prove fatal and at best takes a month or two to heal.

The splints illustrated in the figure have been used with good effect to prevent heel pressure and foot drop. The splint is made of polyethylene, lined with polyurethane, and air holes are made about the heel area. Though the splints can be made from a plaster cast of the foot and leg, it is quite satisfactory to have a few stock sizes and to pad with cotton-wool above and below the heel so that the latter does not actually touch the splint. The splints are kept in position using Velcrotape, which can be readily released. The splints can now be applied when the patient is sitting in a chair, but can also be worn in bed where they are also effective.

I would like to acknowledge the help given in the preparation and use of these splints by the staff of the Physiotherapy Department (Colchester), and to the photographer, Mr. J. Brunard, for the accompanying Figure.

—I am, etc.,

St. Mary's Hospital, Colchester, Essex. KENNETH HAZELL.

Adoption

SIR,—I welcomed Lady Lewis's full and useful article, for a general practitioner can help prospective adopters so much (4 September, p. 577).

May I add to her list of preparation "all manner of voluntary work with children in care." The year spent taking children from a children's home youth hostelling at our expense, thinking over our contribution for their special problems, and discussing this with the staff of the home, or the children's officer, was a preparation for which my husband and I shall always be thankful. We afterwards adopted children ourselves through a society.

We saw *each other* handling other folk's children. We saw adoption in the light of some of the tragedies we had seen together. The discussions with the Adoption Society and my own general practitioner were the more helpful because of this fund of experience.

We kept in touch with the children even after we had adopted our own, and then they drifted away, for they never answered letters and they were fostered, or grew up. It was a service we couldn't do for too long if we were to do it properly, and it was a wonderful preparation.—I am, etc.,

Manchester. M. ELFRIEDA HAPPOLD.

General Practice—at Home, and Abroad

SIR,—I don't know if the following is of any interest to you, but after the College of General Practitioners report I wondered what our surgery did in a comparable time of the year.

I therefore deliberately chose the week following the old Bank Holiday week, as half the town always has been, and was this year too, away on holiday. It is a very quiet week therefore by normal standards.

The survey I have dealt with in the categories listed.

Unnecessary means no medical help of any sort—including social, welfare, or preventive—was required.

Trivial means that they could have been honestly dealt with by my wife, who has had no medical or nursing training at all.

Real means that this required the help of a medically trained person—an S.R.N. could have dealt with these quite easily (where a doctor might be needed, I have put it under the "necessary" heading).

Intermediate Certificate and 1st or *Final* notes explain themselves. The intermediate could easily have been done by a nurse, but I suppose a doctor is needed for first and final certificates—although even this could be disputed.

The *necessary* heading is where my diagnostic skill was really necessary—I detail these:

(1 and 2) Two cases of shingles (one was fairly obvious perhaps to a nurse, but the other one—that on a foot—might well have escaped notice).

(3) An ischio-rectal abscess.

(4) A ? Crohn's disease.

(5) A case of barotrauma occurring in a skin diver.

(6) Hypertension.

(7) Pneumonia of the left base.

In this survey I have not included any patient more than once. The breakdown of the week is as follows:

Unnecessary	4
Trivial	161
Real	95
Intermediate Certificate ...	43
1st or Final Certificate ...	7
Necessary	7
Total	345

Which when you come to think of it seems to be an awful waste of time; and obviously these northern industrial practices seem to be a bit more hectic even in quieter times than the average College of General Practitioners' practice.—I am, etc.,

Wakefield, Yorks. L. J. BURNS.

SIR,—I have just returned from Ontario, Canada, where I had the opportunity to work in general practice for a month. Having been in practice here in England for three years, it was interesting to compare the two methods of work.

Many letters and articles have been written on this subject, and there is no need to give the well-known details concerning hospital privileges. However, there is no doubt in my mind that the practice of medicine in Canada to-day is much more satisfying and stimulating for the general practitioner than it is in this country. My impression is that this is a direct result of allowing general practitioners to look after a large proportion of their patients both in as well as out of hospital. Often he will look after these patients in association with consultants, and the resulting daily contact between general practitioner and specialist can only result in a raising of the standards of practice of both parties. It was refreshing to work in an atmosphere where doctors were satisfied that they were practising good medicine and being rewarded adequately for it. The patients were in most cases covered by adequate medical insurance and were very satisfied with the treatment they obtained. If and when Medicare is introduced in Ontario I feel sure that both patient and doctor alike will try to keep the present methods of practice in existence.

The tripartite system of medical care in this country created at the inception of the National Health Service seems to have done more harm than anything else to general practice in this country. It is almost impossible for the general practitioner who wants to keep abreast with modern medicine to do so, when he cannot look after his patients when they are in need of hospital care. If he is not intimately concerned with all aspects of the treatment and investigation of his patients, then no amount of reading or postgraduate education will prevent him from losing contact with up-to-date medicine. If the Regional Hospital Plan is allowed to materialize many general-practitioner hospitals will close, and those who are at the moment fortunate enough to be able to practise in these hospitals will be prevented from doing so. The result of this will be an increase in the number of young doctors who want to practise active medicine emigrating to the Commonwealth countries.—I am, etc.,

Cheltenham, Glos. J. F. R. ADAMS.

Points from Letters

Diagnosis of Hysteria

Lieutenant-Colonel L. J. F. WARNANTS (Cambridge Military Hospital, Aldershot, Hants) writes: Dr. H. M. Flanagan (4 September, p. 594) associated Dr. D. H. Marjot and myself with the proposition "that mental illness is a more subtle form of malingering" (*sic*), but our original letter (14 August, p. 422) does not contain any statement which justifies such an assertion. What we said was that neurotic behaviour (not mental illness) consisted of adaptive responses. In the penultimate paragraph we clearly distinguished between adaptive behaviour and mental illness in the following words: "if hysteria is regarded as adaptive behaviour it need not be regarded as mental illness, and many other contradictions are resolved."

B.C.G. by Jet Injector

Dr. T. D. LEWIS (Health Department, Truro, Cornwall) writes: Your leading article on this subject (21 August, p. 434) says that the nozzle of the instrument comes into contact with the skin of the subject. It should not. If held too near the skin the vaccine penetrates subcutaneously. The main disadvantage of the instrument in its present form is that there is no method whereby the optimum distance from orifice to skin can be kept constant. A very simple modification could enable this to be done. A possible hazard to the operator, which should be investigated before the method comes into general use, is from the aerosol of B.C.G., especially if large numbers of subjects are vaccinated in a small room.

Jaundice in Severe Infections

Lieutenant-Colonel H. C. M. WALTON (Beck Laboratory, Swansea Hospital) writes: There should be a careful follow-up of the patient described by Dr. M. K. Tandon (7 August, p. 362) over a period of years. Hepatic abscess due to *Entamoeba histolytica* seems the most likely diagnosis. These parasites and their cysts are always difficult to find. With the increasing ease of travel, diseases of the tropics and subtropics are likely to become more common in this country. We must think of this when we meet diseases with puzzling symptoms, and remember to ask the patient, "Have you been abroad in the last few years? If so, where?"