relevant to point out that yeast extract was not used on patients in the relapse phase of the disease, and that careful clinical observation revealed no beneficial effects from it during remission.—I am, etc.,

Staines, Middlesex.

K. D. KEELE.

Hospital Treatment of School-children in Shropshire

SIR,—I wish to bring to the notice of the profession at large a situation which has recently developed in Shropshire, which this Branch regards as one of the utmost gravity in its bearing on the everyday work of the general practitioners of the area, and the implications of which are widespread and ominous. The Education Act, 1944, imposes on local education authorities "the duty to make such arrangements for securing the provision of free medical treatment for pupils in attendance at any school or county college maintained by them as are necessary for securing that comprehensive facilities for free medical treatment are available to them."

The Education Committee of the Shropshire County Council, in drawing up its scheme, has decided that all hospitals with which it proposes to enter into arrangements for the treatment of school-children shall comply with the following conditions:

"(1) There shall be on the staff of the hospital a resident medical or surgical officer, or both, according to the type of case to be dealt with.

"(2) Treatment for eye, ear, nose, and throat conditions shall only be carried out by, or under the supervision of, a specialist in the appropriate condition, who shall be of consultant status.

"(3) Surgical cases of all categories, whether requiring operative treatment or not, shall only be treated by, or under the supervision of, a Fellow of the Royal College of Surgeons of consultant status, who will himself be expected to carry out any operative treatment required unless it is of a very minor nature.

"(4) Medical cases shall only be treated by, or under the supervision of, a physician of consultant status."

It will be plain to all that the application of these conditions results in the complete elimination of the general practitioner from any part in the treatment of such children, which now may only be carried out in such hospitals as have an active staff of consultant status. In Shropshire this has resulted in a remarkable state of affairs. The county is a large one, covering an area of 1,346 square miles, and having a population of 262,000. Within its borders there is only one hospital available for general medical and surgical cases which fulfils the conditions laid down. It contains 280 beds, is already hard pressed for accommodation, and has long lists of patients awaiting admission—nearly 500 in fact.

On the other hand Shropshire is fortunate in having no less than eleven smaller hospitals of the "cottage hospital" type, widely distributed over the county, with a total of about 250 beds, staffed by the general practitioners residing in their vicinity, and in a high state of efficiency, with consultants available when expert assistance is required. In these hospitals much excellent work of an unspectacular nature has been and is being carried out to the satisfaction of the public, the convenience of patients and their relatives, and, not least, to the relief of the major hospital.

As a result of what I can only describe as the deplorable decision of the local education authority, taken without any approach having been made even to the authorities of the main hospital, these 250 beds will no longer be available to children of school age, since the edict has gone forth that none may treat them who is not of consultant status.

I ask you, Sir, is not this an outstanding example of planning gone mad? And I believe that when the matter is raised at the Representative Meeting it will be dealt with in such a way as to convince those concerned and any others—if such there be—of a like mind that the profession will not submit to such treatment.—I am, etc.,

H. W. BAMBRIDGE,

Wellington, Salop.

President, Shropshire and Mid-Wales Branch.

Fowl Paralysis and Poliomyelitis

SIR,—I was most interested to read Dr. J. A. Goodfellow's account of his experiments on fowl paralysis (Oct. 11, p. 586). In 1937 I saw a child with poliomyelitis on an isolated farm in Herefordshire and was surprised to find a hen lying paralysed in the farmyard at the same time. There were no other cases of

infantile paralysis notified in the district and no more chicken paralysis on the farm. I removed the brain and spinal cord from the hen and sent these to the National Hospital for Diseases of the Nervous System, Queen Square, for histological examination. It was reported that no abnormality could be found.

No doubt the simultaneous occurrence of the two diseases was a pure coincidence, especially as fowl paralysis is not an uncommon disease, but it would be interesting to hear from county doctors whether such a phenomenon is often observed.—I am, etc.,

London, S.W.1.

F. L. KING-LEWIS.

Homosexuality and "Sexual Trauma"

SIR,—Those who are concerned with the social and clinical problems of homosexuality will welcome Mr. D. Stanley-Jones's able refutation (Oct. 25, p. 671) of the theory that seduction in childhood or early adolescence is an important aetiological factor in these cases. In addition to his cogent reminder of the frequent occurrence of homosexual experiences amounting to "seduction" in the early life-history of many well-adjusted heterosexual adults it is possible to adduce further evidence in support of the view that the "traumatic" significance of sexual seduction or assault in childhood has been greatly over-emphasized. The usual tendency has been to argue *a priori* on the basis of certain subjective ethical and moral concepts that, because such assaults are deemed to be morally "wrong," therefore they cannot fail to produce disastrous effects on their victims.

(1) As A. J. Rosanoff¹ has stated, "such evidence as is available would seem to indicate that such seduction can only be of lasting effect if its direction corresponds with the inherent sexual tendencies of the subject"—i.e., psychiatric investigations tend to show that any "lasting effect" is produced, not by the seduction, but by (a) constitutional and endocrine factors, (b) psychosexual immaturity resulting from disturbances in the child-parent relationship in early childhood, or (c) more probably (in the light of contemporary research into psychosomatic interrelationship) a combination of both factors.² In all true adult homosexuals who have been thoroughly investigated there has been some indication that one or both of these factors have long been present *prior* to any seduction or assault. Furthermore, psychiatric experience shows that many true homosexuals have never been subjected to seduction in childhood and, indeed, have never had any physical relationship whatsoever.

(2) Psychiatric investigations have established beyond doubt that, in very many cases of childhood "seduction," it is the so-called "victim" who is in fact the seducer, and that the sexual act with the adult may be actively sought by the child as an expression of the latter's unconscious impulses and fantasies⁴—i.e., that a predisposition in the child may not infrequently be the cause of the alleged seduction. K. Friedlander⁵ states that "it is very rare for boys who do not already display homosexual tendencies to be exploited in this way. . . . More often than not, young boys will offer themselves, if not in words then by gestures, to older men."

(3) There is considerable evidence that the large majority of children and young adolescents who have been seduced or assaulted, either by adults or by other children, and whether the act be homosexual or heterosexual, show in adult life no sign whatsoever of sexual or psychological maladjustment or abnormality. Doshay⁶ found that, among 108 unselected cases who between the ages of 7 and 16 had been involved in sexual delinquencies, there was "not a single instance of a known sex violation in adult life"; and of 148 additional cases, all of whom at the same age had been involved in both sexual and other offences, only 8 committed known sexual offences (of a minor type) in adult life, whereas no less than 25% committed further non-sexual delinquencies. Doshay states that the most frequent sexual offence (in over 40% of his cases) involved sodomy with adult men, older and younger boys, or with girls, and observes that "these practices . . . ought not, when occurring among juveniles, to be regarded in too morbid a light, nor should the boys be considered 'perverts' or 'homosexuals,' as noted in some of the texts. The vast majority of offenders engage once or a few times in these unwholesome affairs and turn from them spontaneously with disgust, shame, or fear of

exposure. . . . Of 256 cases, only two . . . revealed such deep interest in and craving for homosexual practices as to warrant the designation of 'homosexual' (and, one may add, the assumption of a fixed inherent predisposition). These findings are largely confirmed by the very thorough investigations of Bender and Blau,⁴ and Rasmussen (in girls).⁷

(4) Finally, in attempting to evaluate, in adult homosexuals, the aetiological significance of alleged early seduction or assault (particularly where the history is based on relatives' accounts or official records of the patient's evidence as a child), it is necessary to bear in mind the notorious unreliability of children's evidence, especially with regard to sexual matters, which has long been stressed by many medico-legal authors.^{8, 9, 10} The child is frequently incapable of differentiating reality from fantasy (and this may equally apply to the adult's "reminiscences"). Furthermore, the relatives of an adult homosexual who is involved in legal action may be very ready to assert, in reply to legal or medical inquiries, that such a "sexual trauma" was responsible for his present predicament, just as others may, with equal force, proffer "evidence" of physical trauma as the alleged cause of cancer or of mental illness.—I am, etc.,

London, S.W.3.

R. H. AHRENFELDT.

REFERENCES

- 1 Rosanoff, A. J. (1946). Quoted by Dillon, F., *British Medical Journal*, **1**, 450.
- 2 Fenichel, O. (1945). *The Psychoanalytic Theory of Neurosis*, pp. 324 ff. New York.
- 3 Abraham, K. (1942). *Selected Papers*, pp. 47 ff. London.
- 4 Bender, L., and Blau, A. (1937). *Amer. J. Orthopsychiat.*, **7**, 500.
- 5 Friedlander, K. (1947). *The Psycho-Analytical Approach to Juvenile Delinquency*, p. 163. London.
- 6 Doshay, L. J. (1943). *The Boy Sex Offender and His Later Career*. New York.
- 7 Rasmussen, A. (1934). *Acta psychiat. neurol. Kbh.*, **9**, 351 ff.
- 8 Gross, H. (1898). *Kriminalpsychologie*, pp. 493 ff. Graz.
- 9 Mill, A. (1931). Revised ed. *Psychopathia Sexualis* of R. Krafft-Ebing, pp. 871 ff. (French transl. Paris.)
- 10 Motet, A. A. (1887). *Les Faux Témoignages des Enfants devant la Justice*. Paris.

The Bedtime Meal

SIR,—“Milk and biscuits at bedtime are the cause of tonsils and adenoids”—is there any truth in so extreme a statement? A bedtime meal is followed, like any other, by the gastro-colic reflex. That in its turn is followed shortly by the filling of the rectum. But, except in infants, there the sequence ends. The final event, evacuation, is discouraged in early childhood and its inhibition becomes habitual. The rectum remains full all night, as is now usual, instead of empty, as is normal. Thus the astringent functions of the lower bowel are in play for some hours. Nothing more happens until, after breakfast, the rectum is filled still further and the sequence terminates in the ordinary way with the morning action. But the unduly firm consistency of the stool calls for a lubricant, which is supplied. The call for mucus is responded to—in the rectum, where it is needed—but the response to that call does not discriminate accurately between the sites needing supply. The nose and throat are apt to receive mucus at the same time as the rectum.

If the only result of the twelve-hour constipation were an occasional sneeze or a brief rhinorrhoea, the penalty might be thought negligible. But the constantly recurring exudation of a little mucus makes the nasopharynx more liable to receive and harbour infective organisms. That chronic catarrh should result and the tonsils enlarge, as armament factories do in war-time, is to be expected—in the way of attack and defence.

To enucleate the tonsils because they have responded to the call is nowadays seen to be bad practice; for, intact, they protect the child—against infantile paralysis certainly and, likely, against a host of other pathogens. Removal is reserved for any that are overwhelmed and stuffed with pus or “cheese” and for those few that are seriously obstructive. But *caveat sanitatis custos*. I have removed, thinking them guilty, tonsils which have proved innocent, and felt shame to take the county council's guinea. I tried to find consolation in Sir Thomas Browne: “Where I do him no good methinks it is scarce honest gain, though I confess 'tis but the worthy salary of our well-intended endeavours.”

How come the children to tolerate the twelve-hour constipation? It is certainly because their food is denatured. From the wheat destined for bread half the offals are taken. That is 15% of the weight of the grist. From that destined for manu-

facturing flour all the offals are still taken, just as they were for the pre-war flour. All the crease-dirt is removed from both. “Offals” and “crease-dirt” are opprobrious words for items of our optimum diet. In the first are the cellulose, some of the semolina, and all the vitamins. The second consists of the minerals the plant has sucked from the soil and stored under the crease in the seed. Deprived of these the gut is languid. That answers the question.

If the child's supper were prepared from the whole grain, ground finely if you will, and made into any chosen form—bread, biscuits, wheaten porridge (though for that it should be merely broken into rather large fragments), or creed and made into frumenty, which is good but forgotten—and if before bed the final reflex of the digestive sequence, the action, were completed, all would be well. For this to happen there must be some interval. Theseus (*A Midsummer Night's Dream*) asked:

“What dances shall we have

To wear away the long age of three hours

Between our after-supper and bed-time?”

That is too long, but Shakespeare's hint deserves attention in the nursery.—I am, etc.,

Holmes Chapel, Cheshire.

LIONEL JAS. PICTON.

R.M.B.F. Christmas Appeal

SIR,—I gratefully acknowledge many generous contributions towards this year's Christmas Gift Fund, but we are still far short of the sum needed to ensure that all of our regular beneficiaries are remembered. May I make a further appeal to those readers who are in sympathy with our work and who have not yet sent a contribution to forward their donations to: Royal Medical Benevolent Fund, Christmas Gifts, 1, Balliol House, Manor Fields, Putney, London, S.W.15, as soon as possible, as the distribution of gifts is made some days before Christmas.—I am, etc.,

ALFRED WEBB-JOHNSON.

President, Royal Medical Benevolent Fund.

The Lazy Eye

SIR,—May I venture to suggest that the wider implications of the discussion as to the value of occlusion in the treatment of “amblyopia” in children merit further study. Recent surveys of recruits called up under the national service scheme show that 6–8% manifest defects of sight as gauged by (uncorrected) visual acuity of not higher than 6/18 (Snellens) in one eye. Thus, after elimination of congenital and other factors, some 5% of the young male population have by the age of 18 incurred an “amblyopia” associated with squint or high refractive error.

A large proportion of these men state that either they have never had their eyes “tested” or else that they have joyfully discarded their glasses at the first opportunity. The recent discussion held at Leeds by the School Health Service Group of the Society of Medical Officers of Health concerning “Ascertainment of Visual Defect in Children” (*Public Health*, 1947, **60**, 215) would indicate some of the ways to tackle this very real problem.—I am, etc.,

London, S.W.1.

G. C. DANSEY-BROWNING.

Ourselves and the Russians

SIR,—You published (Aug. 30, p. 339) a leading article entitled “Ourselves and the Russians” in which you criticized an article in the Soviet periodical *Meditsinsky Rabotnik* of July 3, 1947. In the Soviet article Dr. Radbil had castigated the *B.M.J.* for what he described as its “sham political neutrality.” At the time I was impressed by the spirited reply of the Editor of the *B.M.J.*, though the sneering manner in which Dr. Radbil was referred to personally made me wonder how the quotations from his article would have sounded in their original context. Unfortunately the *Meditsinsky Rabotnik* cannot easily be referred to in this country, and it was finally only owing to the courtesy of the Editor of the *B.M.J.* that I was able to see the Soviet article.

I have no desire now to open a discussion of the merits (or demerits) of either article, and, indeed, having read both articles, I would be perfectly prepared to defend either—or