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.

Twelve (eight per cent) were addicts, 17 (13 per cent) had organic illnesses, five (four per cent) had reactive depressions, and 12 (eight per cent) suffered from endogenous depression. This left 101 (69 per cent) whose symptoms were simply a cry for help—the famous *cri de coeur* of the hysteric. It looks as if the hysteric is as up to date as the schizophrenic—no paralyses for him, but a great deal of depression and anxiety. Of these 47 (32 per cent) have marriage and sex problems, 29 (20 per cent) can't cope with modern life, and 26 (17 per cent) are simply selfish.

We were a little shattered to find that marriage has more to answer for than any other reason, thus confirming the truism that interpersonal relationships remain the most important element in people's lives. We may therefore conclude that the novelist still has a major role to play in our modern world in holding up the mirror to life!

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Sir,

We find the classification of disease as described and used by Dr W. E. Dobson-Smyth (December *Journal*) interesting and practical and we intend to use the classification in our practice. We would take issue with him, however, over his criteria for diagnosis. To require specialist aid in some of the categories described is quite unnecessary, but in other ways our faith in general practice is restored. We are allowed to diagnose, totally unaided, when a patient has lost a limb or an eye!

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Reference

Dobson-Smyth, W. E. (1976). *Journal of the Royal College of General Practitioners,* **26,** 934-937.

ERRORS IN THE MORBIDITY STUDY

Sir,

Dr M. J. Jameson recently commented on the use of patient identity as a "denominator of general research" (November *Journal*) and quoted a range of 1-20 per cent as the non-match rate from the practices in the National Morbidity Study (NMS) 1971. We should like to point out that, taken out of context, these figures are rather misleading. The 1-20 per cent range related to the number of episodes (or parts of episodes) of illness for which a suitable identity could not be found in the practice register at a fairly early stage in the final processing cycle.

When the study files were complete, the distribution of non-matched people was as follows:

Percentage of non-matched people	*Number of practices*
0-	8
1-	25
2-	17
3-	6
4-	3
5-	—
6-	—
7-	1
8-	—
9-	—
10+	—
Total	60

These non-matches included a small number of temporary or private patients who should not have been included in the study and were therefore quite properly not matched in the register of NHS identities. This was particularly appropriate in the practice with the highest proportion.

The problems of linking the morbidity records to the practice registers in the NMS, using three letters of surname, initial, date of birth, and sex of the patient as the identifier, were fully detailed in the report but it may be helpful to emphasize two major sources of difficulty:

1. Transcription errors were possible at three different stages: from the MREs to the practice register cards, from the MREs to the diagnostic index sheets, and from the source documents to the computer input.

2. For new patients the participants were required to record morbidity and complete a register card from the time that the patient indicated his intention of joining the doctor's NHS list, even though this anticipated formal documentation and the receipt of the MRE from the Executive Council. Occasionally morbidity data were processed before receipt of the corresponding registration record.

Despite these problems over 80 per cent of the practices had rates of non-matching below three per cent and only one practice was above five per cent, and some of these were properly excluded as being the result of over zealous morbidity recording.

The method of calculating the population denominator from the data in the practice registers is described in the report in the chapter entitled "Some Statistical Considerations".

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References

Department of Health and Social Security, Office of Population Censuses and Surveys, and the Royal College of General Practitioners (1974). *Morbidity Statistics from General Practice (1970-71).* London: HMSO.

Jameson, M. (1976). *Journal of the Royal College of General Practitioners,* **26,** 843.

AN AID TO THE TREATMENT OF STASIS ULCERS

Sir,

When I was a clinical assistant in dermatology my chief would bet me one pound that he could heal any stasis ulcer in three months. I can recall his losing only once: his recipe for success was active movement of the ankle.

Stasis ulcers—erstwhile varicose ulcers—occur in the 'spat' area, the lower third of the leg above the ankle. They are one of the commonest and most chronic of skin problems that present in general practice. With proper and energetic treatment the majority can be healed, which is very rewarding to both patient and doctor. The cause of the skin breakdown is stasis and oedema. Treatment is by pressure either by elastic stockings or by adequate elastic bandages properly applied, perhaps with the additional pressure of a sponge rubber pad. The choice of dressing is a matter of personal preference and relatively unimportant.

Exercise materially assists in dispersing both oedema and induration. In addition, it re-educates the patient's lower leg muscles. I used to exhort my patients to spend some time each day either playing the foot pedals of a harmonium or the old-fashioned treadle sewing machine. Those who did improved so rapidly that it was apparent that a simple ankle exerciser was desirable, and so the present apparatus was born, as shown.

It consists basically of two pieces of wood, hinged at one end, with a resistance in between to increase or decrease the pressure necessary to pedal. The simplest resistance has been found to be a cube of foam rubber, with an arrangement of steps of wood to vary the load.