FOOTWEAR FOR THE DISABLED

Footwear causes more problems than any other article of clothing, especially for those who suffer from bunions, corns, dropped arches, swollen feet or other difficulties arising from disability. Yet enquiries by the Disabled Living Foundation revealed that little information is available to such people, particularly on sources of supply, and even professional staff are often unaware of what is available.

The Disabled Living Foundation has therefore produced a booklet, compiled by Mrs M. Thornton, called *Footwear—What to Get and Where to Get It,* which contains information specially designed to help people seeking shoes for difficult feet. The elderly and disabled will find it particularly helpful, as will doctors, nurses, chiropodists, and physiotherapists. It is available from Mrs M. Thornton, Clothing Adviser, Disabled Living Foundation, 346 Kensington High Street, London W14 8NS, price 75p.

CORRECTION

The authors of the article "Some Methodological Problems in Studying Consultations in General Practice", which appeared in the December 1976 issue of the *Journal,* regret that the following acknowledgement was omitted:

"The patients and doctors who answered our many questions and let us study their consultations made this study possible, and we are particularly indebted to the doctors who participated in the early part of the study and commented on our findings: Stuart Carne, John Fry, Brendan Jacobs, John McEwan, J. S. Norell, Raymond Pietroni, Katalin Schöpflin, William Styles, Ian Tait, and John Woodall.

Roger Mitton helped with the analyses.

The study was initially funded by the Social Science Research Council, and later on by the DHSS.

We are grateful to all these people and to our colleagues and members of our Advisory Committee at the Institute for Social Studies in Medical Care."

JOINT COMMITTEE ON POSTGRADUATE TRAINING FOR GENERAL PRACTICE

The Joint Committee on Postgraduate Training for General Practice and the Royal College of General Practitioners have now approved the vocational training schemes at Blackburn, Lewisham, and The London Hospital for a period of two years.

The following vocational training schemes have been re-approved for a period of five years: Bridgend, Bristol, Harrogate, Plymouth, and York.

All these schemes are recognized by the Royal College of General Practitioners for the purposes of the MRCGP examination.

LETTERS TO THE EDITOR

CLASSIFICATION OF DISEASE

Sir,

After some years in general practice we began to ponder the usefulness of psychiatric classification. What had happened to all the hysterics we were taught about—the funny paralyses, the stocking and glove anaesthesias? We decided it would be a good idea to check on all patients receiving psychotropic drugs, in the hope that this would reveal nearly all the psychological malaise in the practice at a given moment, and see if we could classify them.

There are two of us in the practice and some 5,400 patients of all classes. We try to run it like an old-fashioned one-man practice, in that we both try to get to know all the patients. We spend a lot of time talking to our patients when they are disturbed, but we always give them at least a small prescription for something to take the sting out of the slings and arrows of outrageous fortune. We never prescribe drugs for more than a month, and that applies to repeat prescriptions too.

There is an international statistical classification which recognizes psychosis, neurosis, and mental retardation but does not mention hysteria, and this is accepted by most textbooks, but there is also a tradition of classifying psychiatric states according to their patterns. For example, depression can mean anything from feeling 'blue' to experiencing 'psychotic intensity'. We attacked the problem from another angle. We looked at every patient individually and were able to find a category for each from our general knowledge of him or her.

We collected all the prescriptions for the month of December 1975 and categorized them, including all hospital-treated patients.

First we found there are the addicts, the sleeping-pill people, the 'Drinamyl' takers—the hard liners, if we had any. Secondly, there are the people with organic illnesses like epilepsy (we include schizophrenia here). Thirdly, there are the reactive depressives, people who have something particular to be depressed about, such as a major operation or the loss of a loved one. Fourthly comes endogenous depression. Although this may be inexplicable in terms of our knowledge of the patient and his life situation it is not, to our surprise, a hiding place for the displaced hysteric.

Next comes marriage and sex, or just sex, or just marriage. Either they do or they can't, or he or she will or won't. In orthodox terms some were depressed, some were anxious, most were both.

Then we found a group who simply couldn't cope. Modern life was just too complicated for them. They were not exactly village idiots, but getting near it and worrying about it.

Finally, we found a group whose only trouble seemed to be that they were plain selfish. Somebody is bound to ask what makes them selfish, but this is beyond the scope of this letter!

We were surprised to find how easily the patients slotted into these groups and on analyzing the results, we were further surprised to find that the total was only 149 patients, or just under three per cent of the practice population. We confess it seemed more.