the family medical attendant. In that letter I made the suggestion that the most suitable person to appoint as specialist would be the medical superintendent of the county asylum of the area in which the patient resided.—I am, etc.,

CHAS. E. S. FLEMMING.

Bradford-on-Avon, Dec. 3rd.

THE PAST AND FUTURE OF THE CRUSADE AGAINST TUBERCULOSIS.

SIR,—If the tuberculin reaction is an anaphylactic phenomenon, there is abundant evidence that in infants any tuberculin reaction is due to post-natal infection, and therefore I do not understand what Dr. R. E. Tottenham means by saying that "the state of anaphylaxis is transmissible by the mother, and possibly to some extent by the father."—I am, etc.,

W. CAMAC WILKINSON, M.D.

London, W., Dec. 10th.

REMUNERATION OF RURAL PRACTICE UNDER THE INSURANCE ACT.

SIR,—I think it would be useful to have some further expression of opinion on the part of rural practitioners as to renewal of contracts under the National Insurance Act before we are invited to do this.

The conditions in rural and urban practices are so utterly different, especially in respect of distances, cost of travelling, and cost of drugs, that rural practitioners may have to take their own line in the matter of further service under the Act. The doctors I have in mind are those in one-man and two-man villages and townlets, with panels of 250 to 1,000 patients, and a radius of five or six miles.

My own opinion is that the multitude of rules and regulations which have been imposed on us, and the bureaucratic way in which we have been answered, when appeals have been made for consideration in view of conditions due to the war and unforeseen when we entered into the contracts, have proved to the hilt the soundness of the contention in 1912–13 that the conditions of service were derogatory to the profession.

I think it is generally agreed that these conditions have only been tolerated thus far from a patriotic desire not to embarrass the Government while the war continued, but this need is no longer operative, and some clear thinking is required before the day when contracts are presented for renewal.

We are scattered all over the country and have no means of meeting, as have urban doctors, and there seems no available or more suitable channel for the expression of opinion than the columns of the BRITISH MEDICAL JOURNAL if space for it can be afforded.—I am, etc.,

J. HENRY STORMONT.

Tanworth-in-Arden, Nov. 29th.