term *academic* and *practical*. The *academic* solution is very unsatisfactory. The patient asks, "Have I, or have I not, amoebic dysentery?" and one is bound to answer, "I do not know." The *practical* solution is to tell the patient to return *immediately* there is any recurrence of the diarrhoea, and if this is in fact due to amoebic dysentery one will always find the *vegetative* form of the amoeba. Of course, there are various objections to this procedure, among which is the fact that the patient may in the meantime develop an acute hepatitis, but this in no way affects the general principle. In addition, one may resort to stool culture on special media and, I understand, there is some work being done on a complement-deviation reaction.

Tropical medicine, like all other branches of medicine, consists of a structure of knowledge and experience based on an appreciation of fundamentals, among which is the action of emetine on the amoeba of dysentery. That so many misconceptions have arisen is, I feel certain, due to the fact that a large number of doctors during the war, through no fault of their own, have had thrust upon them a subject which they have rarely, if ever, had to consider before.—I am, etc.,

London, W.1.

D. LAWRENCE.

Novel Method of Digital Traction

SIR,—Dr. MacLeod (Oct. 26, p. 614) is incorrect in thinking that nail traction in the treatment of fractured phalanges is novel. While in charge of the fracture department at Guy's Hospital I used this method for many years as the routine treatment for oblique fractures of the phalanges. The method was described and illustrated in an article on "Fractures of the Upper Limb" (*Guy's Hospital Reports*, 1921, 71, 360), and on several other occasions. In most cases I found it possible to perforate the free edge of the nail painlessly and without anaesthesia, and a fine salmon gut suture was my material of choice for traction. The method is one I found of great use, and when established the traction, which in my practice was maintained via a rubber "accumulator," is quite painless.—I am, etc.,

London, W.1.

E. G. SLESINGER.

Classification of Psychological Disorders

SIR,—The conclusions of Dr. Dalton Sands in his most instructive and admirable article on "Electro-convulsion Therapy in a General Hospital" (Aug. 31, p. 289) seem perfectly logical. However, in the cases of "anxiety state" or "anxiety neurosis" to which Dr. Frederick Dillon refers, supposed elements of guilt and tension from aggressive impulses may be quite wrongly interpreted by inexperienced psychiatrists when the anxiety is due to perfectly obvious and innocent reasons which they have not ascertained, the real elements of guilt and aggressive impulses lying completely elsewhere.

Under these circumstances, as Dr. Dillon rightly points out, not only are statistical studies on psychological disorders, in the present state of our knowledge, very apt to be misleading, but they may be wholly erroneous, and will continue to be so unless the whole question is considered *de novo*; and it follows that any knowledge based on such false premises is false knowledge.—I am, etc.,

London, N.W.11.

A. LIONEL ROWSON.

Painful-feet Syndrome

SIR,—I was most interested in Surgeon Commander Page's excellent article on painful feet (Aug. 24, p. 260). On the capitulation of the Dutch East Indies in March, 1942, 3,500 Allied prisoners, mostly British, were interned in a camp at Tandjoeng Priok, Java. The painful-feet syndrome developed in July, and by October a conservative estimate of the number of cases in the camp would be 1,000. They presented all the signs and symptoms of Commander Page's cases with the exception that gangrene was not found, possibly due to the warm climate.

Certain canteen supplies were allowed into the camp in October, and it was found that a daily ration of 100 g. of boiled kachang idjau (a small type of green pea) had a most beneficial effect on the condition, resulting in complete relief

of symptoms in approximately 80% of the cases within two weeks.

At a later date a liver extract (crude), obtained from Dutch sources outside the camp, was being tried out in the treatment of patients with "blurred vision," many of whom at the same time were suffering from burning feet. It was noticed that while it proved of no apparent value in the former complaint it completely cured or greatly improved the condition of those patients who had painful feet. Following on this discovery 2 ml. of the liver extract, of which available quantities were very limited, were injected intramuscularly at intervals of two to three days in a few very persistent cases of painful feet, and rapid cure resulted.—I am, etc.,

Naini Tal, India.

J. E. O'DONNELL,
Major, I.M.S./I.A.M.C.

Legal and Medical "Insanity"

SIR,—In your correspondence on crime and insanity, Dr. D. Stafford-Clark (Oct. 26, p. 627) very relevantly points out that nebulous speculations on right and wrong are of little practical value, and rightly draws attention to the problem of the psychopath, a problem frequently encountered by military psychiatrists during the war. Some of the difficulties which arise on how best to deal with these medico-legal problems surely arise from the different psychology of psychiatrist and lawyer. The latter often views the problem too logically; to say that if a lunatic kills because he hears the voice of God he is not culpable, as he would be expected to obey His voice, but that he cannot be similarly excused if it is only the voice of Mr. Smith—an argument once put forward—is good logic, but poor psychiatry. For it is the great effect aroused in a paranoiac, or the impulsiveness of the schizophrenic, which results in the crime, irrespective of the cognitive side.

I believe I am right in saying that the McNaghten Rules were formulated on the legal tenet that a crime can only be excused if the prisoner's state of mind—like that of an infant—could not form criminal intent. The law ignores the fact that insane impetuous behaviour can occur, although full insight into the quality and illegality of the act is preserved. Therefore, while admitting that irresistible impulse in a sane individual cannot be accepted as a plea while there is no means of proving that it was irresistible, one would think the McNaghten Rules could safely be extended to a third clause, i.e., that if there is gross disease of mind and a consequent inability to control conduct, this would justify a plea of guilty but insane. The matter is largely academic, and if capital punishment goes, this plea will probably never be put forward. If the lawyers are too logical, the same reproach is not always applicable to the psychiatrist. I have heard it urged that the obsessional neurotic is not culpable because the *cause* of his behaviour is unconscious—a complete irrelevancy, as what matters clearly is not the causation, but *proof* that control of the impulse is genuinely impossible. Neither do appearances in the witness-box to testify that for years successful forgery was performed in a state of unawareness, or similar sincere but somewhat unlikely hypotheses, help to reassure the legally minded. Yet in the case of the psychopath, as the *Times* states, medical is ahead of legal opinion.

Psychopathy is hard to define, but if we cease to try and find a formula whereby the psychopath can be regarded as not culpable—an impossible and dangerous doctrine—and treat psychopathy as a form of insanity, surely a practical solution lies to hand? A lunatic, like a psychopath, is hard to define, but all we are called upon to do when certifying is to produce evidence of unsound mind, and that the patient in consequence needs "care and treatment for the sake of himself and others." Thereupon he receives an "indeterminate sentence," only as it is to a hospital and not a prison the idea is tolerated. Why cannot the criminal psychopath be dealt with similarly?—i.e., where the court has grounds to regard a prisoner as a true psychopath, let a suitably constituted board certify him as such, and commit him to a form of special institution, with powers to release him if at any time it is felt this can safely be done. As with the insane, borderline cases might not be certified, whereas obvious cases, on whom imprisonment has not the slightest effect, would not be turned loose on society. Nor would a clan of individuals, quite a number of whom are

genuinely desirous of but incapable of inhibiting their impulses, be subject to spells of useless and cruel punishment. For the very same temperamental defects which lead many psychopaths into breaking the law also render them particularly unamenable to ordinary prison discipline. In consequence they are a source of great trouble to the prison staff, and often become severely depressed. It is very much to be hoped that the Prison Reform Bill will make some alternative to ordinary imprisonment where at least the above types of psychopath can be sent.—I am, etc.,

London, W.1.

W. LINDESAY NEUSTATTER.

SIR,—Most psychiatrists will surely agree with the timely observations of Drs. McCluskie and Cuthbert (Oct. 12, pp. 555-6).

(1) It is hardly credible that, in England to-day, the only legally accepted criteria for the diagnosis of mental illness in criminal trials are those formulated over one hundred years ago in the McNaghten rules (1843). It is doubtful whether the latter were even at that time in harmony with contemporary medical opinion; but the tremendous advances made in the twentieth century in psychiatry and in the understanding of criminal psychopathology have been completely ignored by the law. To mention but one gross misconception, the rules assume throughout that an insane person is necessarily "afflicted with insane delusion." To quote the report submitted by the Medico-Psychological Association to the Committee on Insanity and Crime (1924): "Unsoundness of mind is no longer regarded as in essence a disorder of the intellectual or cognitive faculties. The modern view is that it is something much more profoundly related to the whole organism—a morbid change in the emotional and instinctive activities, with or without intellectual derangement. Long before a patient manifests delusions or other signs of obvious insanity he may suffer from purely subjective symptoms, which are now recognized to be no less valid and of no less importance in the clinical picture. . . ." (Cmd. 2005.) The report adds that the McNaghten rules "do not now appear to be considered in Scotland," and quotes in this connexion Lord Dunedin, Lord Justice-General (1907), as follows: "It is quite certain that what may be called the scientific view on insanity has greatly altered in recent years, and Courts of Law, which are bound to follow, so far as they can, the discoveries of science and results of experience, have altered their definitions and rules along with the experts. . . ." It is fortunate indeed that contemporary legislation on the treatment of mental illness or, for example, on matters of public health, is not similarly based on the medical knowledge of over a century ago.

(2) It is time the concept of the "uncontrollable impulse" were given legal recognition, as recommended by the Committee on Insanity and Crime: "It should be recognized that a person charged criminally with an offence is irresponsible for his act when the act is committed under an impulse which the prisoner was by mental disease in substance deprived of any power to resist." This conception is by no means a new one: Pinel (1801) referred to *la folie raisonnée*, a mental illness in which reason and intellect were unimpaired; and J. C. Prichard (*A Treatise on Insanity*, London, 1835) introduced the term "moral insanity" as designating "madness consisting in a morbid perversion of the . . . affections . . . moral dispositions and natural impulses without any remarkable disorder or defect in the intellect or knowing and reasoning faculties and particularly without any insane illusion or hallucination." The McNaghten rules have been rightly criticized in that "they identify responsibility with knowing and reasoning, whereas any medical man with experience of the insane must know of many persons as to whose insanity (and irresponsibility) there can be no possible doubt, who have realized the nature and quality of their act, have known that it was contrary to law, human and divine, and have shown remarkable cleverness in carrying out their object." (M.P.A., *loc. cit.*) In the United States, the "irresistible impulse" test was first introduced in 1884, and to-day it is used in seventeen States.

(3) The importance of ensuring that expert witnesses in such cases shall be suitably qualified psychiatrists cannot be exaggerated. It is true, however, that medical evidence at the present time is seriously distorted in having to fit in with obsolete legal conceptions of insanity. A jury is not competent

to understand the implications of specialized psychiatric evidence, as was abundantly clear when a juror asked whether there was "anything in Heath's physical condition . . . which would cause present disease of the brain," the assumption being, presumably, that in the absence of organic disease there could be no "disease of the mind." There is much to be said in favour of establishing a panel of "medical practitioners with expert knowledge and experience of psychological medicine and of recognized standing" whose competence and impartiality could not be questioned, and who would furnish a report on the accused in all appropriate cases to prosecution and defence before the trial (as advocated by B.M.A. and M.P.A.).

It is to be hoped that these matters, as also the question of indeterminate sentence, will receive full and careful consideration during any future discussion on the Criminal Justice Bill, and that this will result in more enlightened legislation similar to the Briggs Law in Massachusetts (1921), and the laws on sexual offenders in Illinois (1938) and certain other States of the U.S.A.—I am, etc.,

Chelsea, S.W.3.

R. H. AHRENFELDT.

SIR,—Your correspondent (Oct. 26, p. 627) in reply to my letter (Oct. 12, p. 555) states that the "essence of the present legal view is surely that a man is either responsible or certifiable." No, Sir, not by any means. The essence of the present legal view is that in the case of conflicting medical evidence the jury (butchers, bakers, and candlestick makers) are asked to do the certifying—guided unerringly by the McNaghten Rules. Your correspondent also adds that "this has the merits of logic, justice, and simplicity." Simplicity is the word.—I am etc.,

Westcliff-on-Sea.

JOHN A. MCCLUSKIE.

Work of Government Lymph Establishment

SIR,—I read with great interest the article on the work of the Government Lymph Establishment, published in the *British Medical Journal* of Oct. 26. I feel, however, that the late Lieut.-Col. W. D. H. Stevenson, who was the Director of the Government Lymph Establishment from 1929 until his death last year, would have wished to have added to it his oft-repeated appreciation of his entire staff for their co-operation during the war years, when they increased the output of lymph so magnificently.—I am, etc.,

Stanmore, Middlesex.

J. AUDREY M. STEVENSON.

Man in Relation to His Environment

SIR,—In the *Journal* of Sept. 28 (p. 471) it is reported that Sir P. Manson-Bahr (at the British-Swiss meeting) remarked: "There were also geographical questions to be considered. How was it that heat stroke was much more common in the Irak area than anywhere else—for instance, in western Libya—where the conditions were much the same?" This question was answered by Air-Commodore Morton in his paper "Heat Effects in British Service Personnel in Iraq" (*Trans. roy. Soc. trop. Med. Hyg.*, 1944, 37, 347). Morton took a number of "salted" men from the Western Desert for a trip round an Iraq desert—just a few hours—allowing them to wear the headgear they had become habituated to in the Western Desert. They collapsed and had to take to "reactionary" forms of protection. The deserts of Mesopotamia are very much hotter than anything in Libya, in spite of the prestige attaching to the latter.

Prof. McCance, at the same meeting, remarked that " . . . in the Tropics water was lost so quickly that the stimulus was never quite sufficient to enable the individual to drink himself back to normal. This had not been appreciated by those who had to live and work in the Tropics and handle men there." Prof. McCance's remarks do not apply to *all* who were responsible for the care of men in the Tropics—there are many enlightened individuals among the medical profession in hot countries. The trouble is that they cannot get their good ideas put into practice by the authorities responsible for policy. Dr. E. A. Carmichael stated: "The process of acclimatization or adjustment required from 4 to 7 days, by which time approximately 80% acclimatization had occurred."

I showed in 1935 (Marsh, F., *Trans. roy. Soc. trop. Med. Hyg.*, 29, 309) that acclimatization takes from 4-7 months for