

special form of footgear—unless they had only a half-inch heel or no heel at all, particularly those who suffered from hallux rigidus. The low heel might be most pernicious even for a man. Pseudo-intermittent claudication arose from one cause only—the wearing of too low a heel. He did not want to be taken as an advocate of the extravagantly high heel, and he could not honestly say that any human foot, unless extraordinarily abnormal, required a heel of more than 3 in. in height. The sufficiency of the tendo Achillis alone should control this problem, and on this depended that of the flexor longus hallucis. He demonstrated the technique of the wedging of a heel, and added that the wedging of a sole was fallacious unless all hope of restoring mobility was abandoned. A final word on this subject was with regard to the set of the heel, and here he criticized the custom of being measured for a fitting while seated in a shop chair. The fact was ignored that when weight came on the foot the foot would shoot forward for at least one “size,” perhaps for one and a half “sizes.” This slip forward was overlooked, and no allowance was made for the two shoe “sizes” beyond the actual foot measurement, with consequent cramping.

The “Upper”

With regard to the “upper,” he said that reliance should not be placed on the length measurement given on the boxes in the ladies’ department. If a “5” shoe was requested it was as likely as not to be found on measurement to be a “7.” In men’s shoes there was less disparity in this respect. The shape of the upper varied greatly according to different lasts. He emphasized the importance of depth under the toe-cap and over the outside. It was customary to slope the front part of the shoe down gradually over a considerable distance, but if this were done it must reduce the amount of room available in the fore part, over the big toe. It was necessary to have something to keep the heel back in the heel of the shoe. This position must be properly controlled by straps, laces, or other contrivances. Two straps, preferably buckles, were the minimum; one strap would not serve. In children especially it was necessary to have a definite grip to prevent the foot from slipping forward into the front of the shoe, which was just as bad as wearing a shoe that was too short. The placing of a pad of felt underneath the tongue of the shoe should reduce materially the whole instep measurement and so enable walking to take place with freedom without the foot running forward into the front part of the shoe. Inequality of length of the two feet was another problem, and it was often difficult to persuade boot shops to sell a pair of shoes having different sizes for the right and the left.

Dr. Mennell concluded by saying that, save in the case of the victims of some congenital abnormality or gross disease or injury, a painless or perfect foot should be regarded as the human heritage. Of this heritage we had been deprived by our footgear and nothing else, and that was a reflection on the lack of co-operation between shoe manufacturers and the medical profession. The extent of the evil could be gauged by the thriving businesses of the chiropodists, much of whose work should not be necessary if people were properly shod. Our foolishness in subjecting the marvellous mechanism of the human foot to the tyranny of fashion caused intense suffering, was fatal to the maintenance of correct posture, and was a fruitful source of irritability and bad temper.

At the October meeting of the Section of Medicine of the Royal Academy of Medicine in Ireland Professor L. ABRAHAMSON read his presidential address on “Pericarditis.” He dealt with a series of twenty-four cases, treated in the Richmond and Whitworth Hospitals. Thirteen of the cases were clearly and ten were probably of rheumatic origin. Four were tuberculous, one septic; one, associated with anaemia, enlargement of the liver and spleen, remained obscure in spite of necropsy. In ten cases the condition followed pregnancy in patients with antecedent rheumatic heart disease and was probably due to hydropericardium rather than to a fresh attack of rheumatic infection. In the remaining case there was a congestive hydropericardium. Post-mortem examination had been carried out in seven cases, and in each was confirmatory.

Local News

SOUTH AFRICA

Medical Research in South Africa

The report of the South African Institute for Medical Research, Johannesburg, for the year to December 31, 1938, was prepared by the late Sir Spencer Lister, who was Director of the Institute from 1926 until his sudden death in the library there last September. It contains a further account of the investigation into the aetiology and therapeutics of pulmonary diseases in South Africa, including a note on the benefits resulting from prophylactic inoculation against pneumonia in cases which are later treated with 2-(*p*-amino-benzene-sulphonamido)-pyridine, confirming the work of Fleming in London. An unduly high disease incidence and death rate in one district variously ascribed to pneumonia and heat stroke proved on investigation to be due to African relapsing fever. The outbreak was terminated by anti-tick and disinfection measures in the compound housing native labourers, and no fresh cases occurred subsequently. This was the first recorded instance of an extensive outbreak of this infection in South Africa, only occasional sporadic cases having been reported previously. Research was continued into the anti-scorbutic value of kaffir beer, which ought to be regarded, the report states, as a food rather than as an alcoholic drink, since it contains appreciable quantities of anti-scorbutic and other vitamins which are absent from the native diet. It is urged that until present customs have altered, the standard of agriculture has been improved, and other protective foodstuffs have been made available and popularized, kaffir beer should be accepted as, on the whole, a beneficial form of food for the rural population. No one special factor has been detected to explain the frequent occurrence of primary liver cancer in natives of the South African Union and the Portuguese Colonies. Some reason was found for the assumption that in the majority of cases of spontaneous human cancer malignancy was preceded by a definite pre-cancer stage, the diagnosis of which might be difficult, the worst cases being those in which such a stage was absent. The pre-cancer stage was thought to indicate an attempt to combat the cancer-producing factor, and it seemed that with a greater tissue liability to cancer or a more powerful cancerogenic influence went a shorter and less pronounced pre-cancerous period. In the majority of “industrial cancers” there was a longer pre-cancerous period, especially when there was no constitutional or hereditary factor. Work was continued at the Institute on the entomology of malaria, and it was indicated that the half-mile drainage control area was inadequate in South Africa. A survey was started of plague-bearing fleas, and it is pointed out that too little interest has been previously taken in insects of medical significance in South Africa—a country in which the major diseases are insect-borne.

AUSTRALIA

Rural Hospital Management in Victoria

The 28th annual report of the Victorian Bush Nursing Association reveals the great variety of medical institutional work which was carried on successfully in 1938–9 in the State of Victoria, comprising local as well as district nursing relief, and including work in hospitals as well as among isolated communities in the bush regions. The Bush Nursing Association is essentially a co-operative concern, each centre managing its own affairs; in the case of the bush nursing hospitals the visiting medical practitioners are *ex officio* members of the committee of management, the function of the central council being limited to providing the staff and to calling the attention of the local committee to any circumstances which seem to require investigation. The Bush Nursing Association

does not ask any district to adopt its system nor does it publish any propaganda, but gives its support when a wish to form a centre is expressed by the local residents and medical practitioners, all such centres being independent and self-supporting. There are in existence fifty-one hospitals, while three more are being built and organized. There are nineteen bush nursing centres also. The central council remarks that few city dwellers realize the desire of people of independent mind to provide in their own districts modern and well-equipped hospitals, owned and managed by themselves, staffed by their own doctors and by the best nurses in the State, and provided at very low rates. Hospital extensions are often found necessary after their first building by reason of the enthusiasm which results; some have had some financial difficulties in carrying on, but in most cases they are all paying their way without help from outside. Had the co-operative system of nursing in the bush not been developed originally, it is doubtful whether the system could have been transferred later to the rural hospital centres. The local inhabitants regard their subscriptions as a form of insurance; one hospital closed its doors five years ago to non-subscribers and is thoroughly satisfied with the result, so much so that a second hospital has followed this example. A few hospitals have been forced to close by shortage of medical practitioners; if more practitioners were available the number of hospitals could be much increased. Bush nursing hospitals may not be established within twenty miles of the nearest city. A fundamental feature of these hospitals is that they take cognizance of persons before they become definitely ill. The rate charged for care in hospital depends on the number of subscribers; if there are 100 to 150 subscribers the charge can be lowered to about £2 a week, and if there are enough subscribers it falls to 10s. a week. Non-subscribers are charged full business rates of £5 5s. or more. The council's report adds that the association is not to be considered as a charity but as a co-operative movement, the public hospitals remaining available for those in necessitous circumstances, but it is open for anyone to secure the admission of such cases to a bush nursing hospital by paying for them.

ENGLAND AND WALES

Bristol's New Red Cross Centre

On November 18 Queen Mary paid a surprise visit to Bristol to open the British Red Cross Society's new Bristol headquarters and Regional Hospital Supply Depot in Lewin's Mead. During a tour of inspection her Majesty showed keen interest in the various branches of the work of the depot and spent a considerable time in the workshop and in the hospital library. Among those who received Queen Mary at the entrance to the centre were Professor J. A. Nixon and Dr. L. E. Claremont; and Dr. R. H. Parry, medical officer of health for Bristol, with other leading workers, was presented to her by the Lord Mayor, who in a speech of welcome referred to her Majesty's interest in the work of the British Red Cross Society. An explanation of the activities being carried out at the centre was given by the County Director, Alderman F. Sheppard. Working parties, he said, had been formed throughout the five neighbouring counties, where ladies gave their services. "Another branch of the service which is doing a very fine work indeed is the V.A.D. and the Red Cross detachments. The total personnel in Bristol is ninety-four men and 382 women. Work in this connexion has been carried on in peace times, and therefore a large number of fully trained personnel is available to undertake duties with the Forces or for home service. The Red Cross, too, is working in connexion with the authorities in training men and women for casualty and anti-gas duties. An A.R.P. Reserve of 370 men and 900 women has already been trained, and more volunteers are still required. Over 2,000 volunteers, in addition, have been trained for the casualty services." The Regional Supply Officer (Lady Wraxall) said that the Bristol Centre was formed primarily to co-ordinate the work of the British Red Cross Society, the Order of St. John of Jerusalem,

and the women's voluntary services. At the opening ceremony her Majesty named the centre "Queen Mary House."

Cost of Croydon Typhoid Epidemic

The Croydon Borough Council is applying to the Ministry of Health for sanction to borrow £92,169 for the purpose of meeting expenses in connexion with the typhoid outbreak of 1937. The number of claims settled up to the present is 260, of which 28 are in respect of fatal cases. The loan is intended to include the sum of £4,768, being damages and plaintiff's taxed costs in the case of *Read v. Croydon Corporation*. In this case, which was taken as a test, Mr. Alfred Read of South Croydon brought a claim on behalf of his daughter, who became ill during the epidemic. After a nine-days hearing the child was awarded £100 damages and the father was awarded agreed out-of-pocket expenses. Mr. Justice Stable held that the duty of the Corporation was statutory and that there was not a contract between them and the ratepayer; further, that the obligation to provide pure water to the occupant of a dwelling-house was not absolute but was an obligation to exercise all reasonable care and skill to secure its purity, and this duty the Corporation had not performed. The damages and costs paid in other cases amount to £87,401, and this will be covered, together with the Read damages, by the sum it is proposed to borrow. From a statement issued by the Finance Committee of the Corporation it appears that the costs of the public inquiry, which was held in December, 1937, and January, 1938, amounted to £7,728. This sum, together with the Corporation's costs in the lawsuit, amounting to £5,055, other legal costs to the amount of £1,096, and costs for convalescent treatment and sundry expenses amounting to £460, have been charged to the general rate and the waterworks revenue accounts. Recently it was proposed by the Metropolitan Water Board to seek power to acquire the Croydon water undertaking, but now, in view of the altered conditions brought about by the war, the Board has decided that the negotiations for the transfer shall be suspended *sine die*.

Low Death Rates in Sheffield

The health of Sheffield, as shown in the annual report of its medical officer, Dr. John Rennie, is improving rapidly. The general death rate and the infant and maternal mortality rates were all lower in 1938 than for England and Wales as a whole. Up to the end of the last war the mortality rates of Sheffield were always above the national average; since 1921 the position has been reversed. The mortality from infectious diseases, apart from diphtheria, was low, and even for diphtheria the rate was lower than for England and Wales. Deaths from infantile diarrhoea and enteritis were only 1.96 per 1,000 births, as compared with a national rate of 5.5, the mortality being lower in Sheffield than in any other of the large towns except Bristol and Plymouth. Influenza, too, took a relatively small toll in Sheffield last year, only four of the large towns of England having a better record, and even cancer mortality over a series of years has been almost consistently lower in Sheffield than the national figures. The mortality from tuberculosis in 1938 was the lowest ever recorded in the city. The death rate of 581 per million is not much more than half what it was ten years ago; only one other among the eighteen large towns has a lower figure—namely, Croydon, and Croydon is hardly to be ranked with the great industrial centres. Tuberculosis mortality among grinders and cutlers, who at the last census numbered some 8,000, is, however, several times higher than among the general population. Sheffield is proud of its low infant mortality—50 per 1,000 births, as compared with 53 for the whole country. Only fifteen years ago this rate was 90 in Sheffield, as compared with a national rate of 69. The two outstanding problems in Sheffield are slum clearance and smoke abatement. A large part of the report deals with the considerable work of the city council on slum clearance and the rehousing of the people. But the pall of smoke remains as thick as ever over the city; at one collecting station the amount of solid matter deposited during 1938 was equal to 369 tons per square mile.

minister to us, forgetting his own pain and weakness in order to help us who were not nearly as ill as he was. To Naughton Dunn's love and loyalty to the hospital we owe very much. He never missed an opportunity of speaking well of our scheme and interesting people in the hospital and in the various branches of its work. But perhaps the greatest work he did for crippled humanity was by passing on Robert Jones's teaching to younger orthopaedic surgeons, training them in the work he loved so well.

[The photograph reproduced is by Elliott and Fry, Ltd.]

Dr. F. Hernaman-Johnson (London) writes: I should like to add my tribute to the memory of Dr. HENRY AUGUSTUS ELLIS. We were colleagues on the staff of the Margaret Street Hospital for Diseases of the Chest for twenty years. A mutual friend once remarked to me, "None of us was ever as young as Ellis; none of us will ever be as old as Ellis." This was indeed a true saying, for Ellis combined an extraordinary freshness of outlook with the wisdom of an elder statesman. Coming to London when he was nearly 60 he performed the remarkable feat of establishing within a few years a quite considerable consulting practice. His therapeutic methods so far as they applied to the body were original and often successful; but he was also a master in all that pertains to the action of mind on body. He did not confine himself to the usual case history, but induced patients to tell him their intimate thoughts and feelings. I have known many instances in which his sympathy and understanding turned despair into success. Ellis never spared himself, either mentally or physically. His medical friends believe that his experiments on himself with strange drugs laid the foundation of the cardiac weakness to which he ultimately succumbed.

Dr. WALTER GRAHAM REYNOLDS, who died at Chatham on November 16 at the age of 53, was educated at Marlborough College and in Switzerland, and studied medicine at St. Mary's Hospital, qualifying M.R.C.S., L.R.C.P. in 1912. He then held three house appointments in succession at St. Mary's, and after the war worked as clinical assistant at the Samaritan Hospital for Women. In 1921 he went out to China and was appointed visiting surgeon to the Canton Hospital, medical officer to H.B.M. Consul-General, port medical officer for Canton and to the Chinese Maritime Customs and Postal Service. "H. A. B." writes: Dr. Graham Reynolds had been aware for some months that his life could not be of long duration, but with exceptional courage and cheerfulness he had carried on, hiding from all except his intimate friends the knowledge that must have been ever present with him. On the staff of the Canton Hospital he did much good surgical work. His kindly and generous treatment of the various missionaries with whom he came in contact brought him the grateful thanks of the Bishop of Hong Kong when the time came for him to leave the East. He also received the thanks of the Consul-General for his work in connexion with the British Concession. In 1930 he came to Chatham, where he soon established for himself a position of reliability and affection, not only among his own patients but also with his brother practitioners, and was until recently chairman of the local Division of the British Medical Association. Outspoken perhaps, but full of kindness, he was ever willing to lend a friendly hand to all and sundry, and his integrity was unalloyed. Well may it be said of him, "He loved his fellow men."

Dr. CHARLES JOHN CADDICK died suddenly at Nakuru, Kenya Colony, on November 10, aged 65. He was born in 1874, the second son of Mr. Alfred Caddick of West Bromwich, and educated at Edinburgh University, where he graduated as M.B. and C.M. in 1897, also taking the F.R.C.S.Ed. in 1902, the D.P.H.Cantab. in 1904, and the D.T.M. of the London Colleges in 1920. He served in the South African War of 1899-1902 as surgeon to the Imperial Yeomanry Hospital, and in the war of 1914-18 with the rank of major in the R.A.M.C.T.; and afterwards in the Colonial Medical Service in Kenya. He had also been consulting surgeon to the Walsall General Hospital. He joined the British Medical Association in 1898, over forty years ago.

Universities and Colleges

UNIVERSITY OF OXFORD

At a Congregation held on November 25 the degree of Bachelor of Medicine (B.M.) was conferred on J. N. Macdonald.

UNIVERSITY OF CAMBRIDGE

Committee for Medical Radiology and Electrology

The Faculty Board of Medicine has appointed Dr. G. S. Graham-Smith, Dr. G. H. Orton, Dr. Ff. Roberts, Dr. F. G. Spear, Mr. G. Stead, Mr. R. Williamson, Dr. P. J. Kerley, Dr. W. P. Philip, Dr. Russell J. Reynolds, and Professor Sidney Russ to be members of the Committee for Medical Radiology and Electrology for the year 1940. The report of the Committee for the year 1938-9 has been published in the *University Reporter* of November 21. This recalls that at the end of September, 1938, the university lectureship in physics as applied to medical radiology became vacant by the resignation of Mr. Stead. It was decided not to appoint a new lecturer and to discontinue diploma teaching in Cambridge. As in previous years, courses in physics were given in London at the Middlesex Hospital Medical School and at King's College. Lectures in radiology, electrology, and pathology were given at the British Institute of Radiology, and clinical instruction was provided in the radiological departments of various hospitals.

Medical Examinations in War Time

In Congregation on November 24 it was resolved that students otherwise qualified to present themselves for the first or second part of the Final M.B. Examination in December, 1939, whose evidence of medical and surgical practice with clinical instruction falls short by not more than three months of that required by Regulation 30 (e) or 32 (a) for the M.B., B.Ch. degrees, may nevertheless present themselves for that examination if their candidature shall have been approved by the Faculty Board of Medicine. (The Faculty Board will satisfy themselves that candidates who seek this temporary concession have been prevented from completing the last three months of their clinical instruction by circumstances arising from the war and for no other reason.) It was further resolved that students other than those covered by the above provision who wish to present themselves for the first or second part of the Final M.B. during the present academic year, but are unable to produce all the evidence required by Regulation 30 or 32, may nevertheless present themselves for examination if their candidature shall have been approved by the Faculty Board, provided that they shall not be allowed to proceed to those degrees until they have produced the evidence required by those regulations. (Certain candidates may have difficulty in obtaining such facilities for instruction and practice as would justify their being granted the necessary certificates, although sufficient instruction to justify their candidature may be available. The Faculty Board have undertaken to satisfy themselves that candidates who seek this concession have been prevented from obtaining the necessary evidence by circumstances arising from the war and for no other reason.) In accordance with a further recommendation of the Faculty Board, a student may be allowed to take both parts of the Final M.B. in his eighteenth term, inclusive (not exclusive) of his first term of residence, and to take either part in his sixteenth term, inclusive (not exclusive) of his first term. Additional qualifying examinations in anatomy and in physiology will be held in December, 1939, and in March, 1940, and additional examinations in pharmacology in December, 1939, and in June, 1940, the dates to be fixed by the Board of Examinations.

At a Congregation on November 24 the following medical degrees were conferred:

M.D.—J. C. F. Lloyd-Williamson.

M.B., B.CHIR.—*J. Aspin, C. P. Petch.

M.B.—*J. W. Landells.

* By proxy.

ROYAL COLLEGE OF PHYSICIANS OF LONDON

The Harveian Oration (postponed from St. Luke's Day) will be delivered by Dr. R. A. Young on Friday, December 15, at 2.30 p.m., in the large Library of the College.