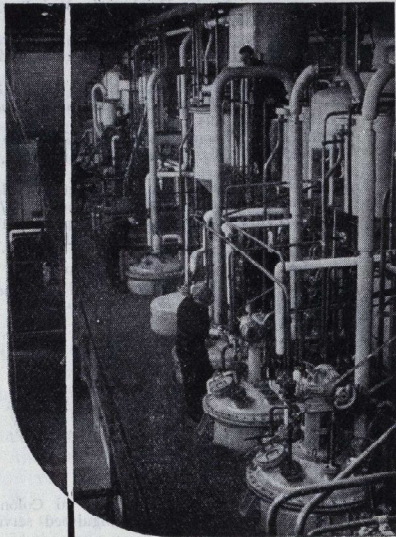


## 'QUINACRINE' & 'PRAEQUINE'



### a new field

It was in the month after war broke out, October 1939, that May & Baker, Ltd., applied for compulsory licences under the Patents etc. (Emergency) Act, 1939, to manufacture synthetic antimalarials.

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and of Pamaquin, were first marketed in January 1940.

This is not the time nor the place to tell the full story of the work that went on behind the scenes and that eventually resulted in output being increased thirtyfold.

We do not think that to make these simple facts known is to detract from efforts made by other firms in this country and in America in a similar direction.

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# ST. BARTHOLOMEW'S



## HOSPITAL JOURNAL

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### THE ABERNETHIAN SOCIETY

This year the Abernethian Society celebrates the 150th anniversary of its foundation. We offer our congratulations and our best wishes for the future.

During the war the Society has not flourished as in former days. Evacuation to sector hospitals, air raids, the increased commitments of staff and students, the scarcity of possible speakers, and all the hundred and one vicissitudes of war have made it impossible to arrange regular meetings: and further, only a small number of people have been able to attend such meetings as have been held. It is gratifying and appropriate that in this anniversary year the Society is showing renewed signs of life. The Society has had its ups and downs before now and we are confident that now, as before, it will triumph over all obstacles and resume its important place in the life of the hospital.

A hospital medical society is not merely a means of retailing detailed or obscure medical knowledge. Nevertheless, perhaps its most obvious function is to enable us to hear at first hand distinguished medical and scientific men from the hospital and from outside it. This instruction in scientific method and in the first principles of research is a valuable adjunct to medical education. Secondly, such a society allows of lectures and discussions on a broader range of subjects, on the history and on the ethics of medicine, and upon any number of subjects allied to its teaching or practice. Thirdly, there is an important social function that the Society can perform. At its meetings members of the staff and students, whether nearly qualified or at the beginning of their career, can meet on common ground and are united by a common band of interest. From this point of view the Abernethian Society is unique among the societies and clubs of the medical

school and potentially a powerful integrating factor in the life of the hospital.

We should like to appeal to all readers of the JOURNAL to support the officials of the Society in getting the wheels running smoothly again. It serves no useful purpose to conceal the fact that those who have struggled so gallantly in recent months to re-establish the Society on its old footing have had to fight the apathy of a large section of the student body. This wholly regrettable state of affairs is doubtless due in some measure to the fact that the traditions of the Society have become obscured by the smoke and the fog of war. The occasional meeting that has been held, though each one has been excellent in itself, has not given an accurate picture of what the Society has to offer when it is working under normal conditions.

With the return to more normal conditions we hope that the Society will extend the range of its activities to include, in addition to lectures, discussions, debates, the showing of films of scientific interest and revive the "clinical evenings," at which cases of exceptional interest can be demonstrated. The Society should not be so awed by its long and distinguished history as to be frightened of innovations. In this connection we would suggest that more attractive methods of publicity could be used to advantage. The dreary, pencilled posters, better suited to announcing the board meeting of a firm of undertakers, invest the announcement of even the most fascinating meeting with an air of shamefaced, apologetic gloom. Whenever possible meetings should not be held in the lecture theatres. Their barren and formal atmosphere serves to create the impression that a meeting is merely an additional, but voluntary, lecture. The likelihood of profitable informal



discussion is greatly reduced.

In 1895 to celebrate the centenary of the Abernethian Society the Committee were able to organise a very ambitious programme of celebrations, including demonstrations in all the various departments of the hospital, lectures, a play, a concert and, believe it or not, a dance

in the dissecting room. Presumably this year such indulgences will not be possible, but in an unspectacular manner we can all contribute to making 1945 just as significant a year in the history of the Society. The co-operation and support of the staff and students can re-establish the Society on a firm and enduring basis.

### SIR GIRLING BALL

It is with profound regret that we have to announce the death of Sir Girling Ball. His death is a grievous blow to the Hospital and Medical College. We take this opportunity to offer our condolences to his family and friends. A full obituary of Sir Girling will appear in the September issue.

### IRON AND ANAEMIA

By R. BODLEY SCOTT

Of all the substances needed to preserve health, that of which the human body most commonly shows signs of deficiency is iron. The earliest overt effect of this deficiency is an anaemia, described in hæmatological jargon as hypochromic and microcytic, for the red blood cells are poorly filled with hæmoglobin and often reduced in size. Proof of its cause is given by the rapid cure of this anaemia by iron. An attempt is made in this paper to show how an understanding of iron metabolism not only reveals the ways in which iron deficiency may arise, but provides this group of anaemias with a unity hitherto lacking and gives the physician a logical basis for their management.

From the standpoint of iron deficiency, the element can be said to exist in the body in three forms: first, as blood iron; secondly, as iron stored but available for hæmoglobin formation, and thirdly as tissue iron. This last may be dismissed briefly: iron is an essential component probably of all living animal cells but, however profound the deficiency, this tissue iron is never withdrawn for hæmoglobin formation; thus its present discussion is irrelevant.

In the blood, iron is again in three forms. The bulk is in combination in hæmoglobin, of which it constitutes 0.335 per cent. by weight; the total hæmoglobin iron in an average normal

adult amounts therefore to some 2.65 gm. The plasma and "easily split off" fractions account for the remainder. In plasma the quantity varies in health between 0.05 and 0.18 mgm. per 100 ml.; it is unionised, trivalent and possibly in combination with plasma globulin.<sup>17, 19</sup> The "easily split off" fraction is so called because it is split off when blood is treated with dilute mineral acids; it amounts to between 1.8 and 5.0 mgm. per 100 ml.; its chemical nature is unknown, but it is in organic combination and may represent an intermediate step in the breakdown of hæmoglobin to bilirubin.<sup>16, 19</sup>

Storage iron is the third type normally present in the body. This exists probably as ferritin, an iron-phosphorus-protein complex, in the liver, spleen, bone-marrow, lymph-nodes and sometimes in the kidneys.<sup>3</sup> When the metal is required for hæmoglobin synthesis, it is withdrawn from these stores. The total amount held in this form is uncertain, but experience has shown that a normal adult's hæmoglobin may be reduced by hæmorrhage to a level of 50 per cent. and return to normal without the administration of additional iron. There must be, therefore, in an available state, sufficient to rebuild at least half the normal mass of circulating hæmoglobin, that is, about

1.32 gm.

Knowledge of the excretion of the metal has grown within recent years: it is known that only small quantities (0.03—0.8 mgm. daily) are lost in the urine;<sup>4</sup> loss in the bile is of a similar order (0.2 mgm. daily in a dog) and bears a constant relationship to the activity of blood destruction.<sup>5, 11</sup> For years it was accepted that the major excretion was by the colon, but work of the past decade has shown this to be untrue.<sup>14</sup> To determine the route of excretion, balance experiments are unsatisfactory as it is impossible to distinguish, by fæcal analysis, between iron which has passed unabsorbed down the alimentary tract and that which has been absorbed and later excreted by the colonic mucosa. In normal adults on high or low intakes of iron, fæcal loss almost exactly equals oral intake and parenteral injection is not followed by notable increase in fæcal excretion.<sup>15</sup> Thus the amount excreted by the bowel is small, and it is justifiable to conclude that the total excretion of iron by the body is insignificant and no mechanism exists whereby it can be varied to regulate iron metabolism.

But a regulatory mechanism does exist and it is founded upon the control of absorption. At this point a digression must be made to explain the method used to elucidate this process. It is possible, by bombarding a solution of an iron salt in a cyclotron, to endow the metal with radioactive properties while its biological behaviour is unaltered. Such radioactive iron can be detected in the most minute quantities by virtue of its emission of beta-rays; it is thus distinctively labelled and if administered to an animal or human being, its subsequent course in the body can be followed. By this means it has been possible to show that absorption of iron is controlled by the body's needs for the element: an iron-deficient dog will absorb 4.1—12.7 per cent. of an oral dose of radioactive iron, contrasted with 0.8—0.25 per cent. in a normal animal.<sup>6, 7</sup> Similarly the iron-deficient human shows an uptake three to ten times that of the normal and in those conditions where iron stores are high, such as pernicious anaemia in relapse, absorption is sub-normal.<sup>1</sup>

Following acute blood loss, there is no increase in absorption for seven days; after this period, which coincides with the utilisation of storage iron, uptake reaches a high level even though the hæmoglobin reading has started to rise.<sup>8</sup> This observation suggests that depletion of iron reserve, rather than anaemia, controls the process.

The details of this unique regulatory mechanism

remain unknown: some view it, in a physico-chemical light, as dependent on relative ionic concentrations of iron, others as a function of the protein metabolism of the intestinal epithelium.

The site of absorption is still uncertain, although it is generally held to be the stomach and upper part of the small bowel. In the dog, it has been shown that iron is rapidly taken up from gastric, duodenal and jejunal pouches.<sup>8</sup> Uptake depends secondarily on conditions in the alimentary tract at the site of absorption: the metal must be in a soluble state and probably in the ferrous form. The normal gastric acidity promotes solubility and prevents conversion of ferrous to ferric ions; thus achlorhydria and administration of alkalis impair assimilation. A further impediment is offered by the formation of insoluble compounds of iron with phosphorus, amino acids and bile salts. Much of the normal dietary intake is in organic combination and consequently of low availability.

After absorption, iron is transported in the plasma. A single dose of an iron salt by mouth is followed by a rise in the plasma iron, maximal in 2½ to 5 and falling to normal in 12 hours.<sup>17</sup> In iron deficiency the figures for plasma iron are low (0.015—0.040 per 100 ml.) and, in some cases, the rise following an oral dose is greater than normal. In patients with pernicious anaemia in relapse, where iron stores are high, the rise is negligible.<sup>18</sup> This transient increase in plasma iron given no indication of the total quantity of the metal absorbed.

Details of the metal's metabolism from this stage onwards are uncertain. Experiments with the radioactive isotope have shown that, of iron injected or absorbed, much is converted in the liver to ferritin; it is probably in this state that storage occurs.<sup>9</sup> When necessary the incorporation of iron into hæmoglobin is effected with great rapidity, for radioactive iron can be demonstrated in red blood within four hours of its oral administration.<sup>10</sup>

On this survey of iron metabolism must follow a consideration of the body's normal needs for the element, from birth to adult life. The new-born infant receives from its mother an initial endowment but, after birth, it is dependent upon external sources for replenishment. Within the first year body weight is trebled, and with this increase in stature goes an increase of blood volume and of the total mass of circulating hæmoglobin requiring an additional 160 mgm. of iron.<sup>13</sup> Until full skeletal growth has been achieved, this progressive increase in total hæmoglobin and its accompanying



demand for additional iron continue; to these must be added the requirements for the tissues and for the maintenance of storage depots.

Apart from the first year of life, bodily growth shows a sudden increase at puberty which is paralleled by an increased call for iron. By the age of 21 years growth will have ceased and, in the male, the iron requirements will fall to that needed to make good the loss in the urine and faeces; this is probably not above 10 mgm. a day. At any time the balance may be disturbed by loss of iron through external hæmorrhage. Loss of blood by epistaxis, from hæmorrhoids or at a surgical operation are banal events, but they must be reckoned as well as loss of iron, only to be repaired by increased absorption.

In the female, there are physiological opportunities for blood loss denied to the male. Puberty sees the onset of menstruation as well as a rapid increase in growth. At each period an average of 50 ml. of blood is lost and, if menstruation occurs monthly between the ages of 13 and 47 years, the total loss will amount to 22 litres of blood, 3 kmg. of hæmoglobin or 10 gm. of iron. Pregnancy offers no respite; the foetus robs its mother of 375 mgm. of iron, while at least a like quantity is lost in the placenta and by post-partum hæmorrhage. After parturition the economies of amenorrhœa are offset by a daily loss of 0.85 mgm. in the milk. Thus in a woman, there is a physiological loss of iron throughout the reproductive period, in addition to the numberless opportunities for pathological hæmorrhage which beset the most tranquil lives.

Normally, as these losses are incurred, they are made good by a diet adequate in available iron and by gastro-intestinal conditions offering no bar to absorption. But if intake is defective, or uptake hindered by achlorhydria, the time will come when the account is overdrawn and further expenditure of iron will be reflected in a falling hæmoglobin level. In such circumstances, symptoms of deficiency might be anticipated at those epochs when the call for iron, on account of rapid growth or increased physiological loss, is most insistent; and, indeed, hypochromic anaemia is commonly seen during the first year, at puberty, especially in the female, and in middle-aged women who have been stripped of their iron reserves by thirty years of menstrual bleeding.

It is now time to point the clinical application of this discussion. The importance of iron deficiency lies in its widespread and frequent incidence. An indication of this frequency is given by some figures from Great Britain,

where, in 1943, 39 per cent. of 917 municipal school children between the ages of 5 and 12 years and 24 per cent. of 570 pregnant women were found to have hæmoglobin readings below normal.<sup>2</sup>

In clinical practice, iron deficiency anaemia may occur at any age or in either sex, but it has long been the custom to recognise several variants which have come to be regarded as distinct "diseases." These variants may be listed as follows:

1. Nutritional hypochromic Anæmia of Infants.
2. Chlorosis.
3. Hypochromic Anæmia of Pregnancy.
4. Hypochromic Anæmia of chronic Blood Loss.
5. "Idiopathic" hypochromic Anæmia.

In all, hypochromic anaemia is found, all are cured by adequate dosage with iron; the variables are the age of incidence and the ways in which the deficiency arises. It is these aspects which must now be considered.

Nutritional hypochromic anaemia commonly appears in the third month of life, particularly in premature and artificially-fed infants. It is at this age that rapid growth increases the demand for iron and supplies may fail for several reasons: intake may be reduced, for cow's milk contains less iron than human, or absorption may be disturbed by gastro-enteritis. More frequently the infant has been born with a subnormal iron store: an anæmic mother is unable fully to endow her baby; accumulation of stocks may be curtailed by prematurity; twins must share between them the available maternal iron. Any combination of these circumstances may lead to supplies being insufficient to meet the infant's commitments and thus to the clinical state of iron deficiency.

It is conventional to say that chlorosis has disappeared, but it is rather that fashions in nomenclature have changed. All clinicians agree that hypochromic anaemia in pubescent girls is not uncommon. The iron requirements at this age are exalted by the sudden increase in bodily growth and, in girls, by the onset of menstruation. If, during perpuberal life, stocks have not been maintained by an adequate intake of iron; if, as is common, bleeding during the first years of the catamenia has been excessive, then the stage is set for iron deficiency. The better diet of present day children makes these conditions less common but chlorosis still occurs, although it is usually called by some other name.

In pregnancy, the demands of the foetus drain the maternal stores of iron. Intake and absorp-

tion may be diminished by gastro-intestinal unrest and, during the second trimester, the decline of gastric acidity further depresses uptake. Iron deficiency is common, but the duration of pregnancy is too short for it to become profound; severe hypochromic anaemia suggests, either that the woman was anæmic before she was pregnant, or that there has been pathological blood loss.

It is obvious that prolonged hæmorrhage entails prolonged loss of iron which, if it outstrips absorption, will in time lead to a state of deficiency. The common sources of such bleeding are the uterus and the alimentary tract, but the latter has a special significance, for only there can hæmorrhage occur without the patient's knowledge. The cause may be peptic ulcer, hæmorrhoids or carcinoma but, if the whole human race is considered, the most frequent reason is infestation with hookworm. Deficiency will arise the more rapidly if the intake of iron is insufficient or if uptake is hindered by gastro-intestinal derangement. In one series of patients with this type of anaemia, there was achlorhydria in one-third.<sup>13</sup>

The last clinical variant is "idiopathic" hypochromic anaemia. It has long been customary to recognise as a "disease," a hypochromic anaemia of middle-aged women, often attended by such epithelial changes as glossitis and spoon-shaped nails, and cured by treatment with iron. This anaemia occurs at a period when the cumulative effect of iron loss by thirty years of menstruation and repeated pregnancies has begun to assert itself. If the diet throughout these years has been adequate and uptake efficient, the physiological loss of iron will be arrested by the menopause before deficiency occurs. But with years of diet poor in iron and with uptake impaired by the achlorhydria which 60 per cent. of these patients show, deficiency is almost inevitable. If, in addition, there has been, pathological loss of iron, it is made certain; and the more closely these patients are questioned the more frequently is a story of hæmorrhage obtained. Bleeding from hæmorrhoids, recurrent epistaxis, mild degrees of menorrhagia, repeated pregnancies, perhaps with post-partum hæmorrhage a little exceeding the normal, surgical operations: such episodes recur in their histories with monotonous constancy. These reflections suggest that the anaemia is miscalled "idiopathic" and that the cause lies on the debit side in the summation of forty years of iron loss, while subnormal intake and defective uptake of iron have combined to keep the credit columns blank.

From these considerations there are lessons

to be learned in the approach to the patient with hypochromic anaemia. Search should be made for the cause: the history may reveal an inadequate diet, gastro-intestinal disease, recurrent pregnancies, menorrhagia or other blood loss. But, before these are accepted as sufficient, active hæmorrhage must be excluded. This can occur, unknown to the patient, only into the alimentary tract and there be recognised by examination of the stools for occult blood; if blood is present, its origin must be sought with the protoscope, the sigmoidoscope or the opaque meal. Not until all these data are available should treatment be undertaken; for a carcinoma of the colon may be overlooked in the satisfaction of seeing the anaemia accompanying it relieved by iron.

The principles of treatment are two: to repair the deficiency by administration of iron, and to control the factors responsible for it having arisen. To consider the second first: hæmorrhage, if still in progress, should be arrested; hæmorrhoids treated, hookworms expelled, menorrhagia controlled or a carcinoma of the colon resected. A normal mixed diet will supply the adult's requirement of 12 mgm. of iron a day;<sup>12</sup> although this has a greater prophylactic than therapeutic value. Gastro-intestinal factors which tend to impede assimilation should, where possible, be corrected. There remains but to remedy the deficiency by oral administration of iron. There is seldom need for parenteral injection which is painful and dangerous, for the effective is so little below the toxic dose. Iron should be taken until the hæmoglobin level is normal, and for four weeks afterwards to replenish the iron reserve. If hæmorrhage has been arrested, the hæmoglobin reading will remain normal without further medication; until it reaches 65 per cent. the patient should be at rest in bed.

The preparation of iron best used has been much debated. There is clinical evidence that, weight for weight, ferrous salts are more effective than ferric; but, provided an adequate dose is given, a satisfactory response follows most preparations. Witts<sup>21</sup> defines as an average effective dose, one which will cause an initial hæmoglobin reading of under 50 per cent. to rise by an average of 1 per cent. a day during an observation period of 25 to 40 days. The average effective doses of the four common preparations are set out in the table.

AVERAGE DAILY EFFECTIVE DOSES OF

|                  | IRON PREPARATIONS |        |           |
|------------------|-------------------|--------|-----------|
|                  | Grammes           | Grains | Iron mgm. |
| Reduced Iron ... | 1.5-6.0           | 23-90  | 1200-5000 |
| Ferrous Sulphate | 0.6               | 10     | 180       |



|                               |         |        |          |
|-------------------------------|---------|--------|----------|
| Ferrous Carbonate (Blaud) ... | 3.0-4.0 | 45-60  | 300-400  |
| Ferric Ammonium Citrate ...   | 4.0-8.0 | 60-120 | 800-1600 |

This dosage suffices for the majority but there are occasional failures. In some, lack of absorption is responsible and this may be remedied by ascorbic acid in doses of 0.5-1.0 gm. daily, probably through its reducing action preventing conversion to the ferric state.<sup>20</sup> In others, a still larger dose is required. In the few in whom no response can be obtained, some cause of impaired haemoglobin synthesis, such as chronic infection or renal failure, must be sought.

This review has attempted to show how the causes of iron deficiency anaemia lie in disturbances of normal iron metabolism; but it has, in another sense, a wider application. Growing knowledge of iron metabolism has enabled us to substitute a single simple concept for a disorderly group of anaemias. This reorientation of our ideas to explain and unify apparently unrelated "diseases" in the light of physiological fact indicates an important trend in present day medical thought.

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## THE THIRD-YEAR STUDENTS CORRESPONDENCE ON THE EXISTING ABUSES AT ST. BARTHOLOMEW'S HOSPITAL, 1853

In the *Lancet* of January 1st, 1853, a letter was published from a third year student at St. Bartholomew's Hospital expressing "the general and well founded sense of dissatisfaction existing among all classes of students" with the administration of the hospital and the medical school, complaining in particular of the teaching methods of Mr. Stenhouse, lecturer in chemistry, Dr. Hue, senior physician to the hospital and Dr. Burrows ("that excellent proficient in the art of auscultation"). The author of what, even in those days of plain speaking and hard-hitting public controversy, must have been an outspoken letter, deemed it wiser not to sign his name but contented himself with the *nom-de-plume* "A Third Year's Student." In later numbers of the *Lancet* other students from the hospital joined in the correspondence.

Finally the Third Year's Student published the correspondence as a pamphlet, at his own expense, and prefaced it with a long address to the President and Governors of the hospital. This address, couched in rolling and sonorous phrases reminiscent of Mr. Gladstone at his most verbose, in addition to renewing the charges against the unfortunate Dr. Hue, who comes in for tremendous abuse, also complains of the preponderance of surgical over medical beds, the conditions in the eye ward, the absence of an obstetrical ward, the condition of the dissecting rooms, the chemical laboratory and the pathology museum, the distribution of prizes and the discomforts endured by resident students. We publish below extracts from the correspondence and the address.

The pamphlet was sent to us by Dr. Langton Hewer. It belonged to Dr. Hewer's grand-

father, who was a student at the time and who is mentioned by name—"Mr. Hewer, Sir, a student of high character, of a firm but most charitable disposition." Mr. Hewer took no part in the correspondence but a pamphlet that he wrote is used by the Third Year's Student as ammunition against the Governors. "... Mr. Hewer published a pamphlet directing the attention of the Governors to the great deficiency of religious instruction afforded to the patients and the difficulty that existed of obtaining the chaplain's aid before a patient was *articulo mortis*, even when his attention had been specially directed to the case. This pamphlet, although written in an illiberal and unfair spirit, contained truth in almost every line. Yet at the annual distribution of prizes which took place three weeks later, Mr. Lawrence in giving away the surgical prize, took occasion on the part of the Governors to 'refute the calumnious charges which had been brought forward' and which he stigmatised as 'the presumptuous and audacious conduct of a rash youth,' and authoritatively denied the charges as 'wholly without foundation' and yet, Sir, that the Treasurer had a committee meeting of Governors within a month of the time this statement was made and actually appointed three extra chaplains and compelled the Rev. Mr. Mitchell to resign the professorship of natural philosophy he held at the time, on the ground that it was incompatible with the proper discharge of his duties to the patients of the hospital." (A Third Year Student in the *Lancet*, Jan. 1st, 1853.)

"Our chemical lecturer at the present time is a Mr. Stenhouse, a gentleman of great constitutional nervousness, but of good repute, I believe, as an authority on organic analysis. He is a 'canny Scot' of the 'veriest brogue' and quite incapable and inexperienced in the art of giving lectures. I have again and again listened to this gentleman, and assure you, that besides being utterly unable to clothe his thoughts in even clear language, his experiments frequently if not always fail, although conducted by himself; while, whenever he attempts to make a calculation, or work out a chemical scheme, his confusion is so great and his powers of arithmetic so deplorably incorrect, that it almost always ends in utter failure, the consequence being personal discomfort and the derision of the class... and thus his habitual nervousness is so much increased that now his lectures in every respect are so extremely badly, if not unintelligibly, delivered, so carelessly arranged and so utterly unsuited to his class that our dissatisfaction is general and just." (Third

Year's Student in the *Lancet*, January 1st, 1853.)

"Dr. Hue, like his colleagues, receives about £600 or more a year, as his share of the annual sum paid by the students for the advantage of attending 'Hospital Practice.' But his brother physicians discharge their quota of allotted duties. Dr. Hue DOES NOT. He receives our money but tranquilly smiles with the most placid dignity at the mere hypothesis of making the slightest return for this "respectable annuity." He denies students access to his wards, scorns the chimera of possessing clerks; and steadily refuses on all occasions, to impart to us the information which his opportunities—if not his talents—qualify him to afford. While the routine in his wards is of the most *recherché* description. Seated in a fauteuil of cushioned luxuriousness this 'Venerable Physician' summons to his side the suffering inmates of his hospital beds. 'Tottering and infirm, languid and sick, all who are supposed to possess even a capability of locomotion, visit in turn their 'senile' official. Enter his wards—this is a frequent scene; when if you attempt in his absence to discover the nature or treatment of a case, you will find that the Board which is suspended at the head of each bed is either a blank as to the patient's disease or else you observe in the minutest text the anomalous hieroglyphics of the 'self-opiniated apothecary'!" (There is a note in the margin in Mr. Hewer's hand—"Written in shorthand"—by the last lines of this paragraph.) (Third Year's Student address to the Governors.)

"Dr. Hue deprives us of the benefit of his wards; he refuses to take clinical clerks; and he never contributes his share of clinical instruction. Yet why does he retain his post? If too decrepit and feeble to discharge the just responsibilities that devolve on his position; if too infirm and aged to offer us the result of his mature experience; if too perverse and peevish to possess clinical clerks, lest their modern knowledge and bustling habits should jar with his cumbersome dogmas and dilatory proceedings..." (A Third Year's Student, *Lancet*, January 22nd, 1853.)

"Lastly I would remark, our instruction in auscultation is extremely deficient. Dr. Burrows is the only physician who practises or relies on it. Dr. Roupell, indeed, uses it, but more, I believe, *pro forma* than from any confidence he himself puts in it. While to Dr. Hue, the stethoscope has ever been a hidden mystery, which at his 'advanced age' he is not likely to fathom." (A Third Year's Student, *Lancet*, January 1st, 1853.)



"Bad accommodation—profuse expenditure—negligent attendance—and extreme discomfort; these are the 'benefits' which residents enjoy. If abuses spring up, they are allowed to continue; and if grievances arise, they are carefully nurtured. The treasurer is silenced, and

the warden submissive at the authoritative dicta of a 'maitre d'hôtel,' while temperate suggestions go unregarded and moderate alterations are facetiously waived." (Third Year Student's address to the Governors.)

## AFRICAN BIRTH CUSTOMS

By COL. L. B. CANE

The birth of a child is awaited with anxiety, and requires many consultations with the soothsayers to determine the outcome of such an important event.

Girls are preferred since they will be more valuable as merchandise, though boys are useful to help their fathers as guardians of cattle and to help in the frequent rebuildings of their houses.

Infantile mortality is very high, fully 40 per cent. in the first year. This is attributable to lack of elementary hygiene by native midwives, the seclusion of the infant at the back of the hut away from sunlight and with very little air until after the separation of the umbilical cord, the custom of giving infants unsuitable cooked grain as food, and to venereal disease.

The pregnant woman carries on with her ordinary work until her time draws near, when her husband will seek for a midwife. When the labour pains begin she is seated upon a low stool or upturned platter on which food is carried.

She is supported from behind by a friend while the midwife receives the child. As soon as it is born the midwife sucks the nostrils to encourage breathing, measures the umbilical cord down to the child's knee, and cuts it off with an arrow barb. Until it falls off the baby must be carried carefully lest the cord should fall across the genitals, which is considered may cause impotence.

Immediately after birth the baby is washed in cold water smeared over with oil, and then fed on light gruel.

To compel the infant to swallow the nose is pinched.

When this causes crying it is attributed to the spirits of ancestors. Diarrhoea, which is frequent and often fatal, is attributed not to the diet but to bewitchment.

The mother washes herself with hot water, and is then massaged in a crouching position by the two women.

The midwife then washes her breasts with hot water, and squeezes the first milk from them until there is a free flow.

The mother then sits by a hot fire, and when she is thoroughly warm is shown her baby.

Besides the two helping women no one is allowed to enter the hut, outside which the father awaits anxiously the result.

Should there be any delay in the placenta coming away he kills a goat, and the mother is given gravy made from it.

The placenta is buried in the mud floor of the house, except in the case of twins, which are considered unlucky, when it may be buried in a well instead of in the house.

Malpresentations are also considered unlucky, and in former times such children and all twins were generally put to death.

Soon after death the child is named by the father, it being customary to give the names of the grandfathers or grandmothers according to the sex. Should the baby cry much it is considered not to like its name, and this is then changed.

The child is not taken out of the house for six or seven days, during which time it is nursed by the mother, who usually has a small girl to help her until she has recovered her strength. The child is not weaned for a year or more, and is carried on the mother's back in a sheepskin sling, often hung with small belts and other articles to amuse it.

If the mother dies in childbirth, the unborn baby is removed before burial. If a girl the husband must pay to the mother's brother two cows, or for a boy one cow, irrespective of whether the child is born alive.

If a woman dies before showing signs of pregnancy the father must return the dowry to the husband, who in return gives three goats to the father. This is regarded as payment for the stomach to be pierced before burial, as is the custom.

The husband of a barren woman, after all remedies for making her pregnant have failed, may obtain another wife on payment of an ox to the first wife's father, from whose family the new wife is selected.

The first time a new-born baby is taken outside its home, if a boy the mother makes a little bow about six inches or a foot long, and tiny arrows which she carries in her hand as she walks round with the baby on her back. This is a sign of his future work, to look after the cattle with his bow and arrows as weapons.

If a girl, the mother carries about a tiny gourd containing the usual food relish, as a sign of her future duties in preparing food for the household.

### TWINS

The birth of twins is universally considered bad luck, and in former times, and to-day probably in remote parts, they are killed. Whether actually put to death, or only symbolically killed, elaborate ceremonies must in every case be performed lest misfortune or death should come to the parents, or dire calamity befall the whole community.

In some tribes the relatives, on being informed of the birth of twins, meet together to decide whether both or only one of the twins should be killed. Their birth is considered to endanger the lives not only of the parents but of the near relations and if allowed to live every calamity that may affect the community, of which the commonest is the failure of crops through drought, will be attributed to this.

In former times children born in the wrong position, and who cut their upper teeth first were also considered to bring ill-luck and were therefore put to death.

In most cases the midwife is responsible for carrying this out, on receipt of the order from the relations. This is done usually by over-feeding them with a mixture of hot water and flour. If there has been no midwife in attendance the father himself suffocates them by closing their mouth and nostrils with his hand.

The rule that they must then be buried near a water hole or stream indicates their connection with failure of the rains and consequent failure of crops leading to famine.

The ceremonies connected with the birth of twins vary in different parts.

As an example of those in one district the following brief outline may be given:—

On the morning after the birth, couples who have themselves had twins go into the bush and collect two pieces of bark of a certain tree, about two feet square, a small specimen of another tree, an aloe plant, and some long

grass.

Entering the house they fasten the twins upon the two pieces of bark with the grass, stick the small tree upright in the ground outside the hut and beside it bury the afterbirth in an earthenware pot—over this is planted the aloe which is left to root there.

After these preparations the parents are led to the spot, the man carrying a stick and the woman a hoe. With them is the midwife carrying a small basket full of seeds.

They go round the village, and in front of every house the husband scratches the ground with the stick, the wife hoes, and the midwife throws in a little seed and replaces the earth with her foot. The planting of the seed in front of every house is considered to remove the danger of the community's crops failing owing to the birth of twins.

The rest of the ceremonies can now be postponed until a supply of native beer has been brewed, or until some date is agreed upon.

On the approved day all those concerned go into the hut together with the parents. The ceremonies then fall into two parts, the first a symbolic repetition of the birth, the second a symbolic, or actual, burial of the twins.

In the first the parents are rubbed all over with a concoction of certain leaves and roots, including some pieces of the bark of the tree on which the twins had been tied.

The parents then have to lie upon a bed of thorns whilst the others sing around, to the effect that the parents who had produced twins are now exhausted. They are then lifted off the thorn beds, and rubbed with oil.

The second part of the ceremony, the actual and symbolic burial of the twins, then follows.

A pot of beer, two small calabashes containing flour and water, some strings of beads, a pot of water, hollow reeds, an axe and a pot-ladle are brought, and then a small parcel representing the twins is put into the pot of beer. The axe, representing the father, and the pot-ladle, representing the mother, are put on top of the pot.

After a dance, called ngoma mabasa, the parcel is taken out of the beer pot and buried in a hole.

This act signifies the burial of the twins, unless they have been actually killed, in which case after these ceremonies they are buried.

The two calabashes are then prepared by inserting the hollow reeds into the mouth of each and closing it around them with the wax of wild bees.

These are considered in some way to represent the twins, and every person present sucks



out a mouthful of the contents of the calabashes and spits it on to the parents.

The calabashes are then decorated with the strings of beads, and taken to the house of the parents, where they are kept as paraphernalia of the family's ancestor worship.

For most of these details of birth customs I am indebted to some notes by R. W. Wyatt, formerly Assistant District Officer at Singida, and to an account of Sukuma Twins ceremonies by H. Cosy, published in Tanganyika Notes and Records No. 17.

CORRESPONDENCE

To the Editor, St. Bartholomew's Hospital Journal  
Sir,

Readers of Professor Mayncord's review of Mr. Phillips' "Supervoltage X-ray Therapy" may have noticed his phrase: "... no one could fail to be impressed by the magnitude of the task and the technical skill brought to bear upon it" (i.e., the designing and building of this machine).

A trifling but amusing sideline of this was the arrival one morning of the heaviest equipment in the Square. We are accustomed to view with awe and admiration the twice daily miracle of the Hospital laundry van steaming through the Memorial Arch at high speed with scarcely an inch to spare on each side. But the run up from the Smithfield Gate clearly disconcerted the driver of this eight-wheeler-cum-trailer. He stopped short of the archway and descended to reconnoitre the position. Encouraged by Mr. Powditch and the Beadle he pushed the snout

of the lorry halfway through and fouled his anterior near side back wheel. He then reversed.

The fact that he eventually accomplished this difficult passage is self-evident unless Mr. Phillips can be credited with an astonishing imagination and the Governors with a high degree of credulity. But how he accomplished it is a match for a more facile pen than mine. The most apt comparison I can draw, and one acceptable to those who know the Norfolk Broads, is of a wherry passing under Potter Heigham bridge at high tide when to the observer following in another craft the archway not only appears to be, but is, completely filled.

Yours faithfully,

HOGARTH.

Officers' Mess,  
R.A.F. Station,  
West Kirby, Wirral.

CRICKET

Optimistically, the Cricket Club decided to run two elevens this season with the aid of a number of players who were willing to make the journey from Hill End or Cambridge each week. At first it appeared that this optimism would be justified, and that regular 2nd XI matches would be possible. However, at the beginning of June the rival attractions of tennis and athletics and the proximity of examinations led to a deficiency of players and the necessity for cancelling the 2nd XI fixture against the Old Rutlishians 2nd XI.

Owing largely to lack of practice as has been evidenced by more recent successes—the initial efforts of the 1st XI were not encouraging. Elliott's sterling performance on Whit Monday at Gerrards Cross appears to have had a cheering and tonic effect upon the rest of the team.

May 12th, v. Orpington. Away. Lost: St. Bart.'s Hospital 63, Orpington 131 for 6.

The Hospital batted first, and wickets fell with distressing regularity. Only Hawkes, Morgan and Jukes reached double figures before the innings closed at 63. A series of "long hops" and dropped catches enabled Orpington to pass this total for the loss of two wickets.

May 19th, v. Lensbury. Away. Lost: St. Bart.'s Hospital 61, Lensbury 110.

Despite the fact of a good wicket and only moderate bowling, the Hospital batting first lost 8 wickets for 20 runs. Enquiries revealed that the lowest total score registered on this ground was 30; and it was only the spirited and confident perform-

ance of Ellis (32 not out) and Mear (14) that prevented the establishment of a new low record. Nevertheless, the total of 61 was passed by Lensbury for the loss of 6 wickets despite the bowling efforts of Jukes (4 for 30) and Mear (3 for 16).

May 21st, v. Gerrards Cross. Away. Draw: St. Bart.'s Hospital 136, Gerrards Cross 124 for 7.

The early batsmen again collapsed, save for Gourlay (19). However, Elliott (53) hit the bowling with most creditable and pleasing vigour all over the field, and was assisted by Jukes (25) in carrying the score to the respectable total of 136. Gerrards Cross had scored 124 for 7 when rain prevented further play.

May 27th, v. Broxbourne. Away. Won by 10 wickets. Broxbourne 52, St. Bart.'s Hospital 124 for 4.

Fine bowling by Mear (7 for 21) on a soft wicket ensured that there would be plenty of time for social activities after the match. Paget (32) and Murley (44) enabled Bart.'s to pass the Broxbourne total of 52 without loss.

June 2nd, v. Old Rutlishians. Home. Won by 8 wickets. Old Rutlishians 95, St. Bart.'s Hospital 144 for 3.

The Old Rutlishians' wickets fell regularly against the bowling of Elliott (4 for 26) and Jukes (3 for 28), and by tea they were dismissed for 95. Dixon (34) batted very well before being unlucky enough to step on his wicket after executing a powerful hook. Murley (44) and Gourlay (41 not out) enabled Bart.'s to win by 8 wickets.

A DREAM ON A PREVIOUS THEME

THE KING'S ENGLISH

First Doctor: I think he is a gastric ulcer.  
Second Doctor: I deny it; he is a man.  
First Doctor: I mean he is a case of gastric ulcer.  
Second Doctor: I deny it; he is a patient, not a case.  
First Doctor: Have it your own way; it is a case of gastric ulcer.  
Second Doctor: I agree with you; he has a gastric ulcer.

THE JOURNAL, July, 1926.

THE DRAMATIC VERSICLES OF THE SEVEN SPECIALISTS, TOGETHER WITH THEIR UNACCEPTED DEPARTMENTAL INVENTORY, COVERING THE TRAINING TO PRACTICE MEDICINE.

They all stood round the bed,

And one by one they said:

The Anatomist: I warned you that you should have learnt your stuff in my department, and I told you that it was what you would be dealing with.

Response: You must know your Anatomy ...

The Pathologist: The nature of the lesion we can safely assume to be degenerative. The degeneration will progress.

Response: Never miss a Post-mortem ...

The Clinician: Now he is in your care. Before you can treat the disease, a correct diagnosis will have to be made.

Response: You must know your chests ...

The Doctor: He must trust you; get to know your patient.

Response: Medicine is an art ...

The Psychologist: But this man has got a mind; the mind influences the body. If you'd study the mind you'd be complete in your outlook and efficient in your methods. And the subject is absorbingly interesting.

Response: Achieve mental adjustment and maintain an even keel ...

The Doctor of Social Medicine: This is not only a patient in Hospital. He is a man with a home and a family and with wages to be earned. His incapacity is a social liability, his health a social asset.

Response: He lives in society ...

Carried forward ...

The Doctor of Theology: Man is a part of a far bigger scheme than this. Created by God, he fell at the Fall, which was the occasion of the Redemption. He is an agent in the operation of the Paraclete.

Response: Man is systematised theologically ...

The Total is declared to be ...

|                         |  |
|-------------------------|--|
| The Body ...            | Pathological Man                                 |
| A part gone wrong ...   | Psychological Man                                |
| The body-in-disease ... | Man-in-society<br>Industrial Man<br>Economic Man |
| The man-in-disease ...  | Sociological Man                                 |
|                         | Natural Man                                      |
|                         | Theological Man                                  |
|                         | THE WHOLE MAN                                    |



Then the Examiner came along,  
His was just a confirmatory song:

*The Examiner:* Gentlemen,

The course is now finished,  
From A to Z.  
Let all else be banished:  
Take out the bed.

No sooner had the command been obeyed  
Than the group, which had turned to go, was stayed;  
For there in their midst they were shaken to see  
The Assessor Himself. He made this decree:

*The Assessor:* I've looked through this list, and you've made an omission;  
The sum is not finished until it is on.  
What you have left out is the essential commission  
In being a doctor—the *sine qua non*.

*(Exit the Assessor.  
Noises off of sounding brass and tinkling cymbals.  
In silence the eyes of the group turn to where the  
bed had stood. They see only its late occupant  
lying dead upon the floor.)*

THE JOURNAL, July, 1945.

NAT.

## OLD WIVES' REMEDIES

By JOSIAH OLDFIELD

The French give their midwives the charming title of "Sage Femme."

Here in England, we are all too ready to think of old wives' remedies as being things to laugh at, and not as manifestations of experience and wisdom.

Our greatest teachers, however, from Aesculapius onwards, have impressed upon all students of medicine that wisdom is gained by experience and observation.

As I look back upon half a century or more of medical work, I recognise that I owe perhaps far more to actual experience, and to opportunities of observation, and to a receptive mind, rather than to the teaching of the great men from whom I have gained much knowledge.

As I think of these things, my mind goes back to early childhood, and village life, and I am quite satisfied that the medical profession owes a great deal to the women of the world, and especially to the country women of the world, upon whom has often fallen the chief burden of looking after the sick and of tending the wounded.

The lives of mediæval women, whether Abbesses, Countesses or Baronesses, were

always taken up with the distilling of spirit medicines and the making up of herbal infusions, and all sorts of what they called "simples" and "still room" secret potions.

The stillroom was associated in every early castle with the Chatelaine of the Castle, and with the intelligent women who had grown up round her and who had become her teachers and who had made her of value as a power of healing.

I think, perhaps, one of the most important discoveries made by these wise women was the value of the Vitamin.

Of course, they did not know the name and had no idea as to what was the rationale by which disease was prevented or cured by these small elements in the food, which apparently made all the difference between sickness and health.

It was noticed that as winter came nearer to its end, the health of young people especially, deteriorated, and little by little, there became associated with the end of winter, something which showed that winter dietary would always cause diseases which spring foods alone would cure.

The old jingle had great truth in it,

"In Spring we turn to Saladies,  
To cure the Winter's maladies."

What did these Abbesses and Old Wives teach?

They said, "Take watercress, which can be gathered in the winter, and eat it."

"Begin the day with a Tisane made by stewing dandelion leaves or dandelion roots or young nettle tops."

They prescribed a dinner of herbs made from the earliest of all growing things in Spring, like Robin-run-ith-hedge, coltsfoot, dandelion, and specially young nettle tops.

They advised a girl who suffered with anæmia to go into the woods and tap the birch trees in the month of February or March, and let that sap run out into a bottle and use that, a wineglassful at a time, as a medicament.

The most important of the actual medicinal herbs were always those that came in the Spring, because that was the time when a prescurbic condition showed itself very widely throughout the land—young men and young women always died in their hundreds in early Spring.

Blotches and blains and boils, sore gums and broken nails, a loss of colour and strength and appetite, recurrence of Leucorrhœa, were the commonest symptoms which were prevalent at the end of a time when people had lived for months upon salt meat and upon rye bread and cheese.

To-day, the manufacturer steps in and makes a fortune, but yet there is nothing so good on the market as an antiscorbatic, as the early Spring growths, found in every country hedge, growing from March onwards.

Scurvy, however, to-day is comparatively unimportant, but its disappearance is caused by carrying out the Old Wives' regimen—by using all through the Winter salads of all sorts, a plentiful supply of fruit brought from every land, and by adding to the diet a great variety of green and freshly-growing vegetables without stint.

Another scientific truth was discovered by the Old Wives, and that is connected with the phenomenon that we find in Nature, by which animals are armed against those dangers to which they are specially exposed.

There is possibly no more serious infection than is found in micro-organisms that grow and multiply upon decaying flesh foods.

Whatever advantages dead flesh may have, it is responsible for bringing into the body of humans many varieties of septic micro-organisms from which Funitarians are free.

Carnivorous animals are therefore specially provided by Nature with a protective saliva and, therefore, the Old Wives watching how dogs and cats licked the wounds of their young and of themselves, put two and two together and said, "A dog's lick prevents a wound becoming septic."

Aesculapius used snakes, also, but the commonest thing in village life was to copy Lazarus, and invite the dogs to lick any wounds or sores from which they might suffer.

They did not know anything about micro-organic life, nor about the immense variety of septic organisms, but they just had learned that a dog's spittle was powerfully preventive against a wound going, as they said, "the wrong way."

Another delightful treatment was to send anyone who suffered from any eye trouble whatever, to the nearest spring, where water came directly out of the earth, and they were satisfied that washing and bathing the eye with this fresh water was a powerful healing treatment.

There is no doubt that to-day we recognise that bathing by cold water is one of the most valuable methods of treating inflammation in a sensitive part of the body.

The effect upon the whole nervous system is far greater than would be expected to result from the mere application of constant splashing of cold water on the delicate parts of the body—but it is so.

The Red Indians would put a man who was badly wounded, or whose wounds had become septic, to sit or stand under a waterfall for an hour! It was a drastic but a splendid remedy!

The Abbesses mingled religion with their treatment, and associated a benediction of spiritual power with many wells. These they then called "Holy Wells." It was an excellent treatment, and is made none the better to-day by adding boric acid to spring water, for external application to sensitive areas of the skin.

I remember how children, who suffered with jaundice, were bidden to hunt in the hedges for a shrub of Berberis, because the inside of its bark was saffron coloured. The early sense of "homeopathy" made people go to take a yellow medicine to cure a disease which manifested itself in a yellow colour!

I say nothing about warts—they are too closely associated with witches, but I have certainly seen warts disappear under very unorthodox treatment.

One of the earliest remedies for sore



throats was an old stocking taken off the foot, warm and moist with body moisture, and in those days perhaps it had not been washed for a week, and wrapped round the throat and neck and then covered over with a shawl.

It was efficacious and was one of the early forms of what to-day we call "a compress."

In my travels through the world I have learned never to laugh at nor to despise any treatment of any sort, however fanciful it might appear, because I have learned that it is by "trial and error," and "trial and success," that Nature herself has proceeded on her great pathway of Evolution.

### BOOK REVIEWS

**OPERATIVE SURGERY.** Described for Nurses. By O. Stanley Hillman. Published by Faber and Faber, Limited.

This book will probably meet the requirements and prove of considerable help to nurses who anticipate specialising or are already engaged in theatre work.

It will, however, be of little value to nurses in training, who already have a wide range of information to grasp in a short time.

Some of the diagrams are not really very clear, and illustrations of special instruments might have been added with advantage.

**AIDS TO FEVERS FOR NURSES.** By Joyce M. Watson, S.R.N., S.R.F.N., D.N. (London). Published by Daillière, Tindall and Cox.

The publication of a Second Edition of this book proves its value.

Miss Watson has added to this edition much new and useful material, and at the same time maintained the object of the "Aids Series" to provide necessary information in a readable form.

The chapter dealing with Chemotherapy is of interest to nurses, and the appendix giving a table of infectious diseases and their characteristics will be an excellent guide for all nurses, the State Registered Nurse as well as the Student Nurse.

**RECENT ADVANCES IN NEUROLOGY AND NEUROPSYCHIATRY.** By W. R. Brain and E. B. Strauss. Fifth Edition. Messrs. J. & A. Churchill. Price 18s. Pp. 363.

The authors of this book point out in the preface that there is no hybrid specialist—the neuropsychiatrist; each specialist, the neurologist, the psychiatrist and the psychotherapist must have a working knowledge of the subjects covered by the other two. All too frequently this knowledge and interest is lacking. This book is designed to keep such interest alive.

This, the fifth edition, has been extensively rewritten, as indeed the advances of the past five years have warranted. We may mention only a few of the vast range of subjects dealt with. Convulsant Therapy and Prefrontal Leucotomy are discussed fully. It is a pity that the authors do not consider the time is ripe for a thorough statistical analysis of convulsant therapy. This treatment has become widely known and criticised: an analysis of the results would give a factual basis for criticism.

Head injuries, peripheral nerve injuries and sciatica are dealt with at length, including the valuable material gathered during this war. Electroencephalography is discussed. The physiology and pathology of sleep are dealt with in an interesting chapter. The pharmacology of sedatives and hypnotics could well be given more attention as these are prominent weapons in the general physician's armoury. Proprietary names of drugs are

used freely, a practice which has little to recommend it.

The student will find this book valuable for reference, using it in conjunction with a textbook. It is very readable and its clarity of language will help him understand more "wooly" parts of other books.

**DISEASES OF THE NERVOUS SYSTEM.** By F. M. R. Walshe. Fourth Edition. E. & S. Livingstone. Price 15s. Pp. 360.

This textbook of nervous diseases is well known to students, and its range is ideal for their use. It is well written and pleasing to read. In this edition there are many more useful diagrams in the text.

In the light of recent developments the chapters on peripheral nerve lesions, herpes, zoster, cervical rib and sciatica have been thoroughly revised. The chapter on psychoneuroses has been expanded, in it the psychoses are touched upon. This chapter is well balanced and should be included in a textbook of nervous diseases, but the subjects are not dealt with fully enough.

Psychoneurotic symptoms can be recognised clinically rather than by the tedious process of exclusion which will serve only to establish forever in the patient's mind the neurosis which might have been cured easily with an early diagnosis. Most general practitioners will agree that the majority of their patients have no organic disorder but a mental upset. Yet no attempt is made to treat them as such—apart from the suggestion that accompanies the medicine bottle. In a book for the general reader the clinical diagnosis and non-specialist treatment of mental disorder should receive adequate attention.

**TEXTBOOK OF GYNAECOLOGY.** By Wilfred Shaw. Fourth Edition. J. & A. Churchill. Price 24s. Pp. 636.

This standard textbook of gynaecology is in its fourth edition since it appeared in 1936. It is designed for the student, its scope is adequate for all examinations, and it is thoroughly up to date.

An attempt is made to deal with endocrinology as a whole, and not only as it affects gynaecology directly. In view of their importance and of recent advances this is a valuable addition, but the chapter is too short and the discussion of each gland is rather scrappy. A thorough outline of physiology of the endocrine glands in their relation to sexual function would not be amiss.

Leucorrhoea is one of the most common gynaecological symptoms and perhaps the most difficult to treat. The chapter on leucorrhoea is too vague. The various causes and the treatment are all given, but as with so many textbooks no attempt is made to access the value of the several treatments advised, or the importance of the causes. Students are accused by their teachers of being vague and indefinite, medical textbooks frequently reveal one source.

### RECENT PAPERS BY BART'S MEN

COHEN, E. LIPMAN. "Conjunctival Haemorrhage after Bismuth Injection." *Lancet*, May 19th, 1945, p. 627.

GORDON, MERVYN. "The Spirit of Research." *Lancet*, June 30th, 1945, p. 807.

HAMBLY, E. H. T. "Fractures: Part I. Principles of Diagnosis and Treatment." *Post-Grad. Med. J.*, April, 1945, pp. 128-133.

KEYNES, G. L. "The Surgical Treatment of Malignant Disease." *Practitioner*, July, 1945,

### EXAMINATION RESULTS UNIVERSITY OF CAMBRIDGE

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Jukes, W. R.  
Philip, P. P.  
Conway, F. J.  
Ellis, R. H.

McMillan, J.  
Strangeways, W. M. B.  
Denbenham, J. A. R.  
Finlayson, R.  
Ostlere, G. S.  
Watson, P.

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Dallas Ross, W. P.  
Gloster, J.  
Paget, C. J. H.  
Buckley, A. R.

Denbenham, J. A. R.  
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Pugh, D. E.  
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# ST. BARTHOLOMEW'S



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### MEDITATIONS ON ESCAPE

The war is over and the world pokes its head out of its air-raid shelter. The general picture is one of havoc, thinly disguised by the sparse garlands of peace. To the pessimists the view is cheerless and drab and the garlands appear to hang limply in sympathy with the heavy livers of their beholders. To the optimists everything appears to be bathed in that soft rosy effulgence which the poets associate with spring and mere mortals with their brief moments of alcoholic suspension.

What do the pessimists see? First of all they see the atomic bomb. One only has to take the most cursory glance at any human inter-relationship to realise the obvious futility of the hope that it will bring lasting peace. On the contrary there is every reason to suppose that in our present stage of mental development, war will be encouraged, because the more terrible the weapon the greater the fear it generates, and the greater the fear, the more violent the reaction against it. Again, the opportunities for secret subterranean preparation and the hope of a decisive coup d'état are enormously increased. It is like giving a monkey poisoned peanuts and telling it not to eat them. As sure as God made little apples that monkey will eat the nuts and kill itself. Even without the atomic bomb the situation is dreary. Geographically we are on the doorstep of a Europe dominated by the communist ideology of Russia. Economically, psychologically and genetically we are the outpost of Americanisation. The Russian and the American viewpoints are diametrically opposite. We are muddling in between and the results of the General Election only serve to show with greater clarity how we would like to go both ways at once. We are like a fat old woman,

suffering from chronic indecision and financial osteo-arthritis, who finds herself in a country lane between two oncoming bulldozers. At home the pessimist sees a Labour government determined to do something and a Conservative electorate entrenched in the responsible positions determined to prevent them doing anything. According to the pessimist there is nothing for it but to make the air-raid shelters more comfortable, and much deeper.

What does the optimist see? First of all he sees the atomic bomb. You can't miss the atomic bomb—it is enormous. It just sits there like an affectionate baby elephant in a high-chair, which is not sure whether to grow into a horrible heffalump or a friendly elephant and either way is determined not to be ignored. The optimists can't see the horrible heffalump angle and look upon junior as a potential bun-eater who will carry humanity about in a gaily painted howdah, with unlimited energy for unlimited time. Diplomatically the optimist sees Britain, America and Russia as benevolent philanthropists controlling the planet from an endless vista of conference tables, whilst all the lions and the lambs, who comprise the lesser nations, parties, minorities and factions, sit submissively by, completely absorbed by the problem of how they can best lie down together. At home they see a benevolent government getting the traditional English muddle organised with a capital O, with subsequent benefits to all, including more wages for less work. They see the nation fully employed making good the ravages of war, while the state and a miraculously wealthy aunt called National Debt foot the bill. They are quite decided that they are unable to see a slump—but then it is not an optimist's job to look



round corners.

We have all heard these differing points of view coming with bewildering conviction from every quarter. We are worried by the one and we don't believe the other, but just at present we personally feel like a rest from reality. The victory celebrations appeared to us as somewhat artificial and filled us with that feeling of excitable melancholy which school boys call "the cud of term feeling." The war has left an empty void and we are not yet accommodated to the conditions of peace, so, like the school boys, our minds are occupied with the little things to which we are looking forward. We know that we are evading our responsibilities and we know that reality is never sympathetic to day-dreaming, but how excellent it will be to taste again a glass of good sherry.

## OBITUARY NOTICE

### SIR GIRLING BALL

*Died July 18th, 1945.*



It would be more difficult to believe that a man of such abounding tirelessness as Ball had passed from amongst us, had not one seen him during these last months struggling bravely and unsuccessfully against illness—endeavouring earnestly to carry on with his strength failing and, finally, defeated in spite of all his efforts, being obliged to give in—and dying without any period of retirement or rest.

This may, indeed, appear a sad picture, but those of us who knew him well will realise that it was not in his nature to cease from his labours and enjoy some years of leisure—so truly earned—when he felt that there was still

We are looking forward to fishing rods, to evenings by the fire without the conscious presence of the "washing up" in the kitchen, to well-bound books, to examinations in happy retrospect and to an ability to do our job well, to hot chestnuts and Christmas parties, to evening dress, to good music and country pubs, to leather chairs, to dogs and pineapples, and above all to the long moments of friendly comfortable silence.

It is such little things as these which lie behind all our conscious strivings. We can afford to ignore the jibes of the consciously active, because we believe that these things are as much a part of our lives as all the talk of policies and politics, and we believe that these things must contribute to that perception of ourselves which some men call wisdom.

work for him to do—that his advice and counsels were still needed in those many institutions, to which he had devoted his life—and, most of all, while he felt that Bart.'s still needed him.

For I know it is true to say that Ball was first and foremost a Bart.'s man. He always gave of his best to the Hospital and Medical College, in which his life was spent and in whose affairs he played so vital a part.

Of his manifold activities—both in the Hospital and in the world outside, this is a brief account.

Ball was the son of a City Merchant and was born at Barnet in 1881. He was educated at the Merchant Taylors School, while it was still on its Charterhouse site. He qualified in 1905 and was, later, House Surgeon to Sir Anthony Bowlby, to whose wise opinions and shrewd judgment he owed so much.

In 1907 he won the Luther Holden Scholarship and was, from 1907 to 1911, a Demonstrator of Pathology at Bart.'s, during the Professorship of Sir Frederick Andrews, one of the most eminent pathologists of his day. He soon showed a special interest in Genito-urinary surgery and became a Chief Assistant at Saint Peter's Hospital.

He was Surgeon to the Alexandra Hospital for Hip Disease, which post he held for 35 years. He won the Jacksonian Prize Essay of the Royal College of Surgeons in 1909 and

gave a Hunterian Lecture in 1912, both dealing with the treatment of surgical conditions by Vaccines and Antitoxins.

He contributed to Gask and Wilson's Surgery and collaborated with Geoffrey Evans in Diseases of the Kidney.

In the Great War he became a Captain in the R.A.M.C. and was, for some months, at the 53rd General Hospital in the B.E.F. Later, he was in charge of the Military Wing at Bart.'s. He was appointed to the Staff of Bart.'s in 1913.

He took a great interest in the Royal Society of Medicine and became its Secretary and, subsequently in 1938, its President.

He was elected a Member of the Council of the Royal College of Surgeons in 1934 and was a Vice-President in 1943 and 1944.

He was a Dean of the Faculty of Medicine in the University of London for many years.

Another of his great activities was in connection with Masonry, in which he rose to high Office. He was for many, many years Secretary of the Rahere Lodge and was Master of the Lodge in the Octocentenary Year—1923.

He was a surgeon on the Staff of the Royal Masonic Hospital.

These details serve to give some idea of Ball's life and work, both inside and outside Bart.'s. And now to deal more especially with his activities at the Hospital.

In 1913 he became Warden of the Residential College, which post he held until 1920.

As Warden of the College, he lived within the precincts of the Hospital and came in touch with many generations of Bart.'s men. His facility for friendship made him a link in the lives of innumerable people. This period of his life naturally deepened his affection for and interest in Bart.'s and marked him out as one of those people who were destined to play an important part in the future of the Hospital and Medical College. And so it proved to be, for in 1930 Ball was appointed Dean of the Medical College, in succession to Dr. T. W. Shore. He held this post until the day of his death. He was, for years, Treasurer of the Students' Union and, at one time, President.

In 1921 Bart.'s had obtained its Royal Charter as a constituent College of the University of London. And soon after Ball had been appointed Dean, it became clear that the Medical College must expand on its preclinical side, and his greatest work was to see this carried out. He was the prime mover in launching an appeal for funds and, ultimately, the College was established on the Charterhouse

site.

A great College arose with all its modern buildings and equipment—a College worthy of the traditions of Bart.'s. And this was in full swing when the present war began.

But his great triumph brought its own anxieties—not the least of which, that the cost of all this new development was and still is only partly met.

And then the war came and the whole picture changed. The Hospital and College were rent in pieces; the preclinical school was evacuated to Cambridge, the Mother Hospital reduced its number of beds—and two Sector Hospitals came into being.

All sorts of difficulties arose—all sorts of new and unusual arrangements had to be made and, in all this, Ball, who had now been appointed Sector Hospital Officer, took a prominent part.

His task was not an easy one. Looking back and realising that his work involved not only dealing with Cambridge and Bart.'s—but with Friern and Hill End Hospitals, one wonders how it was done at all.

But done it was and Bart.'s carried on as always throughout the years, and it is not for us to say how well.

And then came the great tragedy—as the result of enemy action, the new medical college was laid in ruins and was battered throughout the war until only a small part still stands. It needs no vivid imagination to guess what this meant to Ball—to see a great part of his life's work laid in ruins about his feet. And yet, up to last year, one of his chief interests was to push on with the work of temporary reconstruction and never was there a note of defeatism in his attitude.

His work as Sector Hospital Officer was very heavy. He was day and night on the end of the wire and must have spent many heavy days and sleepless nights.

He did not limit his energies to this job but was, also, Chairman of the Services Committee of the Central Medical War Committee and of many other administrative bodies.

Ball sacrificed a great deal to his administrative duties but, until the war, he was a very active surgeon on the staff of the Hospital.

He might be described as a general surgeon with a bent towards Genito-urinary surgery. He was a bold and efficient surgeon and he was, above all, a good doctor and always inspired his patients with confidence.

In his early days he was an excellent coach—and as a teacher he leant towards the dramatic



and humorous. His duties in the war meant giving up his hospital work and teaching, but he was able to continue with his private practice.

Ball was definitely not "all things to all men," but possessed a strong and forceful personality, tempered by geniality and heartiness. He was a surgeon of standing, a fine teacher

and a great Bart.'s man.

Many generations of Bart.'s men will remember him with affection.

We extend our deepest sympathy to Lady Ball, who has been his good companion throughout all the long and busy years.

R. M. V.

## SOME APOTHECARIES AND OTHERS

By H. E. BLOXSOME

Mr. Holder in the Strand was Dr. Johnson's regular apothecary. 'Poticary they often called them in the early nineteenth century and before that. Great ladies and gentlemen "used the 'poticary" when their symptoms were not serious enough to consult a physician.

Mr. Holder, in whom Dr. Johnson had great confidence, attended him for bleeding more often than once a quarter, as was the custom of many.

He prepared his medicines, chiefly expectorants, with very large quantities of squills; calomel, stomachics, and opium.

Dr. Johnson took a good deal of opium as a remedy for dyspnoea at night, but gave it up after an heroic dose of four grains.

Mr. Holder also carried out the directions of the physicians in attendance, particularly those of Dr. Heberden, whom Dr. Johnson called *ultimus Romanorum*, the last of the learned physicians, and of Dr. Thomas Lawrence, President of the Royal College of Physicians.

It appears that Dr. Johnson was rather a tiring and trying patient. Dr. Lawrence told him one day that if he would come and beat him once a week he would bear it, but to hear his complaints was more than he could support. Mr. Holder no doubt felt much the same. Johnson and Dr. Lawrence exchanged notes in Latin asking for and giving advice—which Johnson said he and Holder would carry out.

Johnson was "a great dabbler in physic," and like to prescribe for himself and for his friends. He recommended to Miss Boothby as a remedy for indigestion dried orange peel finely powdered, taken in a glass of hot red port. "I would not," he adds, "have you offer it to the Doctor as my medicine. Physicians do not love intruders." He disapproved of elaborate prescriptions and urged that they should be as simple as possible—an improvement, he said, that should be extended to cookery. An entry in Madame D'Arbly's diary of 1781 reads:

"Dr. Johnson has been very unwell indeed. Once I was quite frightened about him, but he continues his strange discipline—starving, mercury, opium; and though for a time half demolished by its severity, he always in the end rises superior both to the disease and the remedy, which commonly is the most alarming of the two."

More useful than his prescriptions was his advice to Mr. Perkins, the manager of Thrale's brewery, which became Barclay's, and, later, Barclay and Perkins. The present-day bottles of this famous firm have Dr. Johnson's head on their labels. His letter to Mr. Perkins is dated July 28th, 1782:—

Dear Sir,

I am much pleased that you are going a very long journey, which may by proper conduct restore your health and prolong your life. Observe these rules:

1. Turn all care out of your head as soon as you mount the chaise.
2. Do not think about frugality; your health is worth more than it can cost.
3. Do not continue any day's journey to fatigue.
4. Take now and then a day's rest.
5. Get a smart sea-sickness if you can.
6. Cast away all anxiety, and keep your mind easy.

This last direction is the principal; with an unquiet mind neither exercise, nor diet, nor physick can be of much use.

I am, dear Sir,

Your most affectionate humble servant,  
SAM JOHNSON.

Besides Mr. Holder, Johnson had another apothecary, who was also an old friend, but not of the same standing professionally as Mr. Holder. This was Robert Levett, nine years older than Dr. Johnson, one of the most celebrated characters in the Doctor's circle. He was, in Boswell's words, "awkward and uncouth, an obscure practiser in physick among the lower

people, his fees being sometimes very small sums, sometimes whatever provisions his patients could afford him."

It was a matter of principle with Levett never to refuse anything in the nature of food or drink that was offered him by a patient, as he reflected that that might be the only fee he was likely to get for his services. Often, says Johnson, he was made ill by eating when he had no mind to, and was often intoxicated by the brandy he didn't want, but which his rule forced him to accept; "perhaps the only man who ever became intoxicated through motives of prudence." Mrs. Thrale alludes to him as that odd old surgeon whom Dr. Johnson kept in his house to tend the out-pensioners.

Johnson first knew him in 1746, and such was his regard for him that he would not be satisfied, though attended by all the College of Physicians, unless he had Mr. Levett with him. "He was of a strange, grotesque appearance, stiff and formal in his manner, and seldom said a word when an company was present."

Whoever called on Johnson at about midday found him and Levett at breakfast, Johnson in *déshabille*, as just risen from bed, and Levett filling out tea for himself and his patron alternately, no conversation passing between them.

Levett was a man out of the common run. He would not otherwise have attracted the attention of the French surgeons. He was originally a waiter, an Englishman by birth, in a coffee-house in Paris frequented by doctors. They found that he was very much interested in their conversation, and an intelligent fellow, as they made up a purse for him, and gave him some instruction in their art, and put him in the way of attending lectures. In London most of his day was taken up in attending to his patients who were of the poorest class, and in attending Hunter's lectures, and any others that he could get to free. Johnson said that Levett was indebted to him for nothing more than house-room, a share of a penny loaf at breakfast, and an occasional Sunday dinner. He endeared himself to Johnson by many proofs of honesty and faithful attachment, and by his unwearied diligence in his profession. "Levett, Madam, is a brutal fellow, but I have a good regard for him; for his brutality is in his manners, not in his mind," said Johnson to Mrs. Thrale.

Johnson entertained in his house as permanent residents several others besides Levett—blind Miss Williams, Mrs. Desmoulins (daughter of his old medical friend and god-

father, Dr. Swinfen, of Lichfield), and Miss Carmichael (Poll). They were not an amicable party—"Williams hates everybody; Levett hates Desmoulins, and does not love Williams; Desmoulins hates them both; Poll loves none of them . . . Mrs. Williams is sick, Mrs. Desmoulins is poor; I have miserable nights; nobody is well but Mr. Levett."

"And pray who is the clerk of your kitchen, Sir?" asked Mr. Thrale. Dt. J.: "Why, Sir, I am afraid there is none; a general anarchy prevails in my kitchen. Dr. Levett says it is not now what it used to be."

Levett made an extraordinary marriage, alluded to by Johnson in a letter to Baretti in the words, "Mr. Levett has married a street-walker." He generally spells the name with two t's, Boswell always with one. Levett had married a woman of the town, who had persuaded him ("notwithstanding their place of congress was a small coal-shed in Fetter Lane") that she was nearly related to a man of fortune but was kept by him out of large possessions. She regarded Levett as a physician in considerable practice. Luckily a separation soon occurred but not before the lady had narrowly escaped hanging for picking pockets.

Levett was a great companion of Johnson as well as his humble apothecary. He went to bed one night "eminently cheerful," as Johnson says, but died in the early morning. Mr. Holder was sent for, opened a vein, but could draw no blood. "So has ended the long life of a very useful and very blameless man," wrote Johnson to Dr. Lawrence.

A third apothecary, of the standing of Mr. Holder, was Mr. Diamond, of Cork Street. Dr. Johnson used to dine at his house every Sunday in 1752, and talked of going to Iceland with him.

The diagnosis and treatment of Dr. Johnson's very numerous ailments must have been a sore trial to Mr. Holder, especially as Johnson did so much of the diagnosis and treatment himself. No doubt the chief feature was "hypochondria," the English Malady as it was called, meaning an acute depression of spirits. He obtained relief by abstaining from wine and suppers, substituting for wine immense quantities of tea. Tea was ten to twelve shillings a pound in 1734. Sir Joshua Reynolds once reminded him that he had already had eleven cups which annoyed Johnson and caused him to ask his hostess for another to make up the dozen. He was also annoyed when a footman put sugar into a cup of coffee with his fingers, and then at his mistress's request blew



down the spout of the tea-pot to make it pour better. He was subjected to a similar annoyance by a waiter's dropping sugar into his lemonade in Scotland with his finger and thumb which provoked Johnson to throw the lemonade out of the window. Eighteenth century tea was made very weak so it did Johnson little harm. He certainly drank wine in good measure when he did drink it—three bottles of port on one, or two occasions, and Sir Joshua Reynolds once saw him decidedly drunk, but that was the only occasion, and on the whole he drank little alcohol, and for the most of his life nothing but tea and lemonade. He could practise abstinence but not temperance.

Mr. Holder could do little for Dr. Johnson's hypochondria, but there were many occasions when something more tangible could be alleviated by Mr. Holder's blood-letting and prescriptions which he hastened home to compound in his apothecary's shop in the Strand.

Although of a very large ungainly figure, the Doctor was full of vigour, and although much subject to what he called asthma, which was very likely emphysema, he could when sixty-four, embark with Boswell on his tour to the Hebrides at a time (1773) when a journey from London to Edinburgh was equivalent to a distance of two thousand five hundred miles of modern travel, at a conservative estimate.

Dr. Heberden was sent for by Johnson when he had a stroke of paralysis which deprived him of speech on June 17th, 1783. He was not wholly prevented from writing and sent for Dr. Brocklesby also, his neighbour and friend. "My physicians are very friendly and gave me great hopes," he wrote two days later to Mrs. Thrale, and by July 5th he had recovered his speech almost entirely. Dr. Lawrence had died before this cerebral thrombosis. "My nights are restless, my breath is difficult, and my lower parts continue tumid." In February, 1784, he writes: "I have been extremely ill of an asthma and dropsy, but received, by the mercy of God, sudden and unexpected relief by the discharge of twenty pints of water." After this copious diuresis Dr. Johnson was very much better, and soon dined out again, among the company being "that ever-cheerful companion Mr. Devaynes, apothecary to his Majesty." He was as able and animated in conversation, and appeared to relish society as much as the youngest man. Indeed it was after this cerebral attack that he went to Oxford with Boswell to stay with Dr. Adams of Pembroke College, and on the way stopped at an inn (unfortunately the name of

it is not known) where he was exceedingly dissatisfied with some roast mutton, and astonished the company and the waiter by declaring it to be as bad as bad can be: it is ill-fed, ill-killed, ill-kept, and ill-drest.

In December, 1784, when he was 75, Dr. Johnson's physicians, Dr. Heberden, Dr. Brocklesby, Dr. Butler and Dr. Warren called in, at Dr. Johnson's earnest request, Mr. Cruikshank, the surgeon ("a sweet-blooded man," he called him) to make incisions into the legs and scrotum to relieve the dropsy. None of these would take a fee from Johnson, but he gave each one, and Mr. Holder, a set of his *Lives of the Poets*.

Two days later he demanded a lancet from his servant and deeply increased Cruikshank's incisions, and in doing so lost ten ounces of blood. He never recovered and died on December 13th, 1784, with no pain or distress, having kept his brain clear to the end, and his wit as keen as ever.

A post-mortem examination was made five days later in the presence of Mr. Cruikshank. Much cardiac hypertrophy was found with commencing ossification of the valves, emphysema of the lungs, degeneration of the kidneys, and some ascites.

The medical profession at that time was sharply divided into the three classes of physicians, surgeons, and apothecaries. The physicians were men of learning possessed of university degrees, of Oxford or Cambridge, and they had studied the ancient masters in medicine. The avenue to all science was through medicine, so that we meet with physicians whose main duties were to lecture in mathematics, in botany, in chemistry, and even in Arabic. The College of Physicians were only interested in consultants and cared little for, and indeed looked down upon, surgeons, and certainly upon apothecaries. The Corporation of Surgeons were a City Company, and were interested only in their apprentices who worked with their masters for seven years, paying a high premium—from £250 to £1,000. Generally the surgeons only took as apprentices their relations with a view to succeeding to a good hospital post, so that men of merit without capital had no chance of getting appointed to the staff of a London hospital but were obliged to become surgeon-apothecaries. Both the College and the Corporation cared less than nothing for the ordinary medical student who had, literally, to take a back seat at lectures and demonstrations.

The Society of Apothecaries placed them-

selves in a strong position by the Apothecaries Act of 1815, which insisted that any man, not already in unqualified practice, if he attended patients, and prescribed and dispensed medicine, must become a member or licentiate of the Society, and pass their examinations after fifteen months attendance at a recognised dispensary. The Act empowered the Society to take action against anyone, however otherwise qualified, if he practised as an apothecary, that is, if he dispensed his own medicines.

Although there were no qualified specialists as at present, there were very many quacks specialising in single subjects. For instance, Queen Anne had two "sworn oculists," one a tinker and the other a tailor. The tailor, Reade, an illiterate man besides being a quack, pleased Queen Anne so much that she made him a knight.

Talking of "celebrated and successful irregular practisers in physick," Johnson said, "Taylor was the most ignorant man he ever

knew, but sprightly." Taylor styled himself The Chevalier Taylor, Ophthalmiator Pontifical, Imperial, and Royal. It is well that Johnson never consulted him. His sight was poor and he was quite blind in one eye; "the dog was never good for much," he said. But Miss Burney declared that Dr. Johnson saw a good deal more than one would think; "He can see the colour of a lady's top-knot, for he very often finds fault with it."

At any rate he saw through the Chevalier and consulted none but reputable and regular practisers in physick.

I wish to acknowledge the sources for this article:—  
Birkbeck Lill's edition of Boswell.  
Dr. Johnston Abraham's Lettson.  
Dr. Alexander Gibson's History of the Radcliffe Infirmary.  
Dr. Arnold Chaplin's Medicine in England during the Reign of George III.  
Sir D'Arcy Power's advice to write of Johnson's apothecaries and his reference to Mr. Cruikshank.

## CIRCUMCISION CEREMONIALS

By COL. I. B. CANE

In many parts of central Africa circumcision of both sexes is universal, and associated with time-honoured ceremonies and customs.

These take place every few years, and especially when the harvest has been abundant, for after a good harvest, feasts and ample supplies of beer are available for the numerous guests. The season selected is the summer months, when after the rains the weather permits sleeping in the open air. The date is fixed by the Chief, after much consultation, in the first days that follow the new moon.

Messages are then sent to the Sub-Chiefs in his district, and the fathers then consult their own doctors, and receive amulets which their children wear around their loins to ensure success of the operation.

In the case of boys, the Surgeon first chooses a suitable place, on sandy soil, either in a field or in the midst of the forest, where he makes a small heap of sand at the foot of a tree, or against a large stone, and there buries an amulet or charm.

The ceremony begins in the afternoon by the circumcisions of two of the Chief's slaves, as a kind of trial.

Should any severe accident occur it is because the spirits of the ancestors oppose the operation there, or because the place is bewitched. Another place is then chosen or another opera-

tor called in, or in one recent instance, when the first two boys had died, all the others were postponed until the following year.

If the trial is successful the night is spent in final preparation for the ceremonies, and the next kept as a day of rest.

On the following morning all the population is astir, dressed as for great fêtes, and the children to be circumcised, wearing only loin cloths, and with their heads marked with a kind of cross in native butter.

Processions start off from each house, the members leaping up and down and uttering loud cries of joy.

They go out by the gateway of the "Boma" or cattle enclosure round which the huts are built, and after going all round this twice, they join and go to the "Ibalwa," or place selected.

Each boy carries in his hand a long stick, and the mothers follow at the rear of the procession, but are driven away before the ceremonies begin.

The surgeon is seated on the ground opposite his assistant, who leans against the tree or stone and holds the boy seated upon the little mound of sand.

If necessary, two other men hold his arms, and two his legs.

Sometimes the juice of a certain root is sprinkled on the patient. There is no other





I. Mongoose and other skins hanging on a tree in the enclosure

form of antiseptics.

The operator uses a small knife sharp on both sides, shaped like an arrow head.

This he first places across the throat of the child, threatening to pierce it if he makes any noise, whilst others sit around chanting a kind of song to hide any cries. He then pulls down the foreskin and cut it from the tip to each side and underneath, before removing it altogether. This is then buried in a shallow hole scraped in the earth.

Another child is then brought, and perhaps twenty operations may be done in the morning, according to the quietness of the patients and the skill of the operator.

When all is over, and the results buried, an ox is sacrificed upon the spot.

The assistants then tear off green branches

of trees, and go to reassure the women, singing a song, to the effect that he was an infant but is one no longer, his shame having been removed.

After this all go from house to house, for beer and refreshments.

The boys are taken to a sandy spot nearby, where they sit until the hæmorrhage has ceased; no attempt to arrest this is made, and if death should result this is attributed not to lack of skill by the surgeons but to carelessness by one of the attendants, and a witch-doctor or sorcerer is consulted to discover the malefactor. The body is buried at night, and the death concealed from the mother until towards the end of the segregation period, which may last six weeks or even longer.



IIa. Boys wearing ceremonial helmets and covering. On back of second boy in foreground is tied a dead bird.

### LIFE IN THE IKUMBI.

After the operations the boys are given some cooked food and towards the evening are taken by their fathers to the Ikumbi. This is a simple circular enclosure screened with sticks and grasses, and open to the sky. It must be large enough to hold about a dozen boys, with at least as many attendants and in it a fire is kept up day and night.

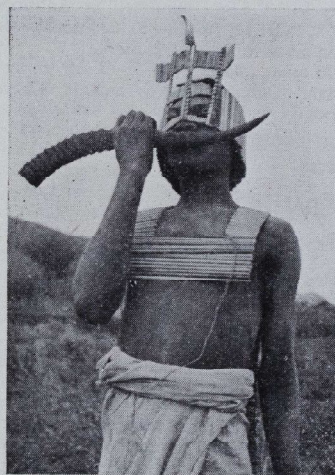
Here they live for periods varying from six weeks to several months and are given practical instructions in the duties which as men they will have to undertake. The days are passed in hunting birds, gazelles, mongoose, etc., with dogs, killing them with clubs and bows and arrows. The skins of the animals are filled

by a priest as like a chasuble with the shorter part in front.

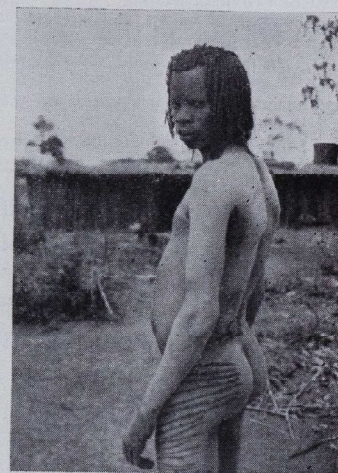
On their heads they wear a kind of cylindrical helmet, of similar construction, open at the top and ornamented with feathers, and a mask with side picces projecting from the level of the temples. (Photo II.)

In this are openings for the eyes and mouth. Throughout their long period of seclusion they must not wash nor wear any clothes, except a "pighri" or thin belt made of bark.

Instead they covered themselves with white earth rubbed over their bodies, which serves as a sign of their state. Sometimes on this white background are painted a number of coloured bars, obliquely upon the outer sides of their



IIb. Boy wearing 'helmet' ornamented with a feather and blowing a horn.



III. Boy, naked except for narrow leather belt with bars painted in colour on outside of thigh.

with sand and hung upon the branches of a tree in their enclosure. If no tree is growing there, one is cut down and planted within the camp. These stuffed carcasses are called their "Pumbu" or ornaments. (Photo I.)

In some tribes the bodies of birds are hung behind their ceremonial dresses instead of on a tree.

In one tribe these ceremonial coverings are like long narrow mats made of sticks fastened together, with a square hole through which the head is put, a short piece in front extending to the waist, and a long piece behind extending nearly to the ground. This has been described

thighs. (Photo III.)

### FINAL CEREMONIES

From time to time the Chief sends his servants to inspect and report upon the health of the boys in the enclosure.

When all are fully recovered, quantities of beer are brewed, and on the great day processions of men and boys approach the Chief's house from all directions, followed by the women.

The boys all sit in a row, facing the surgeon, whose assistants carry round roast meat cut into pieces, soup, and a large pot of beer.

The first piece of meat put into the mouth of



each boy he must put out and return to the attendant, but the second morsel he eats. This process is repeated with the soup and beer, the first mouthfuls of which the boys have to spit out. Finally the large pot of beer is passed round for them to drink in turn all that they want.

This ritual repast is followed by the ceremony of "nyundo" in which each boy is given a light tap on belly and back with a small hammer.

After final instructions in their future duties the boys are conducted to the homes of the masters of the Ikumbi (enclosure) in procession—after much feasting and drinking of beer they sleep there the night, and next morning are taken to a river for bathing.

They return to the village, and in the afternoon again wash in the river or in water holes, and are given new clothes and anointed with butter.

The remains of their enclosures are then burnt.

For the five following nights the boys sleep

with the Chiefs of their enclosures, but during the days are free to return to their fathers' houses.

Finally they receive presents, sometimes a house, an ox, bracelets, brassards, or spears and arrows.

Henceforth they have the right to cut their hair and to take part in all the doings of the men of the tribe. After circumcision they are no longer children but have become men.

The customs vary in different tribes. Those described are found amongst those of the large Central Province of Tanganyika.

For many of the details of these ceremonies I am indebted to a full description in "La Tribu des Wagogo," by R. P. Theobald Schaegele, C.S.Sp., published in *Anthropos*, Vol. XXXIII, 1938, and to additional information given to me by the Author.

Also to an account by R. A. Wyatt, formerly Assistant District Officer, Singida District, Tanganyika.

The photographs are my own.

### HEARD AT FRIERN

- Q. "And what do you think a Rabbi uses?"  
A. "A Jew's harp, sir."

### THE TRAIL OF THE BEAST IN HOLLAND

By CAPTAIN A. C. KANAAR, R.A.M.C.

V.E. day for me was the beginning of a brief but eventful visit to newly liberated North Holland.

I went there to see some cousins who live at Zeist, near Utrecht. I had heard no news from them, apart from a letter dated August, 1944, which reached me in England seven months later via the Red Cross.

My Unit was stationed beyond the Rhine in Germany, but I was able to hitch-hike on Army and civilian vehicles, and to spend the night with an Army Medical Unit on the way. The last part of my journey lay through territory where the final cease fire orders had only been in force for twelve hours. I arrived on VE plus one at 1.45 p.m. (Wednesday, May 9th).

When finally a friendly jeep deposited me outside their front gate and I met my cousin Marian and Jan, her husband, they were dumb-founded at my totally unexpected appearance. They had not even known I was on the Continent. Their eyes boggled with delight as I

handed them my rations. "Real tea! we haven't tasted that for more than four years. and sugar! we've had none for six months. You're like Santa Claus," they said, as I produced my wares—ending with chocolate and cigarettes. "We've had nothing but home made tobacco, wretched stuff—this will be a wonderful treat," said Jan.

The first problem was where to lodge me. "Isn't it awful," said Marian, "we've got the Germans here still—seven of them. There are three upstairs in the spare room and four in our dining room. Can't we turn them out now?" I sent one of them for their Officer. As I spoke no German, and he no English, he explained in French that they had been allotted rooms in four houses for the next few days. It was not convenient for me to see the billeting officer until the next day, so I said the Germans might remain in the dining room, but must clear the upper room. So I slept upstairs, my revolver beside me, while the Boche slept below,

with their rifles! Fantastic, but at least I was on top.

Over a real cup of tea Marian told me what they had had to endure. "The Boche were always harsh, arrogant and brutal, but since last September life has become terrible. When your men came to Arnhem in September, 1944, we felt sure that our liberation was near, so all the Dutch transport workers went on strike. They had never returned to work since that time. The Germans knew we hated them, and they determined to starve us into submission. They allowed us a little food, for if they killed us all we could not have been used as their slaves. Thousands and thousands died of starvation, especially amongst the poorer people, who could get little beyond the ridiculously small bread and potato rations. We had some vegetable and fruit from the garden. We could have scarcely survived without these."

"How much did you actually have to eat during the last few months?" I asked. "The bread ration was only 1 3/5 lbs. per person per week from October, 1944, to February, 1945, but since then it has been halved. That gives one about nine small slices of bread per week! The potato ration was two pounds per week—which is enough for one and a half meals, for this is our main food and we can eat more than one pound at a meal. Sometimes we could get no potatoes at all, and the bread was always terrible stuff which lay like a stone in one's stomach. It was made partly of tulip bulbs! Yes, and people stood for hours in queues to get a few such bulbs to eat. Milk was unobtainable except for babies under one year old—and the dreadful powdered milk, half a pint of which was given daily to the babies, is believed by the doctors to be the chief cause of the rapid rise in infant mortality. As many babies died in January and February, 1945, as in the whole of 1944. Fresh milk was not to be had because the Germans killed cows for meat besides sending many to Germany. The cheese ration, when available, was a fifth of a pound per fortnight and usually of poor quality. The meat ration was 1/5th lb per week, but one quarter of this was bones. Vegetables were also rationed, but there were none to be had in Zeist for three months."

"Apart from the rationed foods, which were too little to support life, there were four sources of supply. Firstly, from farmers who helped their friends in towns. Secondly, the Black Market. Prices were fantastic and latterly prohibitive. This one pound jar of salt on the mantle piece cost me the equivalent of £3, but we could

very rarely afford such luxuries. Coffee was £30 for 1 lb., home made tobacco was £62 for 1 lb.; wheat 34s. for 1 lb. (pre-war price, 1d. per lb.); potatoes 10s. per lb. (pre-war price, 2½d. per lb.); peas 26s. per lb.; eggs 4s. each. I have known £200 paid for 70 lbs. of wheat for baking bread. Thirdly there were the Central Kitchens, where anyone could supplement their rations, but thin soup was the 'staple diet' there. Twice a week there was a little potato instead of soup. Fourthly, there were mass treks to the few places where food was fairly plentiful. The main area was East of the IJser river to the North West of Holland. Countless people went on bicycles a return journey of 500 miles in search of food. Very many bicycles, including my own, were stolen by the Boche and their owners had to trek on foot. Jan, who is over 65, cycled to beyond the IJser twice in the depths of winter. There were 60,000 on the road on one of these occasions. Thousands died and their bodies lay frozen by the roadside. Many who returned did so empty handed. Jan obtained some potatoes and wheat for which he bartered some spare clothes. A pair of children's stockings which a farmer happened to need would get more wheat than £50 in cash. Some farmers who needed no more clothes demanded gold, as it seemed the only commodity whose value would endure."

"So now you see," continued Marian, "how desperately we needed outside help. In the last three months all food beyond the meagre bread and potato ration has been unobtainable. Three times we have received a Red Cross parcel containing ¼ lb. of butter and a loaf, but people are still dying of starvation. The very welcome British help will soon make all the difference. We are expecting our first parcel next week."

"Were the Germans short of food, too?" I asked, recalling their threat that if anyone was short of food in Europe it would not be them.

"No, they fed like fighting cocks while we starved. They even robbed us of the potatoes destined for the Central Kitchens, and rifled the Red Cross supplies."

If I had not seen their behaviour myself I would not have believed that an entire race could be so sadistic. A retired Dutch Colonel near here has four German officers living in his house. He has to lie on the floor in the attic. He is only allowed the use of his kitchen for half-hour a day, and while he subsists on potato he watches and smells the cooking of fowl, pigeon, fish, ham and other delicacies for the Germans. They have boxes of chocolates,



plenty of good wines and everything they need, but they never offered him anything, nor would he accept it if they did.

"The Germans have stripped the country of everything. Our railway stock and factory equipment have been taken to Germany. The boxes in the shops are all empty; there is nothing to buy. Not a pin nor a nail is left. Name anything you will, and it is sure to be unobtainable. Cotton, needles, writing paper, matches, clothes, shoes, china, glass, and iron ware, leather, brooms, brushes, toothpaste, soap, soda, mops, all have long since gone. Our lovely clean houses and streets are fouled by these wretches of the Monster Race. They have left us no dustman or carts to remove the rubbish. It lies in the streets to rot. There is not even wood for coffins. In one church in Amsterdam there lay 2,000 corpses awaiting burial. Finally they were wrapped in cardboard. There are no cars to carry away the dead and no labour to bury them, for all our men from 18 to 40 were compelled to go to labour in Germany. A few escaped and remained in hiding. In the middle of the night the Germans would hunt them down. They knocked at the door, saying, 'Open at once or I shoot!' Woe betide the housekeeper if they found a bed that was still warm but no longer held their prey. My son-in-law, a doctor, was imprisoned for six weeks at Weteringscham, Amsterdam, for eluding transfer to Germany by changing his age on his documents. He lost 20 lbs. in weight

in prison and came within an ace of being shot when fifty innocent hostages were suddenly marched out of his prison and executed in revenge for the death of Rauter, the notorious S.S. leader, who probably died at the hands of a German."

"We have had no gas or electricity since September, 1944, and in the winter we sat in darkness from 4 p.m., for we had no candles. The boredom and misery of domestic life is indeed said to have caused many divorces. We only had wretched little wood burning stoves which would scarcely boil a kettle and did not warm the room. Look at mine. You see it is only about six inches in diameter and a foot high. We had 140 lb. of coal (1 1/5th cwt.) per house for the whole winter. One night in Utrecht four children froze to death from lack of warm clothes and blankets. The children of the poor have nothing but rags to wear and cannot therefore leave the house. Amidst all this dreadful privation the self-styled Herrenvolk sat comfortably in their central heated, well lit houses. There was enough electricity and coal for them!"

Small wonder that the Dutch welcomed their liberators as heroes and beted them in a week of unbounded rejoicing! I left Holland with an even deeper disgust at the inhumanity of the Hun, and a profound admiration for a proud people whose spirit they had utterly failed to break.

### PECCATUM ADAE

OR

### NOW THAT I'M BECOME A MAN

When I was a child  
I was naturally nice; mannered, full of life.  
When I smiled  
I charmed the grown-ups who came to tea,  
And they told my mother so, after meeting  
me.  
Then I didn't know it  
(I was naturally nice)  
Until I learnt that so it  
Was. Thus,—one doomsday  
(As usual I'd been gay)  
My mother, with me by her side,  
Divulged, indulged, her foolish pride.

I couldn't scorn it,  
She had torn it.

Now I spend my time  
Engaged in pantomime.  
The ladies, flatly I'm  
Unable to attract.  
However much I act  
I can't break through the fact  
That charm is born, not made,  
And love that's posed will fade.  
So now the truth's displayed:  
(Advances that I make  
Their own appeal forsake;  
And compliments I pay  
Do in the air decay.)  
Let this account suffice—  
It was naturally I was nice.

NAT.

## SPORT

### TENNIS

The annual general meeting was held in March, presided over by Mr. Fraser, and the following officers were elected:—

Captain, J. E. Marrett.

Match Secretary, E. D. Marsh.

Fixture Secretary, J. A. McDonald.

It was also decided that the affairs of the club should be in the charge of a committee consisting of the captain and two secretaries. A majority vote being sufficient to act upon.

Following the 1944 season, when few matches seem to have been played, some difficulty was anticipated this year in collecting and trying out the various players and in obtaining fixtures. However, trials were held and some indication of individual talent obtained.

The matches played have been listed below, but we regret that only the four better ones have been described here.

*Oxford*—June 16th. We had an extremely enjoyable match which was well prefaced by a hilarious lunch which caused both secretaries some difficulty in persuading their teams to play tennis. We eventually arrived at the courts only to find that the opposing captain was escorting our one supporter with his beautiful friend to the river. Mark S. Marrett played well in parts and just lost to the opposing first pair and then beat the third pair. Guillam and Blackman played well, but were beaten by the unaccustomed accuracy of their opponents' net play. Marsh and Mehta spent three hours playing their first match, losing 10—12 in the final set. We then returned to Hertford College for an excellent dinner, during which our team, unaccustomed to the peculiarities of Oxford, succeeded in getting our hosts scouted more than once.

*Gus*—July 29th. This has been our best match so far, and although we lost it was generally felt that but for a sad attack of "stomick trouble" sustained by Mark the day before while playing for the United Hospitals that we should have won. As it was a substitute had to be found on Saturday morning and the pairs split up. In consequence the team did not do itself justice. We have, however, hopes

of playing them again with a full side later on.

*St. Mary's*—August 4th. This match took place at Chislehurst, and we were very grateful that our president, Mr. Fraser, came down with us. Having each played our respective opposite numbers, Mr. Fraser took over our captain's place in the first pair, beating the opposing second pair easily.

Mr. Smith then replaced our secretary and succeeded in winning his match. The final result was a victory to us of 7 matches to 2.

*Mr. Fraser's VI*—August 11th. Of our lighter tennis there is no doubt that all honours must go to the second occasion on which we played Mr. Fraser's side. A pleasantly close match in the afternoon of a perfect day led to a delightful sense of weariness and well being, and it was not surprising before long to hear a famous pair of red braces singing of a pair of red plump britches. Soon this led to a further galaxy of tunes, among which green growing rushes and one of vogues being led up a garden path were prominent, and these in turn led to a highly successful representation of a mermaid on a rock, for a piece of dainty white beef blending charmingly with the blue tiles of the plunge bath. We may also add that mainly due to the tireless and enthusiastic—almost over-enthusiastic—efforts of the mermaid and rather less to the literally misdirected efforts of others than the limpid blue Mediterranean-like bath became a trifle reddened by the dye from the aforementioned braces. The latter gentleman after imbibing quarts of lipid blue and the former having remetemorphosed the players and supporters returned to London.

We, the secretaries, feel safe in saying for one and all how grateful we are to Mr. Fraser for raising so pleasant a side against us and for such a close game; no less to Mr. and Mrs. White for so materially helping the day's enjoyment.

We have also been able to arrange some second VI. matches as we were unable to provide tennis for all who wished to play in the first VI.

Regular players include J. E. Marrett, P. C. Mark, E. D. Marsh, J. A. McDonald, M. D. Mehta, J. H. Blackman, P. A. N. Weston, T. A. J. Pranker, P. D. Osborne.

Contributions for the "October" issue of the JOURNAL must reach the Office by September 10th.

### RECENT PAPERS BY ST. BARTHOLOMEW'S MEN

- ATKINSON, M. "Tinnitus Aurium: Observations on its Nature and Control." *Ann. Otol. Rhin. and Laryng.*, December, 1944, p. 742.
- BLACKBURN, G. (and Rob. C. G.). "The Abdominal Wound in the Field." *Brit. J. Surg.*, July, 1945, pp. 46-52.
- CUTHBERT, J. B. "The Late Treatment of Dorsal Injuries of the Hand Associated with Loss of Skin." *Brit. J. Surg.*, July, 1945, pp. 66-71.
- DARMADY, E. M. (and Hardwick, C.). "Syringe-

- Transmitted Hepatitis." *Lancet*, July 28th, 1945, pp. 106-108.
- GARNHAM, P. C. C. "Malaria Epidemics at Exceptionally High Altitudes in Kenya." *Brit. Med. J.*, July 14th, 1945, pp. 45-47.
- GREEN, F. H. K. "The Local Treatment of Thermal Burns." *Brit. Med. Bull.*, Vol. 3, No. 4/3, pp. 91-95.
- HARGREAVES, W. H. "Chronic Amoebic Dysentery." *Lancet*, July 21st, 1945, pp. 68-72.



- LUMB, G. D. (and Wilson, J.M.). "Penicillin Assay Methods." *J. Roy. Army Med. Corps*, June, 1945, pp. 247-254.
- PETERS, R. A. "The Biochemical Lesion in Thermal Burns." *Brit. Med. Bull.*, Vol. 3, No. 4/5, pp. 81-88.
- RACE, R. R. (et. al.). "Hypersensitivity to Transfused Blood." *Brit. Med. J.*, July 21st, 1945, pp. 83-84.

SNOWDEN, E. N. "Introspection." *West Lond. Med. J.*, July, 1945, pp. 61-69.

WEBER, F. PARKES (and Samson, G.). "Lutembacher's Syndrome with an Account of a Case." *Med. Press Circ.*, June 20th, 1945, p. 392.

— "Sjogren's Syndrome, Especially its Non-Ocular Features." *Brit. J. Ophth.*, June, 1945, pp. 299-311.

### ANNOUNCEMENTS

#### RETURNED PRISONERS OF WAR

Lt.-Col. G. T. HANKEY to Bellhurst, Layfield, Surrey.

#### CHANGES OF ADDRESS

Dr. JOHN HAYWARD to Hilcot, Shaftesbury Road, Salisbury.

M. R. LAWRENCE to Chicklade, Hindon, Salisbury.

W. F. CHOLMFLEY, F.R.C.S., Newlands, Church Hill Road, Tettenhall, Wolverhampton.

KEITH VARTAN to 25, Harley Street, W.7.

E. D. MOIR, M.Chir., to 56, Wimpole Street, W.1.

E. F. N. CHURRY to The Mount, Aldeburgh, Suffolk.

R. DE V. GRIPPS to 288, Cornwall Street, Coorparoo, Brisbane, Australia.

W. H. W. ATTLEE, Knole House, Manor Road, Milford-on-Sea, Hants.

R. W. L. CALDERWOOD to 222, Cranbrook Road, Ilford, Essex.

JOHN BEATTIE to 78, Hailey Street, W.1. Welbeck 8448.

Mr. F. COLEMAN to 31, Queen Anne Street, W.1. Layhan 2827.

### UNIVERSITY OF OXFORD

#### SECOND B.M. EXAMINATION. TRINITY TERM, 1945

PHARMACOLOGY AND PRINCIPLES OF THERAPEUTICS  
Lloyd, H. M.

#### CONJOINT BOARD FINAL EXAMINATION, JULY 1945

##### PATHOLOGY

Dawson, D. A.  
Clarkson, K. S.  
Rawlins, J. S. P.  
Sahakian, J. G.  
Williams, J. R. B.  
Brierley, D. S. N.  
Buckley, A. R.  
Cocks, R. A.  
Sutton, W. K.

Atteridge, J. H.  
Royle, F. C. W.  
Banks, P. J.  
Fyfe, A. E.  
Taylor, P. A.  
Arundell, P. W.  
Heneghan, N. D. H.  
Ballantine, K. I. W.

##### SURGERY

Cartledge, V. L.  
Hogben, B. H.  
Ostlere, G. S.  
Taylor, T.  
Marrett, J. E.  
Finlayson, R.  
Youngman, R.

Philip, P. P.  
Merritt, D. M.  
Arundell, P. W.  
Dawson, D. A.  
Seed, S.  
Watson, D. A.

##### MEDICINE

Dawson, D. A.  
Gloster, J.  
Rimington, K. E.  
Cocks, R. A.  
Rawlins, J. S. P.  
Denny, W. R.  
Wince, W. H. D.  
Walker, P. H.  
Clarkson, K. S.  
Church, R. E.  
Merritt, D. M.

Taylor, P. A.  
Watson, D. A.  
Davies, I. N.  
Weatherhead, A. D.  
Dallas Ross, W. P.  
Allison, R. C.  
Peck, I. A. W.  
Dingley, A. G.  
Davies, G. R.  
Moore, P. H.  
Debenham, J. A. R.

The following have completed the examinations for the Diplomas M.R.C.S., L.R.C.P.:—  
Arundell, P. W.  
Dallas Ross, W. P.  
Debenham, J. A. R.

Lawrance, K.  
Haire, I. R.  
Dunlop, F. M. C.  
Pugh, D. E.  
Sutton, W. K.  
Backhouse, K. M.  
Chopra, A.  
Teeuwen, J. J.

Ostlere, G. S.  
Watson, D. A.  
Church, R. E.  
Davies, G. R.  
Dingley, A. G.

Davies, I. N.  
Moore, P. H.  
Walker, P. H.  
Youngman, R.

#### SOCIETY OF APOTHECARIES FINAL EXAMINATION, JUNE 1945

PATHOLOGY, BACTERIOLOGY AND FORENSIC MEDICINE  
Osborne, P. F. Wimborne, D.

MIDWIFERY  
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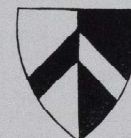
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## ST. BARTHOLOMEW'S



## HOSPITAL JOURNAL

Vol. XLIX

OCTOBER 1st, 1945.

No. 9

### ASPECTS ON CONCLUSIONS

This being our final soap-box, we thought we would like to write a concise, witty and conclusive essay on some knotty controversy of universal interest, the kind of essay that makes a literary reputation in about eight hundred well-chosen words, a breezy but telling little dream editorial which we had hoped might even retrieve our name from the fierce fires of condemning criticism into which we have been irrevocably cast. We had hoped to hand over the editorial arena to our very competent successor with that air of satisfied complacency which is the prerogative of those who bequeath a receptive audience. Alas, we had hoped! It seems hardly necessary to say that the muses did not, could not, or would not hear our fervent supplications, so cast back on our own all too meagre resources, we began to hunt for subject material. Out of the murky confusion of embryo ideas there arose two which clearly demanded attention.

The first we write as a word of warning to all future editors. In the past the editors have been ganged into office with the assurance that people will not read the editorials. At once we wish to dispel that comforting supposition. We assure our successors that even the most unexpected and unwelcome people do—a fact which was rapidly brought home to us by the furtive whisperings and tolerant laughter of our friends. While on this subject we would add that what is good for the student goose is certain to be a red rag to a qualified gander. Again we would like to contradict any hopes that the students will contribute to their own journal. With the fewest exceptions they do not and now we believe that they cannot. The young man of yesterday was forced to write carefully on at least two subjects—on his studies

by his teachers and on his love by the conventions of his time and his beloved. Now the abortive attempts of the fifth form mark the climax of his compulsory literary education, while journalism has stolen the superlatives from the language of love, and the telephonic has rendered their very necessity an anachronism. We would add that those few who are willing to write are the same few who are willing to do everything else and in consequence they are always far too busy. But by far the most serious pre-occupation of the editors is to make their tenure of office long enough to save their respective faces and short enough to enable them to push unwanted censure backwards onto their predecessor and forward onto their successor with equal facility.

Switching from the ridiculous to sincere, the second subject is one on which we have been wanting to write for some time. When we read of the ever increasing acuity of international and intranational problems, it seems to us that the great obstacle in the way of solution is the lack of any common understanding between the conflicting parties. Not only have the various nations and classes different scales of values and different aims in view, but their whole ethical background has little in common. The scientific revolution has given us new conceptions of time and the universe, and these have undermined the great religious doctrines. This has naturally resulted in a gross materialism which manifests itself through the various political theories and while we would like to believe that all share a common regard for humanitarian principles, there are now no universal standards on which we can base our lives and our relationships with others.

It is our belief that religion is a progressive



awakening to a consciousness of our position in relation to the infinite. In the past each step forward has been heralded by an advance in knowledge or society, which has provided the soil in which the new conceptions of eternity flourished. We are now on the eve of the greatest turning point of all. Modern inter-communication and modern invention makes a mutual ethical background an essential. The world has looked to the old doctrines and found

### A CASE OF TETANUS IN A BOY AGED SIX YEARS. WITH RECOVERY

Colin C., aet 6, was admitted to Chase Farm Hospital on June 16th, 1945, suffering from trismus and with a history of having trodden on a nail in the garden, nine days previously.

On Admission: The patient, an otherwise healthy boy, had tonic spasm of the facial muscles, giving a risus sardonicus, and allowing him to open his mouth to approximately only one quarter of the normal extent. There was stiffness of the neck and some slight generalised stiffness of the back and lower limbs. On the sole of his left foot was a small, healed, puncture wound. He had not received anti-tetanic serum.

Within twelve hours of his admission to Hospital, generalised spasms occurred and the tonic was such that he could be lifted up "all in one piece." His head was now retracted and frequent spasms occurred, producing typical opisthotonus and causing him to cry out with pain.

After admission, but before the occurrence of generalised spasms, he had received 50,000 units of antitoxin, but no sedative. Immediately after their occurrence, paraldehyde, four hourly, was given, and he remained, with few exceptions, free from severe spasms during the rest of his illness.

#### TREATMENT.

This may be summarised under six headings:

- I. Specific.
- II. Sedation.
- III. Prophylaxis—against secondary infections.
- IV. Nutrition.
- V. Rest and quiet, with skilled and patient nursing.
- VI. Local treatment.

#### I. Specific.

On admission, 32,000 units of tetanus antitoxin, intramuscularly.

them wanting and this has resulted in tremendous divergence of purpose. H. G. Wells long ago saw the need for a universal system of knowledge, but that need now is much broader. Unless we establish a singleness of purpose founded on a singleness of ethical perception, we believe that our way of life faces a destruction as complete as anything that must have overtaken the biologies of the past.

Four hours later, 6,000 units of tetanus antitoxin, intramuscularly.

Hourly, for next 36 hours, 3,000 units of tetanus antitoxin, intramuscularly.

On 4th, 6th, 8th and 13th days one injection of 100,000 units of tetanus antitoxin, intramuscularly.

Total dosage over 13 days was 638,000 units, all given intramuscularly.

#### II. Sedation.

The principle: Prolonged reduction of excitability short of full anaesthesia. The drug to have a minimum toxic action on the liver and other organs, and not to be too strong a respiratory depressant.

Following the onset of generalised spasms, paraldehyde, half a fluid ounce per rectum, four hourly, was administered. The paraldehyde, dissolved in about 5 ounces of warm water, was given through a soft rubber catheter, under low pressure: the injection took some twenty five minutes. Occasionally, he was unable to retain the drug per rectum, so, instead, 5c.c. of undiluted paraldehyde were injected intramuscularly into the buttock, also four hourly. At the end of a fortnight he appeared to be acquiring some degree of tolerance to paraldehyde, so, for two further days, the following sedative was substituted for it:

|                   |  |         |
|-------------------|--|---------|
| Chloral hydrate   |  | a a     |
| Potassium bromide |  | grs. 15 |

#### III. Prophylaxis.

On the second day in hospital, coarse crepitations and rhonchi were heard in his chest and, to guard against further pulmonary complications, sulphamezathine gm. I, six hourly, was administered. At times there was much mucus in the upper respiratory tract and, on these occasions, the foot of the bed was raised, he received mist. ammon et ipecacuanha co. half a fluid ounce t.d.s. and the dosage of paralde-

hyde was slightly diminished. Under these conditions he usually drained away the mucus satisfactorily. His lungs remained almost clear throughout.

On the ninth day, his temperature rose to 102° F. and a generalised morbilliform rash appeared. The sulphamezathine was discontinued but, by that time, its work had been done: the patient received a total of 38 gms.

On admission, he had two ulcers under his tongue which may have been caused by spasms.

Penicillin pastilles (500 units each) were given to him to suck at frequent intervals to prevent spread of infection and a possible stomatitis.

#### IV. Nutrition.

The principle: adequate nutrition, having regard to difficulties in feeding and digestion and taking into account the additional requirements of the body necessitated by the muscular spasms and increased metabolism.

The feeds were given shortly before the next dose of paraldehyde was due, the patient then being least drowsy and most capable of taking food. With patience, it was always possible to feed him by mouth. His feeds consisted of 4-6 fluid ounces of milk, to which had been added 2-4 drams of glucose. Water and orange juice were given ad lib. After a week, eggs were given beaten up in the milk. On the twentieth day after admission, he was on a full diet.

His daily fluid intake for the first fourteen days averaged about 70 fluid ounces:—50 fluid ounces by mouth and 20 fluid ounces per rectum, along with the paraldehyde. The daily caloric intake averaged between 900-1,100 calories.

#### V. Rest and Nursing.

The patient was placed at first in a room by himself, with the curtains drawn continuously. A warning notice was placed on the outside of the door, and the nursing staff fully acquainted with the risk to the patient should he receive sudden stimuli. He was nursed in a cot.

Throughout the first fortnight he was incontinent of urine. For the first six days his bowels were not opened naturally and no attempt was

made to evacuate the rectum. At the end of a week, a simple soap and water enema was given with good results, and this was repeated occasionally as required.

#### VI. Local Treatment.

The healed wound on the sole of the foot did not receive surgical treatment.

The patient's temperature on admission was 99.4° F.; it then rose slightly and remained mainly between 100-101° F. for fourteen days. There were three peaks in the chart: After taking 22 gms. of sulphamezathine, the drug was discontinued for 24 hours and the temperature immediately rose to 102° F., to return to the previous level on resumption of the drug. It again rose to the same level at the time of the morbilliform rash on the 9th day. Both rash and the "temperature spike" subsided with cessation of the drug.

On the day following his last dose of antitoxin his temperature was 103° F., and the next day, just fourteen days, almost to the hour, after his initial dose of antitoxin, it rose steeply to 106.2° F. He was tepid sponged until the temperature reached 104° F., and then placed in a tepid bath for five minutes, after which his temperature was 100° F. The following day his temperature fell to 96° F.—a fall of over 10° F. in twenty hours. Thereafter, it climbed to normal and there was no further pyrexia.

On admission, he had a very slight, right internal strabismus. On his recovery from tetanus, there is no doubt that this was accentuated.

On the twentieth day after admission, he was able to open his mouth to the full extent, to sit up in bed and take a full diet.

#### SUMMARY.

A case has been described of a boy aged six years, who developed generalised tetanic spasms on the tenth day following a perforating wound of the foot, and who recovered under treatment.

I wish to thank Dr. P. Hamill for most helpful criticism and for his kindness in permitting me to publish the case.

T. H. TIDSWELL.

July, 1945.

*The article printed overleaf is published in connection with the appeal of the International Student Service for new or second-hand medical text-books and clothing for Dutch medical students. Would old Bart.'s men who can spare any of their old text-books or clothing send them to the Secretary of the Students' Union at the*

*Hospital? Both clinical and pre-clinical text-books are urgently needed.*

*Mr. Haenen was a student at Delft. He visited the Hospital in September, and at our request has written this article in order to give a first-hand account of the situation in Holland.*



## MEDICAL STUDIES IN THE NETHERLANDS

By ALFRED HAENEN

Reviewing the outlook for Dutch Medical students to return to their studies, it will be good to give a short recapitulation of those facts that are responsible for the present situation.

Medical studies in the Netherlands could only be done at the medical faculties of four of our Universities: Leiden, Amsterdam, Utrecht, and Groningen. In total there were some three thousand medical students in Holland.

When our country was overrun by the German Armies, the Nazi Party came into action with its programme of nazification. Freedom and Democracy, outstanding features of Dutch national life, were in danger and found a protection in the formation of a front of resistance which grew more organised as the attacks increased. Universities always play a great part in outlining a people's national sphere, and it is the pride of Dutch Universities that they were looked upon by the Germans as a dangerous source of inspiration of national Dutch resistance. Breaking University freedom seemed a necessary step in breaking Dutch minds, so the Germans started a slow but wicked process of nazification.

In November, 1940, all Jewish professors were banned from the universities. Though only a few professors were involved, a reaction of indignance resulted, followed by a three-days' strike of protest by the Leiden professors and students, and by the students of the Technical High School at Delft. The other Universities and High Schools reserved their action of protest until more heavy attacks were launched.

To Leiden and Delft the consequences followed instantly: both the University and the High School were closed and students were prevented from studying elsewhere. Yet the instant reaction of a strike was not expected by the Germans, who proved to be worried by it very much, and no doubt it caused a delay in the issue of other measures.

In April, 1941, Delft was re-opened, which, students were told, was due to the magnanimity of Nazi authorities. In Leiden, however, professors too had made their positive protest and the Germans decided not to re-open Leiden with its staff again. Their pains to replace the Leiden professors by Nazi men and to establish the first Nazi University in Holland never succeeded owing to the lack of collaborator-scientists. Leiden since November, 1940, remained closed and its professors and students

switched over from the open to the underground resistance.

Not until about February, 1942, the next step came: Jewish students, like all Jews in Holland forced to wear a mark as such, were banned from Universities and High Schools. Far from being indifferent, the Dutch students unanimously decided not to demonstrate openly until other expected measures were taken. University life went on.

In December, 1942, it was known that Germany planned to mobilise thousands of students for forced labour in Germany and Eastern Europe. Students kept clear of the Universities, but came back after some time, when they were assured that nothing like this was planned. On February 6th, 1943, however, several University buildings were suddenly surrounded and several hundreds of students were removed to the Vught concentration camp, near 'sHertogenbosch. No one appeared at the University since. But a thorough organisation of resistance and mutual help was built up in those days, and spread over the whole of the Netherlands. Students, no longer able to study, were likely to deal with matters the Germans feared very much, and in general Dutch resistance an ever increasing number of students were involved.

The Germans apparently wished to regroup Dutch students at the Universities in order to deport many of them to Germany and to keep the rest under a firm control. For this, confidence of the students had first to be regained. On March 10th, 1943, the authorities issued a decree that in spite of their former behaviour students were to be given one more chance of showing their adherence to the European Order by signing before April 10th an Act of Loyalty to the authorities. But to those who signed there was no assurance that they would be allowed to continue their studies unmolested. For at that time the Germans introduced the system of a "Numerus Clausus" (a limited number of students who would become essential technicians of the European Order and its battle against Bolshevism, etc.), the number of which would be decided only after April 10th. The students, under arrest at Vught, were given freedom again to show the German good-will.

Yet it became clear after some weeks that too small a minority of students would sign the Declaration of Loyalty, so the authorities hastened to promise that all those who would sign it would automatically be included in the

Numerus Clausus, which thus lost its former significance.

There was still one week in which students could decide between two alternatives. On the one hand, if all signed the Act, the German intention to reduce the number of students would not be fulfilled except by openly breaking their promise and mobilising "loyal" students for forced labour. (Signing the Act could be interpreted as excusable as its formula left the decision whether an official resolution should be obeyed or not to the individual conscience and honour. Yet it was not attractive to make use of such a lawyer's excuse, nor was there any evidence that the Germans feared to break their word openly.) On the other hand the second possibility of unanimously refusing to sign the Act would make studies certainly impossible, but would save the honour of Dutch students and would, by its character of a demonstration, greatly inspire general Dutch resistance.

The students decided not to sign. Only about 13 per cent. of them did, and they will now be expelled from Universities for a period at least as long as that during which they were able to study since April, 1943. In addition, their degrees will be annihilated.

Those who did not sign had to hide from May 6th, 1943, when they were ordered to go to Germany for forced labour. About one-third of them actually went to Germany, being faced by the most intimidating threats of reprisals, to be carried out under a state of that martial law which reigned over Holland in those days and which in justice can only be compared with the brutality of the defeated German armies since September, 1944.

From April, 1943—in practice from December, 1942—normal university life in the Netherlands had ceased; but the students remained firmly organised. Those who were deported were helped to escape, resulting in the safe return of about three-quarters of them up to September, 1944. In Holland students joined in helping the allied interest in all respects, awaiting their duties after the liberation of their country. Their total losses during German occupation amounted to about 600 killed, and many more have been forced to abandon their studies, by causes of all kinds.

By now, Dutch universities have started again, and the severe shortage of young graduates in Holland presents a great emergency. On top of that they are faced with enormous spiritual and material difficulties.

Dutch students are faced with spiritual difficulties after having been roving in uncertain circumstances, dealing with all kinds of work; it will be very difficult for them to return to normal student life, and many will want help. In addition, the behaviour of the average Dutch professor was not respected very much by the students. Though very few could be called collaborators, most of them always tried to find a compromise between pursuing university life with freedom greatly restricted and incurring German reprisals by resigning and siding with the students. The majority of them continued to teach. Respect for the professors has diminished, and will have to be re-established.

Material difficulties in the way of a good start are, however, much more substantial. As far as the medical faculties are concerned there is a serious shortage of professors in Amsterdam and Groningen, where some outstanding professors are not found acceptable owing to their national behaviour. There is, too, a large gap in learning owing to the cessation of scientific and technical research for about three years, and to a very unsatisfactory knowledge of what has been achieved abroad since 1939. In addition, the universities have become very short of instruments of all kinds, because supplies have failed to reach them since 1939 and because of German robbery of the greater part of their electrical and optical equipment. Libraries have lost many books, and there is a great lack of latest publications.

Like the average Dutchmen, the individual student suffers from an inadequate supply of clothing. More or less he has got used to this. He will not get used to the enormous shortage of bicycles, tyres and tubes, which compels him to walk for hours a day. Yet it proves possible to do without them. Students are waiting for better days. Indispensable, however, in their studies is a minimum number of those elementary books which should be consulted daily and which are totally absent in Holland. They can only be provided from overseas.

*Contributions for the November issue of the JOURNAL should reach the Journal Office by Monday, October 15th.*



## OBITUARY

## COL. H. A. GILKES, M.C., R.A.M.C.

Those of us of the 1922-23 vintage are grieved at the sudden death of Humphrey Gilkes in an air crash whilst on his way to England for a spell of well earned leave.

Before he took up medicine, Gilkes served with Field Marshal Montgomery in the 1914-18 war, and gained the unique distinction of winning the Military Cross on no fewer than four occasions.

After leaving Bart.'s he finally joined the Colonial Medical Service and at the outbreak of war, was D.D.M.S. Trinidad. By his persistence and in spite of powerful official opposition, he managed to obtain permission to join the Army and was sent to East Africa, where he served with a Field Ambulance during the campaign. After the fall of Somalia (Italian Somaliland), he was appointed A.D.M.S. Somalia.

At the time of his death he was Principal Medical Officer to the British Somaliland Military Administration, and I had the pleasure of meeting him once again, after 23 years, at Hargeisa, a few days before his fatal accident.

I found him living alone in a tent pitched in the Somaliland scrub, with his violin, banjo and books. He preferred this to the comfort of a mess.

After doing a ward round with him at the Native Hospital, one realised with what affection Gilkes was regarded not only by his colleagues but by the proud Somalis also. One heard that Natives crowded the vicinity of his tent when the bush telegraph announced his return from a long safari, even though there was no official news of the date and hour of his arrival.

He was a man of great charm and whilst he listened to us discussing the cases, there he stood leaning on his favourite ash plant stick,

one foot crossed over the other, hand on hip, with his head tilted to one side—a characteristic stance of his.

His love of adventure, combined with energy, kindness, humour and profound knowledge of human nature, made him an outstanding member of that happy breed who are Britain's unofficial ambassadors to undeveloped Colonial peoples. His keenness to help the backward Somali was imparted to all who worked with him and his anxiety to do the best for mankind over-rode all else.

His hobbies were music and writing and in addition to being a versatile and accomplished musician, he had written several novels.

Beloved by his countrymen and Somali alike, he will be much missed in a rather uncomfortable and lonely out-post of the Empire.

C. NAUNTON MORGAN.

I knew Humphrey Gilkes well, for soon after the last war he began to study medicine at Bart.'s and presently was a dresser on Professor Gask's Unit. The Honourable Artillery Company is proud to recall that he began his military service in its ranks in September, 1914, and later got a commission in the 21st London Regiment, in which he achieved the almost unique honour of being awarded three bars to the Military Cross. It was a great pleasure to meet him again when I was the predecessor of Naunton Morgan in East Africa Command. I can fully endorse all that he says. He was calm and imperturbable, yet alert and always ready to face difficulties if he found them in his path, and one felt that it was just those qualities which had made him as a junior officer the fine soldier that he was.

R. OGIER WARD.

## THE LETTER

Feeling in a reminiscent mood to-night, I am tempted to reproduce as near as I can, word for word, the text of a letter written by a doctor and which accompanied the patient to hospital. As this was no ordinary medical case, nor indeed it would appear, no ordinary medical practi-

tioner, although after the lapse of all these years, I cannot guarantee the wording as being exactly that of the original letter. I can on the other hand, guarantee that the substance is completely authentic. Here, then, is the actual letter:—

"Dear Doctor Sir.

Introducing my patient Mrs. Henrietta Brown, whom I have known well, if not intimately for many years. I am therefore in the position to say that she is an excellent woman—cats well, sleeps well, and up to the present, has been regular in her habits. Therefore no one was more surprised than myself when she came to my surgery this morning complaining of no show for the last two months. I quickly gathered she meant amenorrhoea (for I have not known Mrs. Brown all these years for nothing), and on closer questioning ascertained she was also experiencing pain in her right shoulder.

On abdominal examination (it is my own opinion that this is sometimes worth doing), I was very surprised to find a tumour arising out of the right costal margin, and indeed more surprised still that it was tender to my palpation, and I must say I am always a careful palpator of the gentle sex. I therefore doctor sir, have no hesitation in diagnosing this case as an ectopic of the under surface of the liver, for has she not got amenorrhoea, a swelling of the

right costal margin, and right shoulder-tip pain? I am sure you cannot do other than agree with me that this constitutes a most interesting case—indeed may it not be the most interesting case of the year? I am happy to think I have been the means of bringing such a rare case to your notice. In conclusion, it is only fair for me to add that for many years her husband has suffered from a bilateral hydrocele, and I cannot, therefore, regard the seed as healthy.

Yours etc."

The point of this rare and exclusive case would undoubtedly be lost if I did not explain that the diagnosis made on admission to hospital was one of antritis of the shoulder with early congestive cardiac failure, producing a palpable liver. The amenorrhoea?—well, she was past the menopause, dear doctor sir!

ANON.

## WITCH DOCTORS

By COL. L. B. CANE

The profession of "Witch Doctor" includes practitioners who by various methods claim to cure diseases, remove their causes, produce rain, or in other ways confer benefit upon those who may consult them.

Under this general term may be included those by some called "diviners," who by supernatural means profess to discover the persons or causes responsible for disease or disaster; the "sorcerers," who cast spells thought to produce these results; and the "mgangas," or general practitioners, who prescribe or apply remedies, and in some cases even set fractures and do simple operations. Though for their results all rely to varying degrees upon magic and the credulity of their clients, the third class depend largely upon their inherited and acquired knowledge of simple indigenous herbs and roots. Of these some are undoubtedly of therapeutic value, and more may in the future perhaps be analysed and eventually enrich our pharmacopoeia.

## "DIVINERS"

Those who may be termed "diviners" are called in to discover and denounce the sorcerers whom they allege to have been the cause of any illness, death, or disaster. They are also consulted on many subjects, the choice of a bride, the site for a house, the result to be expected from an operation, the sacrifice to be offered to appease an ancestor, the discovery of a person who has bewitched the rain, and the

means to counteract the influence of missionaries.

They make and sell amulets to preserve the wearers from injury, illness, and the evil eye, and to ensure safety on a journey, or success in hunting or warfare.

When any disaster, such as failure of the crops, befalls the community, or death or some strange disease affects one of its members, the chief or headman holds a "kula-gulwa" or inquest.

At this the "Diviner" is called in to discover the cause, and to indicate who may be responsible. The complainants are first questioned, and after much drinking of pombe, the locally brewed beer, the procedure varies. In many cases two fowls are ceremoniously killed and cleft in twain. The halves of each are then held in either hand, and their entrails examined to indicate replies to questions addressed to them. If the appearance of the kidneys, for instance, in one fowl gives an affirmative answer, and this is confirmed by a similar condition in the second fowl, the diviner is enabled to give a definite decision.

The person whom he states to be responsible for the disaster or disease is seldom indicated directly by name, but indirectly, in the manner of the Delphic oracle of old.

On hearing the Diviner's verdict the people, however, have little doubt who is the person who by witchcraft or the evil eye is held to be





*A consultation between doctor and patient in a mongoose skin on which are pieces of stick and cowrie shells to assist in diagnosis and prognosis. Also his fee—3 cigarettes.*

responsible, and action is taken accordingly. This usually results in that person's death, either by beating, spearing, poison, or other means.

Besides diagnosing the cause the Diviner also advises what must be done to improve matters, either a cure or to prevent recurrences.

This usually takes the form of votive offerings to spirits or ancestors, and the offering of animal sacrifices.

#### RAINMAKERS.

Amongst these the most renowned are the Rainmakers, for whom in some tribes there are definite rules of life.

The Rainmaker and his wives should wear black clothes, since clothing of different colours may cause the clouds to break up and disperse without rain. He should also wear black beads, cowrie shells, and hair from the tail of a giraffe or wildebeeste. His walk should be stately, lest if he hurries the rain may fall too fast and too quickly soften the ground. He should speak softly, lest if he raises his voice the rain when it comes may be accompanied by thunder and lightning. He may not touch a dead body, nor eat either an animal that has been used as a funeral sacrifice, or the hind legs of any animal, because these are heavy, lest the rain be also too heavy for the crops. When the rains come he should not travel, lest they cease when he has gone.

Amongst the methods in a certain district employed by the Rainmaker are the following:

In the courtyard around his house he keeps smooth stones, with a kind of diamond pattern, called "rainstones." These he places in a vessel with sesame and castor oil, and because of their

beauty and sparkle in this the people think they must contain water.

To the stones beneath these oils the Rainmaker adds various roots, pieces of rhinoceros hide, and human and other bones. The whole he then stirs and boils until the steam that rises begins to gather and hang about like clouds. Removing his clothes he then declares that the rain is gathering and cries out, "Rain, rain, come hither."

It is obvious that the Rainmaker must necessarily be a shrewd observer of the weather, and that for the sake of his reputation must postpone his rites until he considers that rain is imminent.

#### SORCERERS

Of "Sorcerers" the number in some parts are legion, and those suspected of sorcery are greatly feared. Few dare to denounce them, and must consider it wise to treat them as friends, at least serving them first, and with double portions, and cooling their beer.

They are spoken of with terror, and few will pronounce even their names. They are thought to work spells in secret, and to have the power of changing themselves into wild animals, for which reason few dare to kill or injure even a hyena, lest a sorcerer's curse should descend.

A belief in sorcerers is of advantage to the "doctors," since their denouncement increases their own reputation, and may also provide a ready means of disposing of an enemy.

Besides what may be termed the professional sorcerers other members of the community may be accused of witchcraft. These may be harmless old men or women living on terms of friendship with their families. Though these

may never before have been suspected of witchcraft, their indirect denouncement by the Diviner often leads to the same fate

#### MGANGAS

Unlike the sorcerers the Mgangas, or healers, work in full daylight.

They are honoured by all, and after death their spirits are considered an influence equal if not superior to that of the ruling chiefs.

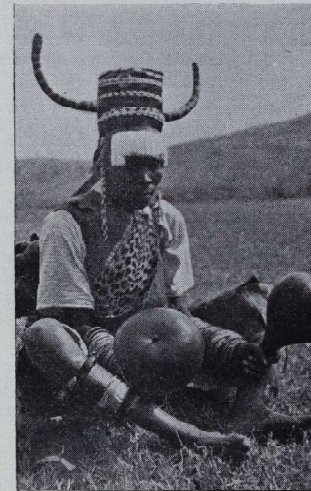
The underlying tendency of the African to attribute all illness to witchcraft must be appreciated if an attempt is made to understand some of the strange mixtures that are often employed. Though the mgangas may have a considerable knowledge of simple herbal remedies, and of the magical ingredients which they add, their

the thin curved ends of gourds. Most include in their headdresses a "halo" of giraffe or zebra hair, and one I saw at a Victoria ngoma (dance) had his horned headdress crowned by a blue enamelled teapot, whose lid kept opening as he leapt up and down.

Around their necks are hung strings of cowrie or other shells, and on their legs are garters bearing a number of spherical iron bells, whose sounding announces their approach.

Each holds in his hand a polished ornamented gourd containing millet seeds or small stones which rattle, and around him are hung smaller gourds containing "medicines."

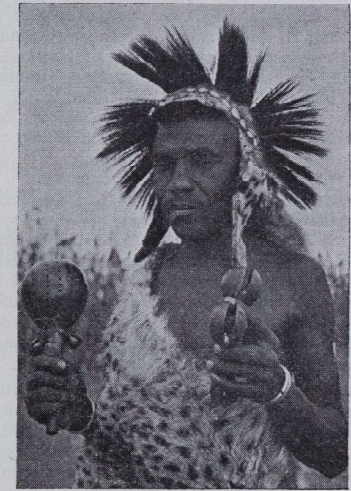
Their methods of diagnosis and treatment differ considerably. One may read the future



*A Diviner. Horns of gourd stems ornamented with brass rings. Leopard skin. Iron bells below knees. Gourd rattle in hands. Small gourds containing medicines on back. Brass and copper bangles on arms.*

treatment is essentially symptomatic, and as they are ignorant as to which of their ingredients may be effecting apparent improvement, their medicines and methods are frequently changed without any obvious reason.

The witch doctors in some tribes are not distinguished by special clothing or insignia of their office, but in others, notably in the western parts of Tanganyika, where these portraits were taken, they wear skins of lions or leopards, and the higher classes have on their heads long horns, either of antelopes or fashioned out of



*A General Practitioner. In right hand a perforated gourd rattle, in left some iron bells.*

in the lines of the hands, another draws in the sand figures from which he professes to learn the nature of the illness, another throws his sandals in the air, and from the way in which they fall to the ground discovers hidden things. Some practitioners retire to bed to discover the future in a dream, others profess to find it from the movements of water boiling in a pot, or from the grains of millet shaken up in the polished gourd.

One who permitted me to take photographs of a "consultation" squatted down opposite his patient, and spread out on the ground between them a mongoose skin. On this he poured



out from a receptacle a number of small pieces of wood, of two colours and about an inch long, and some cowrie shells and other small objects. On this skin the patient then added his fee, in this case three cigarettes.

The doctor then began to sing a kind of song, the opening lines of which were afterwards translated to me to mean: "You have given me a good profit" (*i.e.*, fee); "I have been far, even to Bushingo" (a district which like Harley Street is famed for its doctors); "My Masters have taught me what I am doing"; and then, "Hold out your hands" (for examination).

This was followed by a questioning of the patient, presumably on his symptoms and history. When this was finished the doctor examined the man's palms, and then juggled about with the pieces of stick and cowrie shells, and from all this apparently reached a diagnosis. He then advised the patient what he should do, and gave him a few grains of apparently dried herbs from one of his little gourds.

This was the extent of what I observed: of the nature of the patient's complaint, if any, or the treatment advised I know nothing, as I was unable to understand their local language.

To compensate the doctor for his feared loss of reputation from having been photographed I added from my cigarette case an honorarium equal to the amount of the fee he had received.

The others, whose photographs I secured a few days later, were called in for me from nearly ten miles away by a woman sultan, or chieftainness, for whose inflamed eyes I had given some treatment the day before.

Incidentally I learnt later that this lady had succeeded to her position by murdering her mother. The chiefs in these parts are considered in some way as the Spirits of Agriculture, and if they should become seriously ill or feeble the crops might be expected to fail. They are therefore frequently strangled, although a neighbouring sultan had complained before he died that his wives had poisoned him.

The one with the horns ranks as a "priest," the other is his attendant "general practitioner."

The Mnganga's art is usually hereditary. When growing old he chooses one of his sons to whom to transmit his secrets. He takes him into the forest or the bush, and there teaches him to recognise and prepare medicinal roots, barks, and fruits, and their methods of administration. He also instructs him in the art of enhancing their effects by the addition of various magical ingredients. Amongst these have been noted such items as morsels of crocodile or hippopotamus fat, buffalo eyelids, eyelashes of a hyaena, eyes or gall stones from a crocodile,

portions of elephant liver, or wrinkles from the forehead of a lion. "Patent medicines" such as these must be greatly prized, and with the rest of his stock, stored in small boxes or in horns of antelopes at the back of his hut, are bequeathed before his death to his son.

No detailed account of these native medicines can here be given, even if my knowledge of them were sufficiently wide.

Amongst these practitioners, as in the profession elsewhere, there are of course specialists. Of these the most renowned perhaps are those who treat sterility, whose patients often travel from long distances to consult them. Others boast specifics against venereal diseases, and are reputed at times to make truly astonishing cures. Amongst the remedies given for syphilis is an infusion of the root of the common paw-paw (*carica papaya*). There are also specialists for diseases of the eye, chest, intestines, diseases of children, and even for mental disorders.

Their methods are crude, and their results often disastrous, but until education and adequate medical facilities can be brought to these ignorant people the influence of the Witch Doctor will continue.

A Witch Doctor, unlike his white confrere, has no bad debts. His fee, either money or in kind, a cow, goat, sheep or other gifts, is always exacted before treatment is undertaken. Many by local standards become comparatively wealthy, and all are held in great respect.

#### A COURT CASE

As an indication of the extraordinary hold over the people possessed by witch-doctors the following incident may be of interest.

A witch doctor and rainmaker who had amassed considerable wealth in the exercise of his profession was found to have paid no Hut or Poll tax for many years, in fact his name was not even included in the assessment roll of taxpayers. The tax clerk of the area was accordingly instructed to demand immediate payment of his tax.

As time passed and the money was not forthcoming the clerk visited the mnganga's hut and insisted that he should appear before the chief.

Tired of these importunities, the mnganga said: "I am not permitted by the spirits to pay tax to any man. You know my reputation. If you persist in worrying me I shall cause the lightning to strike your women folk and children."

The clerk was exceedingly afraid, but duly

reported the threat.

He was told to return to the mnganga with the assurance that if he did not appear before his chief immediately he would have the Government to contend with.

One morning, a few days later, a large procession of natives bearing three stretchers was observed approaching the station. The stretchers were carried up the steps leading to the headquarters and placed before the Administrative Officer. Two stretchers contained the dead bodies of two young children. On the third was a young girl suffering severely from shock. Down one side of her body was a clear light fern-like impression, significant of the effect of lightning on a dark skin. She was treated in hospital and eventually recovered.

No coherent explanation could be elicited from the excited crowd.

The tax clerk said: "A large cloud came over my hut. There was a sudden crash of thunder. The result you see before you now."

It was clear that the crowd was curious to learn what action the white man proposed to take against a mnganga possessed of such formidable powers. The position was not without difficulty. The arrest of the mnganga would have been a tacit admission of his supernatural powers. On the other hand his original threat to exercise witchcraft with malicious intent could not be overlooked.

The Court House was filled on the morning of the trial. The witch doctor, wearing his

*The Publication Committee of the JOURNAL are especially indebted to Colonel Cane for sending this article. Eye witness accounts of Witch Doctors in consultation are extremely rare, and the photograph of the consultation is unique.*

## CORRESPONDENCE

### THE ATOMIC AGE

*To the Editor, St. Bartholomew's Hospital Journal*  
Dear Sir,

The Editorial of this month's JOURNAL seemed to me to be pitched in rather a minor key, and I asked myself "Is it justified?" In case it had the effect on the minds of other readers that it had on mine will you allow me to try to present a more hopeful outlook?

We have passed through "Ordeal by Battle," and now we are face to face with other realities which will further test our character. I myself gain strength by turning over records of the past, and in my scrap book I find the following extract from *The Observer* of October 31st, 1931. My mother copied it out and enclosed it in a letter to me of about the same date.—"We quoted last week a letter we have received from an old friend who had come over once more to watch the campaign. He said, 'British character is going to assert itself with historic regularity. There is no fear.' The writer

trappings and badges of office, stood in the dock, and calmly surveyed the witnesses appearing against him.

The proceedings were hampered and hearing made difficult by a sudden and violent thunderstorm overhead. On being questioned the accused admitted that he had occult powers and could control the elements.

To allay the growing uneasiness which was apparent amongst the natives in the court, the Magistrate asked: "Can you make the lightning strike me?" After some deliberation the mnganga replied: "No, but—" and turning he scolded the crowd behind him, "—I can make it strike the others who are now present."

The room cleared in a trice, and it was with difficulty that order was restored sufficiently for proceedings to continue.

For some of the details given in this article acknowledgments are made to "La Tribu des Wagogo," published in "Anthropos," by Father R. P. Theobald Schaegelein, C.S.Sp., who also gave me other information, and for notes on Rainmakers to a translation from the vernacular published by J. W. T. Allen in *Tanganika Notes and Records* No. 7.

Further information given by His Honour Judge Wilson is also acknowledged with thanks.

The Court case that concludes it is recorded in the Mkalama District book, by C. P. Lyons, Assistant District Officer.

of these remarkable words was Edward Price Bell of the *Chicago Daily News*. Because he has given devoted affection to this countryside, where he lived for many years, E. P. Bell has always been right about us. "He knoweth best who loveth best."

And I would like to add the words written by Percy Bysshe Shelley—

"A glorious people vibrated again,  
The lightning of the nations."

I think these words are appropriate to the peoples who inhabit Great Britain and our Commonwealth of Nations.

I cannot, of course, do much to calm the fear which the arrival and explosion of atomic bombs has aroused in some of us. But I recall that an Englishman, by name John Short, was shocked by the decision of the inhabitants of a French town called Givet to light the town with gas. On September 29th, 1835, he wrote:—

"Tis well for us the Sun and Moon are up so very high

That no presumptuous hand can reach to pluck



them from the sky.

If 'twere not so I do not doubt but some Reforming Ass

Would soon propose to snuff them out and light the world with gas."

Perhaps we shall be able to light the world with gas made by splitting atoms instead of using the sun or moon, and that will be fun.

I am, Sir,

Yours faithfully,

GEOFFREY EVANS.

7, Mansfield Street,  
Portland Place, W.1.  
September 15th, 1945.

### JOHANNESBURG HOSPITAL— —A PROTEST

To the Editor, St. Bartholomew's Hospital Journal  
Sir,

Dr. Melle, who is also a Bart.'s man, gave me a ST. BARTHOLOMEW'S JOURNAL to read, and pointed out an article, "A Visit to South Africa," by W.

Norman Taylor.

In this article, Mr. Taylor made certain remarks concerning the honoraries of the Johannesburg Hospital. These remarks are neither tactful, nor in good taste, for had Mr. Taylor enquired from the professor of medicine with whom he went round he would have learned that of the four senior honorary physicians, three were away on active service, two being up in Egypt with hospitals (of whom I was one) and the third was in charge of a medical division at a military hospital at the coast.

I was rather surprised that a Bart.'s man should make these remarks concerning the honoraries of another medical school. Even if these remarks were true (which they are not) one still feels that they would have been better left unsaid.

I am,

Yours faithfully,

L. I. BRAUN,

Senior Honorary Physician,  
Johannesburg General Hospital.

184, Lister Building,  
Johannesburg,  
September 3rd, 1945.

Dr. Malcolm Donaldson and Mr. Donald Fraser have been elected to the Council of the Royal College of Obstetricians and Gynecologists, Dr. Donaldson representing the Fellows, and Mr. Fraser the Members in London.

### THE TRIAL OF MARY DUGGAN

Some years ago, you may remember, an American playwright called Bayard Veiller had an idea. No doubt bearing in mind the sublime delight with which the people of the State of New York saw their case lost against Miss Nan Patterson, and the general upset it created at the time is what was—and strangely enough still is—fulsomely described as the civilized world, he decided it would be a capital notion to put on the boards a trial of his own. A trial complete with judge, counsel, witnesses, prisoner, and—brightest flash of all—the audience flattered to the extent of comprising the jury, and spasmodically addressed as such over the footlights.

For Mr. Veiller's convenience, a woman is accused of murdering a middle-aged banker to whom she has been a, shall we say, obliging friend, and who subsequently embarrasses her by being found one night stabbed in the back in their sinful bedroom. All of which ensures the presence on the stage, to the inevitable delight of the audience, of a pretty woman

prisoner, a six-inch dagger and a blood-stained chiffon nightdress.

Of course, we are more than certain before the rise of the curtain that the woman whose name is in the title will eventually be proved innocent, just as the heroine of old-time melodrama would be saved at the last moment from the whirling teeth of the circular saw. And similarly will Mary Dugan be disclosed a Good Girl at heart, kind to her brother, and by circumstances alone forced to suffer the fate that is, technically at any rate, worse than death. The means by which she is eventually acquitted form the thinnest dramatico-legal proceedings since Shakespeare finished the *Merchant of Venice*. But although as a play *Mary Dugan* is high-grade corn, no one who has ever picked up a Sunday paper could wonder for a moment at its widespread popularity.

My job is not to criticize the play, but to castigate the players, which, considering the piece even in relation to the high standard of

Hill End dramatics, I find surprisingly difficult to do. A play like this survives by team work—one weak link in the chain of character parts making up the large cast and the illusion is dead. This performance not only stayed alive, but thrived: so for managing this team, for setting the pace, and for keeping the audience's attention, full marks to Mr. Gordon Leslie, who produced the affair and made a suitably bashful speech at the end.

As for the acting, there seems to be a sudden burst of talent at Hill End at the moment. Mary Dugan was played by Miss Berenice Hughes, who gave an extraordinarily able and convincing performance on the witness stand, and also wept very nicely at reasonable intervals throughout the trial. She was, as I said, obviously a good girl at heart—but to her disadvantage, a little too obviously most of the time.

An equally meritorious appearance as the Widow was made by Miss Sheila Higginbottom, who fainted very charmingly. And to the bouquets for these ladies I will add two extra blooms for avoiding the terrifyingly easy temptation to over-act that their parts certainly afforded.

Mr. Michael Whiteley had the heaviest task of the lot as the prosecuting attorney, and had obviously put a good deal of thought into the matter—which repaid him with the sustained attention of the audience. He managed very well to convey his character over the footlights, and had the ability to carry most of the weight of the play on his sharp shoulders. Mr. Brian du Heume appeared originally for the defence, and don't look now, but he's the chap who really done the dirty deed. He too gave a very sound performance, both as accuser and accused, as well as managing to catch a dagger left-handed four nights running. (Yes, Mr. Veiller exposes him with the old left-handed gag—would you believe it?)

Towards the end of Act I. there bursts on to the stage a Virile Type who turns out to be Mary's brother, and who, by convenient forethought, she has put in for law, and now comes hot-foot to defend the family honour and his sister's neck. Mr. David Sacks was well cast as this Jimmy Dugan, and having got the character set in his own mind, ably proceeded to play it as it should have been—i.e., giving a BMR of about 250.

Mr. Cecil Lloyd, adopting the facies of a dyspeptic Parkinsonian, made a good gravelly-voiced judge. All the witnesses made the most of their character parts, especially Miss Leslie O'Field, who deserved all the laughs she got

for her sketch of a lady from the *Follies*—the Misses Pearce and Easton, as two further Follies dollies, were competent but too Roedean. They acted as if they thought Sister was looking all the time.

Miss Peggy Nisbet was well cast, and skilfully portrayed the inevitable French maid these sort of plays drag in. Mr. Walter Poole made a good job of the equally inevitable cluck of a detective, as did Mr. Howell Davies of Dr. Llewelin, whom we were glad to see from his tie was an old Bart.'s man. Mr. John Hindle made a very pleasing appearance as a negro lift-boy, and Mr. Bill Fairbank got quite a lot out of a rather distant finger-print expert, while Mr. Freddy Chapman was the murdered man's tailor and undoubtedly did his medicine at Cell Barnes. There were several other members of the court who remembered to look excited or bored as the proceedings or their importance dictated.

I think the heartiest congratulations go to whoever it was who decided not to do the play in its original American accent, but there still remained too big a contrast between characters like Mr. Whiteley, who remained frightfully English, and those like Mr. Sacks, who was the dynamic American screen attorney in everything except inflexion. Another important fault was that the older characters—and consequently the most important ones—were old in make-up only. It takes skill for youth to convey maturity on the stage, but nevertheless, this to me seemed a very juvenile court.

The scenery, which appeared to set the scene in St. Pancras waiting room, with a little imagination could have been made into a more impressive setting. The stage furnishings were bad enough to detract from the acting, even if each witness did agree to tell the whole truth over a copy of *Gray's Anatomy*. The costumes lacked American *chic*, and although I admit clothes for both sexes are a problem these days, I think at least the prosecuting attorney ought to have worn suspenders on his socks.

I shall docket *Mary Dugan* with my more favourable, but mixed, remembrances of Hill End drama—along with Mr. Ian Proctor triumphantly opening the windows in *The Housemaster*; Mr. Cozens Hardy smoking his way through *Robert's Wife*; Mr. Michael Dickenson anxiously reading the entire "Field" and half the "Tatler" waiting for the unexpectedly delayed entrance of Mr. Kenneth Nuttall in *The Middle Watch*; and the curtain nearly falling in one of the Christmas shows, on the nape of Mr. Donald Richard's neck.

ALAN TOIS.



## THE CAMBRIDGE GRADUATES CLUB

The Secretary announces that the club is hoping to meet in November—the first time since before the war.

## RECENT PAPERS BY BART'S MEN

- APPLETON, A. B. "The Arteries and Veins of the Lungs." *J. Anat.*, July, 1945, pp. 97-120.
- BEACH, H. L. W. (and Rennie, J. K.). "Four Cases of Typhus Fever in Great Britain." *Brit. Med. J.*, August 4th, 1945, pp. 153-154.
- BROOMHEAD, R. "Malunion of Fractures." *Practitioner*, August, 1945, pp. 78-83.
- CHAMBERS, G. O. "A Review on Pruritis Ani." *Post-Grad. Med. J.*, May, 1945, pp. 151-158.
- COHEN, E. LIPMAN. "The Relationship of Acne and Hypertrichosis." *Brit. J. Dermat.*, May/June, 1945, pp. 102-106.
- ETHERINGTON-WILSON, W. "Primary Carcinoma of an Ectopic Bladder; and Primary Benign Papillomata of the Ureter." *Brit. J. Urol.*, June, 1945, pp. 62-64.
- FRANKLIN, A. W. "A Handlist of the Writings of Sir Thomas Barlow." *Arch. Dis. Childhood*, June, 1945, pp. 50-51.
- HAMBLY, E. H. I. "Fractures, Part 2. The Upper Limb." *Post-Grad. Med. J.*, May, 1945, pp. 167-172.
- HAMILTON, W. J. (and Day, F. T.). "Cleavage Stages of the Ova of the Horse, with Notes on Ovulation." *J. Anat.*, July, 1945, pp. 127-131.
- HARDWICK, S. W. (et. al.). "Nicotinamide Methochloride Elimination Tests." *Lancet*, August 18th, 1945, pp. 197-199.
- JENKINS, G. N. "Cooking and the Nutritional Value of Food." *Practitioner*, September, 1945, pp. 149-155.
- JOHNSON, R. T. (and Dick, R. C. S.). "Neurosurgery in the Eastern Theatre of War." *Lancet*, August 18th, 1945, pp. 193-196.
- MCALPINE, D. "Epidemiology of Acute Poliomyelitis in India Command." *Lancet*, August 4th, 1945, pp. 130-133.
- TUBBS, O. S. "Surgical Closure of the Patent Ductus Arteriosus." *Post-Grad. Med. J.*, May, 1945, pp. 158-167.
- WARD, F. G. "'Orthopaedic' Rehabilitation." *Brit. Med. J.*, August 18th, 1945, pp. 225-227.

## EXAMINATION RESULTS

## M.D. EXAMINATION, JULY, 1945

Branch I (Medicine)  
Watkinson, G.

## SECOND EXAMINATION FOR MEDICAL DEGREES, JULY, 1945

|                   |                 |                    |                  |
|-------------------|-----------------|--------------------|------------------|
| Batten, K. L.     | Stanley, H. W.  | Mendel, David      | du Heaume, B. H. |
| Chesover, I.      | Thomas, B.      | Partington, M. W.  | Jenkins, A. V.   |
| Dobson, J. D.     | Benett, G. R.   | St. John, J. M. S. | Morgan, D. J. R. |
| Gosling, R. E. G. | Coombs, G. A.   | Taylor, D. G.      | Rees, F. G.      |
| Johnson, W.       | Dower, G. E.    | Weller, M. A.      | Segall, M. L. J. |
| Newman, W. T.     | Hathaway, A. E. | Berman, J. M.      | Taylor, G. B.    |
| Rossdale, D.      |                 | Davies, H. F.      |                  |

## FIRST EXAMINATION FOR MEDICAL DEGREES

|                 |                   |                   |                  |
|-----------------|-------------------|-------------------|------------------|
| Aubin, D. F. A. | Rosser, E. M.     | Latham, R. P.     | Farley, J. D.    |
| Bexon, W. H.    | Stebbing, N. E.   | Moor, G. J. M.    | Hale, B. C.      |
| Cookson, T. S.  | Whiting, N. E.    | Moynahan, A. R.   | Ibbotson, R. N.  |
| Gittings, D. J. | Barratt, A. J. F. | Scott, W. C.      | Luke, M. F.      |
| Horwitz, H.     | Burn, J. I.       | Stephenson, J. W. | Morgan, D. C.    |
| James, D. C.    | Cooper, C. J.     | Wise, M.          | Parker, R. B.    |
| McKee, J. F. M. | Haigh, P. G.      | Bennett, W. R. C. | Simmons, P. H.   |
| Morrison, B. A. | Hovenden, B. J.   | Goldrey, P. A.    | Warlow, P. F. M. |

## SOCIETY OF APOTHECARIES

## FINAL EXAMINATION, JULY 1945

Medicine  
Roden, P. I.  
Wimborne, D.

Surgery  
Wimborne, D.

The Diploma L.M.S.S.A. was granted to  
Wimborne, D.

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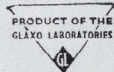
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# ST. BARTHOLOMEW'S



## HOSPITAL JOURNAL

Vol. XLIX

NOVEMBER 1st, 1945.

No. 10

### BOOKS — AND G.B.S.

So much has been written in this JOURNAL and others on the subject of medical text-books that it is difficult to believe that the last word has not been said. The only excuse for disinterring the subject is to offer constructive suggestions, with suitable apologies for our presumptuousness in rushing in where other editors have trodden in vain.

Almost all critics agree that there is a dearth of medium-sized books—intermediate between the synopsis written in medical journals and those monumental tomes, the standard works of reference. As to what should go into these medium-sized books there is no great measure of agreement. Probably no two persons make use of text-books in the same way and it is correspondingly difficult to make any categorical statement as to their function. There can be no question that it is impossible to get a satisfactory idea of a disease from reading about it. Books can only be used to reinforce clinical experience. The superficial study of a particular group of diseases in a text-book may give an impression that they are all much of a muchness as regards their symptoms and signs, and a more detailed reading may be equally misleading, giving the impression that they can be differentiated and diagnosed in the twinkling of an eye.

What a text-book should do, in addition to setting out the usual details about symptoms, signs, course, complications, etc., of a disease, is to give an account of its scientific background, its anatomical, physiological and pathological basis. Nowadays the unfortunate student is faced with an ever increasing multiplicity of specialised books, both large and small. Perhaps the essential interdependence of the various services that go to make up medicine could be stressed by a complete series of text-books

covering all the subjects studied for the first and second M.B.s and finals: the whole series to be edited and co-ordinated by one man, and preferably written by the staff of one medical school: each volume giving, where necessary, reference to others in the series. This plan will not commend itself to everyone; some will see in it one further step towards standardisation ("the curse of the age"), nevertheless it deserves sympathetic consideration. And finally, what medical school is better equipped to provide such a series than our own?

\* \* \* \*

Many people will have read and been irritated by Bernard Shaw's "review" of Dr. Douglas Guthrie's history of medicine. A consulting surgeon to the hospital sent a copy of the article to the JOURNAL office with "This needs answering" written across the top, and indeed it does need answering, but quite where to begin is another problem. The article is riddled with scientific inaccuracies; to deal with them in turn would need an extended article. He claims that most of what he knows about medicine has been taught him by doctors, whom he numbers among his best friends. They must be singularly unorthodox members of the profession. Who, for instance, told him that "Heart patients were, and still are, immobilised and stimulated with whisky until they die of hypertrophied liver"? The immobilisation of fractures, the use of potassium iodide in the treatment of syphilis, and vaccination are all dealt with in equally high-handed manner. He seems to deny the microbic theory of infection and to cite as evidence for that that antiseptic surgery has been replaced by the aseptic technique. And yet his main conclusion that poverty with its attendant squalor and dirt are responsi-



ble for much disease is surely valid? It is a pity that this important point, which cannot be sufficiently stressed, has been submerged under a welter of bogus scientific arguments. Also his claim that laymen should sit on the General Medical Council, to represent the patients, is reasonable.

Bernard Shaw is undoubtedly one of the greatest men of our time, and deserves our homage and our thanks on his eighty-ninth birthday, but he cannot be allowed to get away with so many preposterous statements unchallenged. He claims that he has not a down on doctors and yet he has always delighted in "having a go"

### VISUAL EDUCATION IN MEDICINE

By FLT/LT. MANDIWALL

Can anyone deny the value of photography in medicine? No. Then why is it that it has not been employed in this art as it should have been? There are two reasons. One, that in the past, the teachers were not aware of the capabilities of photography; second, that when it was employed in the service of medicine, the photographs were so poorly executed that either they did not convey the meaning the lecturer wanted to put over or that the teachers themselves were ashamed of showing their own or their friends' handiwork. These excuses no longer exist. To-day, the value of photography in all the arts and sciences is well recognised, and also photography has been perfected to such an extent that one just cannot accept or execute a bad picture.

Photography is not mere button pressing or flicking caps on and off a lens. It has been proved as a science, and is a science of paramount importance. Those who take it up seriously can be compared to torch-bearers, who bring light, wisdom, justice and peace among mankind.

The often quoted Chinese proverb, "A picture is worth ten thousand words," is getting out of fashion now, for a really good picture is worth "X" times more than what the proverb suggests, the value of "X" depending upon the quality of the picture and its ultimate use. Visual education should be of paramount importance, as the educationists tell us, that about ninety per cent. of what we learn passes through the eyes, and also that what we see is believed to be more authentic and impressive than what we hear. There are quite a few visual aids and one could say much about them, as for example,

at them. Is it some quality of character of doctors that provokes him, the too unctuous bedside manner, the supercilious attitude to the layman and his opinions, the faintest trace of humbug? Or is it an impish cavilling at accepted institutions (such as once prompted him to take the chair for a lecturer who contended that the earth is flat). At any rate, he does the profession but scant justice. If he knew more doctors he would find that, like the surgeon who treated him for osteomyelitis of the foot, they "happen to understand the exact relationship between science and good sense wonderfully well—for a surgeon."

whether cine is better than still, sound or silent, subjects suitable for the same, value of drawings, specimens, blackboard and chalk, etc. One certainly does not want to enter into details of these, as this would not be a short paper but rather a big text-book. Each has its peculiar and inherent qualities not possessed by the other media.

The biggest change in photography and equipment came about after the first world war—1914-1918. New apparatus and materials were produced at a rate which had never before been thought of. New branches of photography, aerial reconnaissance and air survey work called for a solution to an entirely new set of problems. Radiography developed to a considerable extent leading to the double coated X ray films to replace the clumsy thickly coated plates that had to serve during the first world war. It will be evident that few if any of these improvements arose from the intervention or the request of scientific workers in photography who were beginning to appreciate the qualities and the value of the tools that photography offered to them.

One need not remind oneself the part photography played during the second world war in bringing knowledge to millions of people who had never dreamt of touching that particular part of occupation in which they were forced to work during the last four or five years. What has helped them? Visual education has played its part to the most. In the future, methods of teaching will help more rather than the amount as in the past. The days are thus dwindling when the professor used to come and lecture to the students by reading adverbium lines from

his favourite book. The lecturer nowadays usually dispenses with his notes and gives as it were a running commentary with the visual aids which impress the mind forcefully and permanently. If we just cast back our eyes to our books we must confess that illustrations and drawings conveyed to us much more than hundreds of words.

Medical knowledge can be imparted in three ways, by the lecturer, by books, and by visual aids. Photography will never entirely replace the lecturer or books but it will materially help both of them to an extent which has never been dreamt of in the past. Now visual aids can be classified as follows:—

1. ORIGINAL MATERIAL.
  - (a) human body,
  - (b) wet or dry specimens.
2. MODELS.
3. ILLUSTRATIONS — BLACK AND WHITE OR COLOURED.
  - (a) drawings,
  - (b) sketches,
  - (c) photographs.

All of these can be presented by means of slides, film strips, and motion pictures.

Why is it that in the past medical photography has not been used as it should have been? It may have been due to (1) lack of knowledge in medical photography; (2) lack of personnel; (3) lack of skill and appreciation in executing medical photographs. These days one need not excuse oneself from not using photography in medical science as all the above mentioned reasons are invalid. To make the medical profession believe the advantages of photography one must consistently turn out photographs of high quality and these cannot be produced without adequate training and proper equipment. Is medical photography as easy as one is made to believe? In my opinion it is not, as the variations in such work are so great that it will tax the resources of the finest and the most expert photographer.

What are the qualities of a medical photograph? (1) Simple straight forward record photography with perfect definition and well graded tonal values. The importance of a good well finished print with perfect detail and tones cannot be underestimated. One never knows when that print will be required again; perhaps for publication, after 10 or 20 years, when sufficient material has been collected. If that print was not of the first quality it will lose all its value. The photographer must bear in mind the possibility of publication, as under the very best conditions there is always some loss of detail in the processes of reproduction for print-

ing, and therefore he must make quite sure of his definition and emphasis, the tones of light and shade, so that the final result is not meaningless when a bit of detail is lost. The problem of the medical scientific photographer is the same as that of a writer, namely that a writer does not write what he can understand, but writes so that he cannot possibly be misunderstood; in other words he must make the record clear enough so that it can be understood not only by the research specialist but by other workers at a later date and after it has been reduced to a half-tone print. (2) Must include essential portions only. (3) Must tell its own story. (4) Must be well presented, that is, absence of scratches, stains, spots and well mounted and finished. (5) If in colour, must be true to original otherwise may mislead diagnosis, as for example in skin lesions.

A medical photograph cannot be produced by an amateur who has occasionally dabbled in photography. One would expect the following qualities of a medical photographer. (1) Photographer of the first order. That is he must have a good knowledge in the fundamentals of photography. (2) Ingenuity, that is—he must have the power of ready invention and also be prepared to undertake work no matter how complicated the set up, or the technique may be. (3) Love of labour—always smiling in difficulties and ever prepared to work hard. (4) Observant. Power to observe should be a great asset to him. The continued practice of this gift will improve his approach both to the patient and to photography. (5) Thorough. Every step taken must be a perfect step, full of confidence and exactness. No make-shift or slipshod work of any kind must be allowed.

In the past many doctors had to do photography of medical cases for three reasons:— (1) For teaching students and addressing the profession. (2) For their own convenience. (3) To eliminate expensive photographic assistance. I must say that as the practitioner got busier in his profession he could not devote sufficient time to this side line, with the result that he had no option but to turn to the ordinary photographer and in the end he got disappointed with the results and what was the reason? Because the man he employed had not sufficient training and experience behind him.

I should like to make a statement—a statement perhaps objectionable to many of my colleagues but nevertheless true—that the duties and responsibilities of medical men are enough to occupy their time. A doctor with time on his hands is almost a contradiction in terms! Such men should leave photography to one who



is specially trained. If they must do this sort of work they should take time and trouble to learn to do it properly. Good medical photography is not a mere button pressing proposition. A broad knowledge of photography plus the skill to apply this information to medical subject is most vital.

One word about financial matters, as photography involves expense. How should the financial question be satisfactorily solved? In my opinion, the medical man who orders photographic work for his own use must be made responsible for the cost of the material and for the extra hours of work put in by the photographer. The expense for the photographic records of hospital cases and laboratory specimens should be met by the hospital. For their photographs, lady almoners are quite within their rights to charge paying patients a little extra, an amount sufficient to maintain a fund which will allow for photographs in charity cases, post mortem specimens, and other relevant matters, with only a slight burden to the private patients, but with far reaching benefits to those so aided. The hospitals and medical schools should realise that photographic records help to improve the scientific spirit of the reputation of the institution and should be glad to provide funds necessary to keep the photographic equipment in perfect working condition, pay for the materials, and last but not least, offer

## A GENERAL HOSPITAL IN NORMANDY

By H. B. STALLARD

"Now all the youth of England are on fire,  
And silken dalliance in the wardrobe lies!"  
*King Henry V., Act 2, Prologue.*

This is a brief account of the conditions under which a tented general hospital worked in Normandy in the summer and autumn of 1944. Such adventures, trials, successes and failures that we had were in no way peculiar to this unit. Indeed, I know that others had a rougher and more exciting time than was our lot.

Security demanded that we spent four days in a marshalling area, a military "purdah," before embarkation. This retreat lay concealed in a wood and was surrounded by barbed wire. The U.S. and the British Army were synergic in the conduct of the camp. We never again enjoyed the hygienic advantages of "pre-dip"

a salary which is attractive to an able photographer. The time has come when no general hospital or medical school will be regarded as complete without the help of an efficient photographic department. For many years the standard of medical photographs was very low. It has certainly improved, a lot, but there is still room for further progress. Medical photography requires broad photographic knowledge and experience and thorough training in all branches of commercial photography, plus a natural aptitude for medical work. It is a specialised branch of the photographic art requiring the highest type of skill. If medical photography is to go forward, it must attract men and women with the fundamental training necessary to carry on the work with a minimum of error. It should be the aim of every person engaged in medical photography to deliver the very best work that can be made. Anything but the very best is a reflection not only on the photographer, but also on the institution he represents. Perfect results in every case, without exception, should be the aim and final goal of a medical photographer. Don't let ignorance, indifference and lack of imagination enter into your work. To defend such work as "good enough" is only admitting ignorance and slovenly thinking. Slovenliness in this respect is no more a virtue than it is in any other form of human expression.

and "dip," for cleansing our eating and drinking utensils. There was a constant service of good food amiably tendered by loose-limbed giants who chewed gum and were democratic. This monastic life under canvas had its points. We talked deeply of things that mattered and grew to know each other as a team should do. Some of our troops wrote that Stalag would have no further terrors for them after this, but these were men of the cinema, dance, cigarette sucking calibre.

Our day came and we marched out in three companies. In the sheds at the port the embarkation I weighed myself and found the load of equipment, small arms and uniform to be

84 pounds. So it was well to have trained. After some hours of waiting we went on board and in the hull of the transport lay cheek by jowl with the Pioneer Corps. We were grateful for a snap inspection by their commander which recovered equipment losses that had occurred with Maskelyne mysteriousness. We had been at sea nearly three hours and had just changed course when a ship to starboard struck a mine and her stern caught fire. Part of our escort turned back to escort her.

None will ever forget the sight of Arronanche. We came through squalls of rain into sunshine and a clear sky to see the coast of Normandy. Mine sweepers were busy forward and destroyers bounded to port and starboard. The harbour, made in twelve days, is an historic tribute to our Navy, Merchant Navy, Marine engineers and the Army who worked it. A balloon barrage protected it from low level attack.

We went over the side of our transport into landing craft which were designated Nan, Queen, Sugar, Mike, Love and Charlie. There is always someone who is easily gullible. The descent into the bobbing landing craft was down a narrow iron ladder and in full kit, steel hat, respirator at the alert and all the other parts of the military Christmas tree this was no mean physical achievement, particularly for those of substance and middle-age. To one such was given in jest the advice, "lean well back" as he was about to descend the ladder. The weight of his pack projected him suddenly backwards and he would have gone to the bottom like a stone had not a saving hand seized a part of his webbing harness. We circumvented a mine and went ashore to march up hill through a village and an orchard  $1\frac{1}{2}$  miles to the transit camp, a bare field on some high ground. Here we rested on the grass and prepared an evening meal from part of our 24 hour rations. This ration, among other things that the Army does well, was admirably planned and simple to prepare. One of our chronic grouchers stated that the minced meat made from a dried cube tasted like roast monkey, but whether this was so or not, it was good. It rained. Six to eight miles away the guns were firing and as darkness fell the sky became like a giant firework display, and the noise increased as the British Army slogged its way towards Caen and Caumont. At about 22.30 we were ordered to fall in and we were marched off down a leafy lane. So ponderous and clumsy was our movement in the dark that we received pungent invectives from the bivouacers whom we passed. From one com-

fortable nest of "old soldiers" came the remark, "Is this a . . . g Panzer division?"

After about four hours of interlacing movement with military traffic we had gone about six miles and at 02.00 hours were decanted into an open field. We were grateful for the moon in these strange surroundings. For the next two weeks our daily round was concerned with fending for ourselves in orchard and fields. There was nothing stereotyped or regimented about the style of our bivouacs, which expressed much individuality in construction. Some arranged elaborate arbours in the hedgerows, others constructed from sticks wooden cradles which kept them clear of the dewy ground. Our surgical specialist, E.N.T. specialist and myself formed a trefoil pattern with our heads based upon a young sapling from which we draped gas capes to protect our heads. Water was hard to find. A pump about half a mile away served a shallow well, but this was soon banned, for the farmer required this for his beasts. Articles of great value were a disused tin for holding water, pieces of wire and a strip of sacking. Upon such things depended our major comforts.

One water cart holding 350 gallons served us. This had to travel some miles to a river the pollution of which was evident. The integrity of those who collected the water was not of the highest grade, they were not gifted with a bacteriological conscience and failure to supervise sterilization caused the consumption of some infected specimens with the expected consequences. Sometimes there was no water for washing and none for drinking from 09.00 hours to 20.00 hours. Our feeding utensils were rinsed in one pail of water which served about 360 of us, including our engineers and pioneers. Later this single cart had to serve a hospital with 1,100 patients, the above-mentioned 360 and about 80 nursing sisters as well. A pipe line did not reach us till October, when we slipped about in a sea of mud, and eventually closed.

Sanitation was inevitably crude. At first a democratic affair for all ranks to accommodate 32 in a row, was fashioned by felling a slender tree supported by two props over a ditch. Privacy was secure in the vicinity of an unexploded mortar bomb in the hedge of an adjacent field. It was hot and the white dust of Normandy roads was irritating to the eyes and respiratory tract.

Our site for establishing a hospital was changed and at last one day we were stung into activity by an order to open a 300 bedded hospital in three days and to expand this to



1,100 in five days. With surprising suddenness tentage and equipment was tipped into our field and we toiled daily until light failed erecting tents, sore and blistered by friction from guide ropes and canvas. In all this sweat and labour there were moments of light relief. In preparation for the advent of the Sisters the pioneers had prepared a pit 12 feet deep by 2 feet by 20 feet. This gehenna they had left unguarded during their lunch time. I forgot to mention that the beasts of a farm, horses, cattle, pigs and hens wandered freely about our bivouacs. An enterprising sow of gross dimensions came in her reconnaissance for forage to the edge of this pit and in a moment of ataxy plunged into the depths and was thus trapped. We acquainted *Monsieur le fermière* with this catastrophe and the lively scene that followed was rich in incident. The alarm was raised as only it can be in Latin countries and running *en echelon* and exclaiming volubly there came all hands bearing ropes, a ladder and other equipment for the operation of extraction. *Madame, la fille de la maison*, and some inquisitive children came trotting in the rear of the assault party. *Monsieur*, arrived at the abyss, quickly surveyed the situation and decided on a plan. His pear-shaped figure was lowered in the rear of the sow and ropes were passed transversely beneath her liberal belly. These were flung up to the tugging team disposed on either side of the pit. The volume of chatter was considerable and it rose to a crescendo as the warrior in the arena dived beneath the sow to effect a *vis a tergo*, as she was levered up her cloven hooves beat upon the pate of her subterranean rescuer. A moment of thrilling suspense was afforded when the surface deliverers gave under the strain and *Monsieur's* knees ceased to be braced.

For adequate ablutions some of us walked or ran three miles to a little water-fall in a valley. Immediately above this a herd of swine wallowed in the mud at the verge of the stream and, soaped all over, we lay beneath the rich flora that this cascade poured upon our hot and soiled bodies. About October the swine closed their season of wallowing, human attendances fell to the smaller single numbers, but the R.A.S.C. were wont to tip their waste oils and other garbage into the water and I resorted to cold douching outside my tent, enshrouded in darkness, at 23.00 hours nightly. The sound of this made those abed beneath six to eight layers of blankets feel the warmer and I had the pleasure of steaming.

In the early days the Luftwaffe came over us at night and there was a clang of steel hats

followed by the pause of indecision as to the relative anatomical value of the mid-thorax, cranium and abdomen. Our ack-ack fire was the greater menace and when dawn came we found long slivers of ragged shell fragments near our resting places and even on a pillow. Old soldiers dug themselves in.

About the eve of opening the hospital there arrived in our orchard a screen of outriders in a variety of motorized vehicles and from an assortment of units, including the R.A.F. We became aware that these were the "boy-friends" of the Nursing Officers and were the heralds of their approach. About an hour later they arrived, a memorable invasion of our monastic precincts. Several lorries full of chattering and laughing modern "ladies of the lamp" bounded across our orchard, in their wake a host of male camp-followers in jeeps and on motor-bicycles, a reversal of ancient military tradition we had not anticipated. Their luggage train when dumped showed formidable stacks of tin trunks and other paraphernalia (memories of a return journey from Egypt when an attachment of twelve Sisters had between them 14 tons of luggage). There followed one or two hours of twitter in the camp before a number of the new arrivals departed in the vehicles of the camp-followers to dine out. The revellers returned at a late hour and drove in their jeeps through our bivouacs and I narrowly escaped traumatic amputation of both legs. As we laid awake we wondered whether Florence Nightingale would have approved. There was, however, no doubt about the fact that her spirit and the quality of her work were evident in the days to come. The conditions for nursing could scarcely have been harder and more full of irritations and difficulties. Over all these they rose supreme and did a grand job of work cheerfully and well. Generally there was no water to wash patients and little for them to drink. When we opened latrines were not ready. Primus stoves consistently misbehaved, illumination was by hurricane lamps. Many of the orderlies were raw and untried in nursing and in service conditions. We were about eight miles behind the lines and for some weeks we worked as a C.C.S., not holding our patients longer than 48 hours. We had to start operating with the tables placed at bizarre angles on the rough field surface, but in a few days concrete floors were laid in the two tented theatres and gave us stability so far as the position of the patient and our stance were concerned. We operated in mackintosh aprons. Gowns and gloves were reserved for work inside the body cavity and

joints. Washing was done in an enamel basin in which the water was changed about once in two hours. The efficiency of soap is shown by the fact that bacteriological tests on the water before use showed the presence of colonies of micro-organisms, whereas that which had been washed in about six or more times and was apparently dirty, proved to be sterile.

We worked all day and much of the night. The load of "full documentation," in spite of C.C.S. conditions, made our burden heavy indeed. We were told before the campaign that this time we would not be unduly tried by excessive documentation. A new form was devised, the A.F. I.1224, and the A.F. I.1220 was to be typed out from the former by the hospital office staff. Within a few days the office staff could not contend with the A.F. I.1220 and cast these upon us. Including the field medical card, we had therefore to write three copies of every note and a fourth when we wished to keep a record for ourselves. Apart from this were other forms dealing with S.I. and D.I. lists, accidents, self-inflicted wounds and so on. Such work necessitated long nocturnal sessions by the light of a hurricane lamp. It was wasteful of time and energy and in time sapped even the toughest.

Three days after opening we accommodated 1,100 patients, and fresh convoys arrived about every other day. Some nights will ever remain vivid in our memories. The sky fitfully lit with tracer, artillery fire, flares and exploding bombs, the bark of the guns, the patter of rain on the tents and the bobbing and swaying of hurricane lamps carried alongside the stretchers as the bearers squelched and slipped over the sodden ground with their load of soiled, bloody and mangled humanity to the resuscitation ("resurrection") tent and thence to the theatre. The smell of blood, mortification, gangrene and dirt stayed in one's senses for hours after leaving the theatre. Wounds alive with maggots and matted with filth of middens on which the soldiers had lain for several days, and uniforms loaded with lice will not be forgotten. The Germans stank considerably, and this was particularly so in the battle around Falaise, where they had been left out unattended for up to four days.

About this time we collected the contents of two Section Sanitat (German Field Hospitals). These had been shelled and retired to be shelled again, and then to escape this had advanced again. They were in an appalling state of professional demoralisation. Their vehicles contained unpacked anaesthetic apparatus and nursing utensils. Their wounded lay untended

on stretchers. Those who had the strength turned to urinate on the ground, others did so into their clothing. Doctors and orderlies stood about smoking cigarettes, except one surgeon who was amputating an arm without an anaesthetic. Their wounds were foul, being covered with thick greyish-green sloughs and dripping with pus. Those that had been operated on had thick rigid black rubber tubes stitched into the skin. One of my German patients who had been wounded over the sacral region was bristling with seven such tubes. Three developed tetanus, two of these survived. It seems that the German Army does not give tetanus prophylaxis. I understood from a German medical orderly that typhus inoculation is only given for good Nazis with four or more children. Several prisoners asked us for tetanus prophylaxis.

Some of the Germans, particularly the junior officers, were arrogant and most unpleasant, others were cowed and believed that they were going to be shot, although indeed there were no guards at all on some of their wards and the escape route was easy, as indeed some of the officers found.

Knowing the very low and dreary diet given to our prisoners in German hands, it was irritating to see the Germans given second helpings of our liberal hospital rations and to receive Grade I salmon and other luxuries.

The toughness of some of our countrymen is remarkable. One soldier, a west countryman, was hit by a shell fragment in the neck. He had a sucking wound over the apex of his lung and an oesophageal fistula. He was taken prisoner. In a German C.C.S. he arranged his escape with four Americans, murdered the German guard by stabbing him to death with his pocket knife, and roved with his companions behind the German lines for four days. Any food or drink he took came out of the wound in his neck. He and his colleagues persuaded about fifty Germans to surrender to the Canadians and so were rescued.

In the autumn torrential rain made living conditions under canvas rather damp and adhesive. In some places the mud was ankle deep and fluid, in others it was boggy. Our clothing was never dry, we had no stoves in our tents and it was not till nearly mid October that one was obtained for the mess. Despite the squalor, we were remarkably fit and only once was a rum ration considered necessary.

Normandy will be remembered for its rolling hills and woods, its orchards, substantial stone farms and its calvados, an alcoholic beverage of varying potency made from cider apples.



We discovered too late that the maturer forms of this local fire-water should be treated as a liqueur and not quaffed like vin ordinaire, as occurred on one memorable night when spirits were flagging and bodies fatigued. The toxic effect of this drink has an acute and critical onset. It struck at the apparently sober in a pole-axing manner. Respectable doctors were suddenly prostrated in the long grass, in ditches and hedgerows, a revered quartermaster lay in the Trendelenburg position festooned and blaspheming in the guide ropes of a marquee

## PLASTER OF PARIS BANDAGES IN SURGICAL CASES

The following paper has been prepared in the hope that it will provide a practical knowledge of plaster technique and at the same time eliminate some of the mistakes liable to be made by the novice. Upon the correct application of the plaster of Paris bandage depends, not only the successful maintenance of the surgeon's work, but the immediate comfort and ultimate rehabilitation of the patient.

The older metal or wood splinting has been gradually replaced by plaster, because the plaster, by conforming firmly to the contours of the limb, holds it in position more firmly and more comfortably. At the same time the application is easier and quicker, depending only on the setting time of the plaster, and the progress of the lesion can be followed by X-ray without disturbing the splint. Detachable splints may be made for occasional wear.

The material required for making the bandage is Plaster Muslin, sometimes known as Book Muslin, Gauze or Crinoline. This is used as a base for the plaster of Paris which is rubbed into the mesh. After careful experiment the mesh of the material has been standardised at about 30 threads to the square inch each way. Plaster of Paris (Calcium Sulphate) is a white powder derived from gypsum, dehydrated and pulverised. Immersion in warm water causes re-crystallization which makes the plaster set firmly. The amount of plaster in the bandage can be varied according to the surgeon's requirements. The setting time can be hastened by using hotter water or by the addition of a little salt or Potassium Sulphate, but an excess makes the plaster too friable and likely to crack. Alum in the water is used to make it harder. Other materials used in

tent. Some in attempting dental ablutions fell to the ground, never to rise again. A small band of survivors had to act as a rescue, recovery and search squad for the casualties, some of whom looked nigh unto death.

About the middle of October we closed the hospital, sat down in the mud and waited. I was posted to a hospital in Belgium. It was odd to tread a firm floor, to have laundry facilities and a bath again, but the heated air of the building made the nasal sinuses congested; and the feeling of rude health departed.

plaster technique are Stockinette, Open Wove, and Domette Bandages, Gamagee tissue, Draper's wool, felts, flannel bandages and wooden poles which can be used as extra supports.

The making of the bandages requires practise to maintain a uniformity in size and a high and consistent percentage of plaster. The muslin should be cut in strips about six yards in length and four, six or eight inches in breadth. The strips are rubbed carefully into the powder at the bottom of a strong, oblong box, leaving the first six inches free to act as a sop to the water. Then the bandages are rolled loosely and stored in a damp-proof box. If the bandage is too tightly rolled water will not percolate through completely and if it is too loose the plaster will seep out. The length of time in store has a slight effect on the setting time.

When required the bandages should be immersed for two to three minutes until all the bubbles have ceased. Two bowls of water with three bandages in each gives the best result. The bandage is removed by holding both ends and pressing towards the centre to expel the water. One is then unrolled for a few inches before it is handed to the surgeon for application.

It has been found that soft water is unsuitable for plaster work and if it has to be used it should be hardened with a little chloride of lime.

Reinforcing back slabs can be made to any size and thickness by folding lengths of the bandage on top of one another. Alternatively a length of rubber tubing can be cut as required and used for the same purpose.

Plasters do not stretch or contract when

drying and so they should be wound lightly round the limb. It is important to rub the plaster continually into a solid mass in order to spread it evenly and to avoid opacities in the X-ray pictures.

During the application and the drying of the plaster the limb must be maintained in the correct position. Indentations can be avoided by resting it on a pillow as these are likely to give rise to pressure sores. A plaster which includes the knee should be put in about 50° of flexion.

Plaster casting may be required when it is necessary to provide a model for the construction of a surgical appliance. The limb is

smear all over with vaseline and a thin metal strip is placed along it. Plaster is applied over this and when semi-set, a sharp knife is used to cut down onto the strip. The plaster is gently removed and a bandage wrapped around it to keep it in shape. The instrument maker can then block the end with paper and make an internal cast with paraffin wax.

The type of plaster to be applied and the extent of application is the surgeon's decision, but it is the responsibility of he who applies to calculate where the strain will fall and to strengthen the plaster proportionately.

A. W.

## ON TWINS

By D. W. WINNICOTT

The first thing to say about twins is that they are a perfectly natural phenomenon and really nothing to be sentimental or facetious about. I know many mothers who have loved having twins and I know many twins who have liked being twins. But nearly all mothers say they would not have actually chosen twins had they been asked, and twins, even those who seem quite contented with their lot, usually tell me they would have preferred to come one at a time.

Twins have their own particular problems to solve. Whatever the advantages of being a twin, there are also disadvantages.

First I must remind you that there are two different sorts of twins, because the problem is not exactly the same for each kind. Sometimes after the first division of the newly-fertilized ovum each of the two cells divides and then develops independently, and this is the beginning of identical twins, two babies developing from the same fertilized ovum. Identical twins are always of the same sex, and they are usually very like each other in appearance, at least at first. The other kind of twins may or may not be of the same sex, as they are just like any other brothers and sisters, only they developed from ova that happened to be fertilized in the womb at the same moment.

Looking at twins of either kind we easily feel that it must be nice for each child to have company, to be never alone, especially as the two get older. There is a snag, however, and to understand this we have to remind ourselves of the way that infants develop. How does an infant first come to accept another?

In ordinary circumstances and with ordinary good management infants start immediately after birth to form the basis of their personalities and of their individuality, and to discover their own importance. We all like unselfishness and a willingness to allow for the other person's point of view and hope to find these virtues in our children, but if we study the emotional development of the infant we find that unselfishness only comes in a healthy and stable way if it is based on a primary experience of selfishness. It might be said that without this primary selfishness a child's unselfishness gets clogged up with resentment. Anyway, this primary selfishness is no more than the infant's experience of good mothering, a good mother being willing at first to fit in with her baby's desires as far as possible, letting the baby's impulses dominate the situation. A good mother is contented to wait for her baby's true concern for the other person's point of view to come in the course of time. At the start she must be able to give her baby the sense of possession, the feeling that he has control over her, till he becomes able to allow her her own private life. With the experience of primary selfishness in his bones he will be able to become unselfish without too much resentment.

Now in the ordinary way, when babies come in ones, each little human being can take his own time to recognise the right of his mother to other objects of concern, and it is well known that another baby is not welcomed by a child at first—not in fact for many months. No mother would worry if her baby failed to appreciate the benefits of the companionship of



other babies till well after the first birthday, and even two-years-olds may bash each other rather than play together at first if they are put together. The fact is that each baby has his own time for welcoming a brother or sister. It is an important moment when a little child can genuinely "give" (that is allow) his mother a new pregnancy.

Now the twin has another baby thrust on him quite apart from his ability or willingness to allow his mother to add to the family. This is one of those places where those who hold the view that little things do not matter in the early months come unstuck, because it matters very much whether twins do or do not feel that they each had possession of mother at the start. The twin's mother always had another baby. The mother of twins has an extra task on top of everything else, which is to give the whole of herself to two babies at once, and to some extent she must fail, since it really is impossible to treat two babies exactly alike. The mother of twins must be content to do her best and hope that the children will eventually find advantages that will compensate for this inherent disadvantage of the twin state.

It is impossible for one mother to treat two infants alike because, for instance, she cannot take up each of two children first, whether to feed them, or to change their napkins, or to bath them. She can try very hard to be fair, and it will repay her if she takes this matter seriously from the beginning, but it cannot be easy.

As a matter of fact she will find her aim is not to treat each child alike but to treat each child as if that one were the only one. That is to say, she will be trying to find the *differences* between each from the moment of birth. She of all people must know each from the other easily, even if she has to tell one by a little mark on the skin or by some other trick. She will usually come to find that the two temperaments are different, and that if she easily acts in relation to each as a total personality each will develop personal characteristics. It is thought that a lot of the difficulty about twins arises out of the fact that twins are not always recognised as different from each other even where they are different, either because of the fun of it or because there is no one around and about who thinks this task worth the trouble. I know of a quite good home in which the matron never learned to distinguish between two twin girls, although the other children had no difficulty in knowing one from the other because the two girls really had quite distinct person-

alities. The matron used to call each one "Twin." This seems to me to be awful.

And it is no good for the mother to try to solve the problem by looking after one herself and handing the other over to a nurse; she might have to do that for some good reason, if she is very run down, for instance; but by that method she will do no more than postpone things, because one day the twin she parked out is going to be very jealous of the one she kept, even if the parked-out twin had good mothering from someone else.

Mothers of twins seem to agree that even when the twins like being alike and being mistaken for each other, these same children need their own mother to recognise the identity of each without trouble. It is essential in every case that there should be no confusion among the children themselves, and for that there must be some person in their lives who is quite clear about them. A mother I know had identical twins, exactly alike to outsiders, but they were distinguished by their mother from the beginning, because of their temperaments. In the first week or so this mother complicated her feeding routine by wearing a red shawl. One twin reacted to this and simply gazed at the shawl, perhaps at its bright colour, and lost interest in the breast. The other, however, was unaffected by the shawl, and fed as usual. After this the mother felt not only that the two were two persons but also that they had already ceased living parallel experiences. This particular mother got round the who-to-feed-first? difficulty by having the feeds ready well on time and feeding first the infant that seemed more eager. It was usually easy to decide by the crying. I do not say this method would suit all cases.

Certainly the main complication in the upbringing of twins is this question of the personal treatment and management of each, so that the wholeness and oneness of each gets full recognition. Even if there were twins that were exactly alike there would still be need for their own mother to have a whole relation to each.

One good idea is to put one baby to sleep in the front garden and the other in the back. Of course, there may not be two gardens, but it may be possible to arrange things somehow so that when one infant cries there will not always have to be two crying. Not only is it a pity from the parents' point of view to have the two at it at once, but also when a baby cries he likes to dominate the scene; it's maddening for him to have a rival in early infancy

at the stage of natural dictatorship, and I have known the effects of this sort of thing persist long into a twin's life.

Twins of one kind are called identical twins. Surely this word gives the whole show away. If the children were identical they would each be the same, they would add up to one, so to speak, which is silly. They are similar but not identical, but the danger is that people insist on treating them as identical, and if people do this, the twins will feel *themselves* muddled about their *own* identities. And infants do become very muddled about their own identities apart from being twins; it is only gradually that they become sure of themselves. As you know, it is quite a while after words are used that children use pronouns. They say, "mum" and "dad" and "more" and "dog" long before they say "I" and "you" and "we." It is more than possible for twins to sit in a pram, each thinking the other is not a separate person. Indeed, it would be more natural for an infant to think he sees himself at the other end of the pram (rather like looking in a mirror) than to say in infant language "hullo, there's my twin opposite me." But when one of the two gets lifted out of the pram the other feels infinitely lost and let down. Here is a

difficulty that any baby may have, but that twins must have, and they can only hope to manage if people play their part and know them as two people. If the twins do themselves eventually become quite confident about their identities they may enjoy exploiting their likeness to each other, and then, and not before then, is the time for fun and games on the theme of mistaken identity.

Finally, do twins like each other? This is a question that twins must answer. From what I am told I feel that the idea that twins are specially fond of each other needs looking into. Often they accept each other's company and enjoy playing together and object to being separated, and yet fail to convince one that they love each other. Then one day they discover that they hate each other like poison, and at last the possibility that they may get to love each other has come. After the hate is expressed the love has a chance. So it need not be taken too much for granted that twins want to spend their lives together. They may, but they may not, and they may even be grateful to some chance thing like measles for separating them, it being much easier to become a whole person alone than in the company of one's twin.

## MY LADY AND MY LADY PHILOSOPHY

(With deference to Dante)

Last night we lay  
And loved the line of limb  
That leads to life's (and love's) display:  
The nuptial line of lap and limb that leads  
Its likeness to the cold and warm  
Compress of lips, that spends  
Its passion.

So was this passion spent.  
As treasure, loved and lost, it went.  
And yet no void remained, no ache, no lack  
Of what had gone, no vacuous space of pain;  
It was her eyes that turned the passion back,  
Both clapped it off and caused its stage again.  
It was the corneal clarity,  
The utter sparkling charity  
With nothing in disparity,

Though born in nice obscurity;  
Its end its own annuity;  
The floating pupil purity,  
The single depth beyond.  
And thus the thrill of old returned, refined.  
I saw it first aslant, my eyes on her's,  
Set deeply in the singleness of mind,  
Which she alone, my second love, confers  
With intellectual clarity intent  
Upon the sparkling sport of argument.  
I find without surprise  
I've plighted twice my troth,  
And through my lady's eyes  
Last night I met them both.

NAT.



## BITS AND PIECES

Glancing through my London University guide book for the 3rd M.B. examination, I came across Section 2 of Part 1.

(2) Hygiene and forensic medicine

(a) One paper of three hours duration.

(b) An oral examination in Hygiene. (*Public Health and State Medicine*).

This reminded me of the lack of attention given to these subjects in the college curriculum. No doubt this is due in part to lack of time during the shortened wartime course. All the same it seems a little incongruous that when the country is clamouring for more food, more babies, better housing; when we are threatened with epidemics, declining populations, inadequate hospital accommodation, that the average qualifying student should have so little knowledge of Social Medicine.

The annoying little section I have noted above is regarded in the best circles as just one of those damned things one is asked in the finals. There is no desire to approach the subject fully since there is little understanding of the need for the social approach to medicine.

A forecast of the population of 1995 shows a considerable decrease, mainly due to a decline in the birth rate.

The writer knows of an anatomist who is not at all surprised at this and to whom the event

of parturition is so remote a possibility in a woman's life that it's a wonder there is a human race at all. But then there is you know, and the Maternity department can vouch for it that a baby is born once in a while.

Why though this decline in birth rate? Well, some people who ought to know say it is due to the average parents' fear of social insecurity. This means among other things not knowing whether the family income will amount to enough to house, feed and clothe it and whether war will remove the breadwinners, destroy life, property, kith and kin.

There is a rumour going round that the country needs more doctors. The writer suggests that many suitable individuals would be able to set out on a course of medical studies if more financial help were available to enable them to live during the expensive years of undergraduate life.

At the present time it is estimated that the minimum cost of board and lodging in London is £2 10s. per week and in the provinces somewhat less. State bursaries were granted in various sciences considered vital to the war effort. The nation's health is of vital importance in peace or war.

Then how about State Bursaries in Medicine!

ONLOOKER.

## ANNOUNCEMENTS

## THE ROYAL COLLEGE OF PHYSICIANS

*Dr. C. M. Hinds Howel is now the Senior Censor and Dr. George Graham the Second Censor of the Royal College of Physicians.*

## THE JOURNAL

*Mr. Peter Banks has resigned the editorship of the JOURNAL. The Publication Committee accepted his resignation with great regret. He will be succeeded by Mr. Hugh Cornford, formerly Assistant Editor.*

## CORRESPONDENCE

THE MARRIED  
EX-SERVICEMAN

*To the Editor, St. Bartholomew's Hospital Journal*  
Sir,

In these days when the younger amongst us in the Services realise that a period of many months must elapse before our astronomical "demob." numbers turn up, we have to satisfy our longing for home with vague conjectures as to the future. Some definite statement of policy from the "mother hospital" would, therefore, be very welcome as it would give us some idea as to what is being planned for our further medical education and welfare.

What scheme has the Hospital for allotting

"House Jobs" for ex-Service personnel, and how will those of us who went straight in after six months "on the House" stand in competition with the more fortunate ones who did B2 and/or B1 jobs?

One of the London teaching hospitals has made arrangements for married ex-Service housemen to be accommodated in an adjacent block of flats. Could anything similar be found in Charterhouse Flats or Chambers?

Yours faithfully,

J. R. COOPER, Capt., R.A.M.C.

No. 3 British Base Transfusion Unit,

Poona,  
India Command.

October 3rd, 1945.

## THE ABERNETHIAN SOCIETY

At a meeting of the Society on September 28th, Col. Hugh Leavell, of the United States Public Health Service and UNRRA, addressed members on the subject of "Public Health Services in the United States." In this talk conditions in the United States were contrasted with those of our own country; in particular the speaker referred to the gross variation in population in different parts of the vast country, the colour problem, the climate, and to diseases such as amoebic dysentery and malaria which are endemic in certain states. It appeared that the American public showed a greater disease-consciousness than our own, as evidenced by the widespread appeal of charity supported "foundations" for the relief of poliomyelitis and tuberculosis and by the almost universal insistence on pasteurised milk from tuberculin-tested herds. When Col. Leavell dealt with

the actual organisation of health services it came as a surprise to learn of its close similarity to our own. Although a system of Health Centres was by now well established in many states, it served for the most part a solely administrative and educational function. Many of the deficiencies of our own health services are no nearer to solution upon the other side of the Atlantic, and it was a comforting thought that even in the country of the otorhinolaryngologist, the autopsy surgeon and the esophagus, patients sometimes wait for three hours in an outpatient department reminiscent of the booking hall of a railway terminus for their ration of *Hausus Gentianae cum Rheo Alkalinis*.

The November meetings of the Society are a Clinical Evening to be held on November 8th.

## SPORTS

## SWIMMING

The Swimming Club is being reformed in London. They have already won their first match. A full account of this and subsequent matches will appear in the December Journal.

## SOCCER

*Bart's v. St. Mary's Hospital. Home. Won 4-2.*  
In a fast moving game, Bart's began pressing early, and our forwards were moving the ball well against a heavier defence. Burns was unlucky to have a good shot fisted out before Bart's opened the scoring, through Thomas, who headed in a good centre from Burns. Pilling then scored from close in, and Morgan again increased our score shortly afterwards by sending in a good header, this time from a centre by Blackman.

In the second half Mary's played better, and

quickly scored. However, Mangan sent across a low centre from the left wing, and Thomas put in a first-time shot which gave the goalie no chance. Mary's continued to play hard and scored again just before time.

Our forwards played well, but would be better if they played more together. The defence was rather unconditional, and indeed the two goals scored against us could have been prevented. However, the game was an encouraging start to the season.



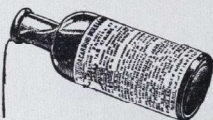
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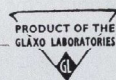
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# ST. BARTHOLOMEW'S



## HOSPITAL JOURNAL

Vol. XLIX

DECEMBER 1st, 1945.

No. 11

### EDITORIAL

First of all, may we wish all our readers a very happy Christmas. We have tried to make this December issue less gloomy than it has been in past months. There is no mention of atomic bombs or pestilence and famine. We are sure that everyone will enjoy reading Mr. Vick's inaugural address to the 150th session of the Abernethian Society—not less those who were privileged to hear it in person. His address, combining as it did scholarship and wit, wisdom and charm, was fully worthy of a great occasion and will be enjoyed by Bart's men of all ages and in all parts of the world.

\* \* \* \*

It is not being unduly gloomy to say that since the end of the war our relations with the United States have worsened. Despite the determination of politicians to co-operate and their many glib assertions to that effect, there is widespread suspicion and ill-feeling between the two peoples. To the average uninformed American we are no longer heroic little Britain but a collection of parasites who wish to batten off their wealth. Many of us feel that we stripped ourselves to the bone as the advanced outpost in the fight and are now morally entitled to help from an ally who suffered less. On the other hand, wherever Americans and Englishmen worked together on a common problem in the war, or an English family really got to know an American serviceman, genuine and enduring friendships have resulted. Wherever there has been contact there has been understanding. In the realm of medicine there is mutual respect between the two nations because there has been a constant exchange of information and personalities across the Atlantic. For the last five years a score or so of English medical students have

gone to the United States each year to study medicine at American universities; at the expense of the Rockefeller Trust. They have spent between two and three years there doing clinical work. They have been excellent ambassadors and are convinced, though not entirely uncritical friends of the U.S. Incidentally a contemporary now at Harvard writes that the other day he was asked by one of his colleagues what language was spoken in England. It would be a fine thing if the Nuffield Trust or some similar organisation would finance scholarships in this country for American students, both to reciprocate their hospitality and to further genuine international understanding.

\* \* \* \*

### ELECTION OF NEW DEAN

The College Council at their October meeting elected Dr. Charles Harris to the office of Dean of the Medical College.

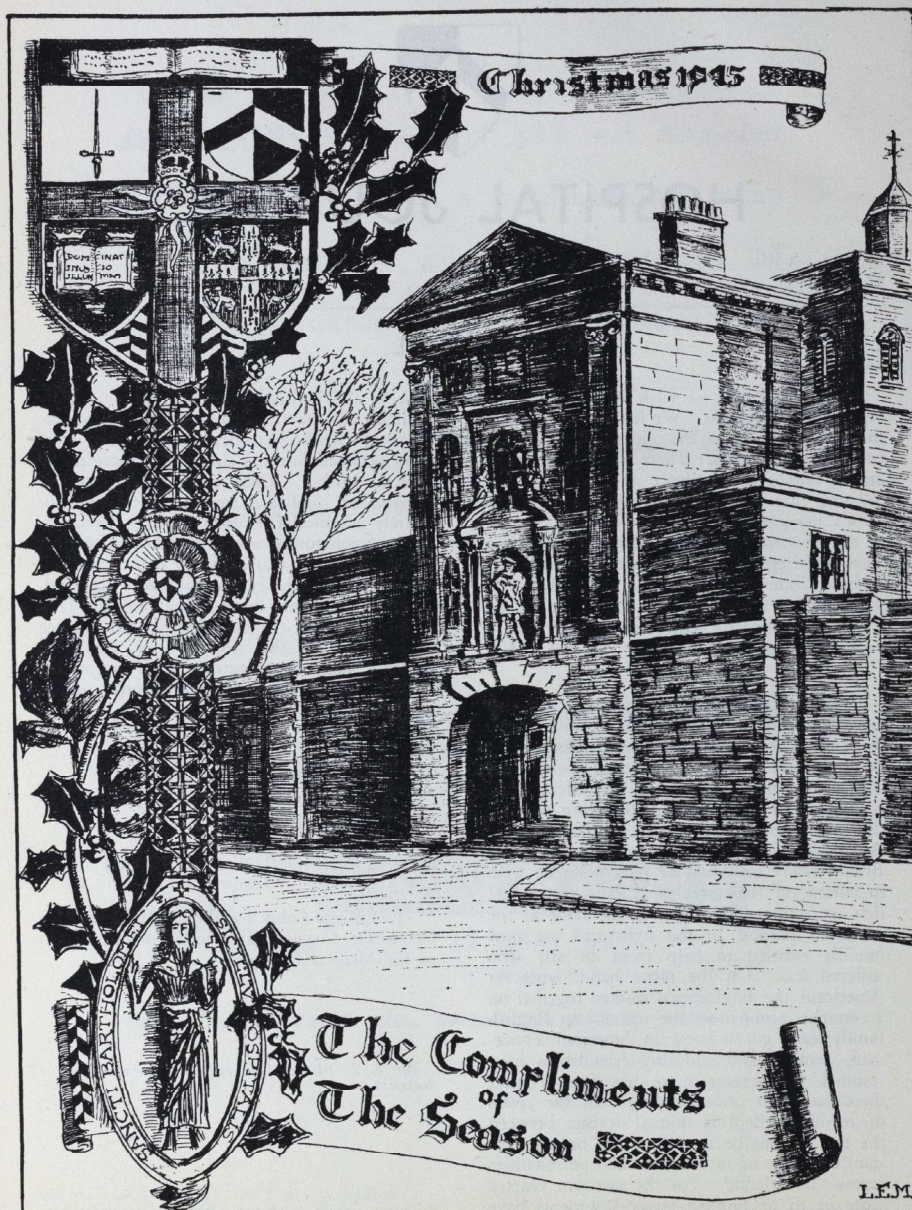
\* \* \* \*

Mr. L. E. McGee has been elected Editor of the JOURNAL.

\* \* \* \*

Contributions for the January issue of the JOURNAL should reach this office by December 13th.





## ONE ASPECT OF PRISONER OF WAR LIFE

By G. C. H. CHANDLER

During this period, when after the greatest and bloodiest war that mankind has fought, one hears on all sides fresh stories of the horrors of incarceration and of the bestial habits of our vanquished enemies. Despite the united efforts of press, radio and films it is often impossible for the normal human being to imagine—far less to realise—the conditions under which many of our fighting men were forced to exist, for to say that they lived is, I think, a gross exaggeration of the situation. Many of us have seen these men on their return to England and so with a risk of appalling some of my readers, I wish to describe some of the conditions and the diet in one particular camp in Germany.

Stalag 357 was originally situated in Poland, about five miles north of Thorn, beside the main Thorn-Bromberg road. In August, 1944, the entire camp, which consisted of approximately three thousand Army N.C.O.s and three thousand Royal Air Force N.C.O.s, was moved to Fallingbomel, about thirty miles north of Hanover. This new situation of the camp, though pleasant in its surroundings, will be remembered by the nine thousand men who eventually filled it. The actual barracks of the camp were of two different kinds, namely, wooden huts housing about fifteen hundred men and stone blocks which housed the rest of the nine thousand men. The stone blocks were by far the worst and were condemned by both the International Red Cross Representative and the Representative of the Protecting Power. Though they varied slightly in the various compounds they were all of the same fundamental design. The particular kind in one compound, which I will describe in detail, were situated on a clay-like soil which was impossible to drain. The blocks were approximately fifteen yards wide by ninety yards long and were divided internally into eight rooms, each with a door and four small unhinged windows. If any fresh air was required the complete window had to be knocked out of the wall. These rooms which measured approximately thirty-six feet each way, housed anything up to seventy-two men, who lived entirely in the room. The roofs were made of wood with a pretence at rubberoid felting on the outside, but during wet weather they leaked continually and owing to the appalling ventilation of the rooms, moisture always condensed on the inside of the roof and

dripped in an unpleasant manner. In the centre of the room six wooden tables made of unplanned deal were provided, together with two very collapsible wooden benches for each table. The beds consisted of double-deckers made of deal, with wooden boards laid across as slats. Under normal conditions paliaasses were provided. The lighting consisted of four twenty-five watt bulbs for each barrack room, but owing to the frequent air-raids or to the wires shorting in the dampness of the barracks, we went without light more often than we were allowed to use it.

In January, 1945, the German Authorities decided to turn the camp into a special reprisal camp, with a result that they confiscated all our paliaasses, tables, benches and only allowed the water to be turned on during certain hours. In addition we were only allowed to have five bed boards when the normal complement was twelve to fourteen. These conditions wouldn't have been nearly so formidable, even though the Germans only issued two thin blankets to each prisoner, had we been issued with decent rations or if we had been able to get adequate supplies of Red Cross Food Parcels. The Geneva Convention states that prisoners are to be provided with identical rations to the depot based troops of the detaining power. In Germany, however, as with many other vital clauses of the Convention, this was disregarded and prisoners were given non-working civilian rations—the lowest ration scale in Germany. During 1943 and 1944, when Red Cross Food Parcels were reaching the camps, it was quite possible for a man to keep physically fit on the diet, but after September, 1944, the situation rapidly deteriorated, reaching a climax in March, 1945, when the calorific value of the diet was only 1,100-1,200 cal./day. This figure alone accounted to a great extent for the appalling physical condition of many of our P.o.W.s, especially when many of us had to take part in forced marches with no regular supply of food, and having to carry our own kit.

In conclusion I should like to record my appreciation of the work done by the International Red Cross and all the national Red Cross Societies, who gave us such tremendous help, without which we could not have survived.



## THE CHANGING FACE OF BARTS

*An Address delivered to the Abernethian Society at the opening meeting of the 150th Session of the Society*

By REGINALD M. VICK

Mr. President, Ladies and Gentlemen,

When I was invited to deliver the Inaugural address on this most important occasion—the 150th Anniversary of this famous Society—my feelings were mixed—or, in the jargon of the present day, my reactions were diverse.

On the one hand, a keen appreciation of the honour done to me, and, on the other, a not inconsiderable fear that I might not justify your choice.

And when, as was natural, I harked back into the past and found that, at the 100th Anniversary, the Inaugural address was given by no less a person than the great doyen of surgery of those days—that most observant of clinicians and master of English, Sir James Paget—I realised that my best effort could hardly compete with what happened in those far off days.

Sir James Paget's subject was "The advancement of knowledge by the scientific study of disease in medical and surgical practice."

When his address was delivered, Paget was over 80 years of age and was able to recall his first communication to the Society 60 years before. He did not mention, though it is recorded in his *Memoirs*, which make such excellent reading, that on that occasion he described for the very first time, the *Trichona Spiralis* encysted in muscle and that he had then only been a student for a few months.

His discourse is printed in full in the *Bart's Journal* of that day. It is very clear and concise and he pleads with his hearers to exercise their powers of observation—to be patient—and to be accurate.

It is interesting to recall that he dealt with the study of diseases and their remedies and that surgery hardly came into it at all.

I would like to quote his final words.

"In all our scientific researches, in all our practice, we need the mind of the detective. I believe we may boast that the writer, by whom the love and power of detection have been described better than any one, Dr. Conan Doyle—is one of our own calling and first studied it when he saw it exercised in practice."

"Well, good detectives are always on the watch; and so should we be; there are facts all round us, why should we leave them to others to discern."

Thus spoke Paget in 1895, at the time when the "Adventures of Sherlock Holmes" were coming out and everybody awaited eagerly the next number of the "Strand Magazine."

I think, that in spite of the spate of detective stories that have flooded over our bookshelves since that day, it is true to say that for dramatic vigour and clear demonstration of reasoning used in detection, no one can hold a candle to Sherlock Holmes. I trust that you will include all his adventures amongst your text books.

In 1896, another notable but very different address was given to the Society by Mr. Howard Marsh—later Professor of Surgery in the Ancient University of Cambridge and Master of Downing College. He dealt at great length with the History of the Abernethian Society since its inception and it appears that, at one time, the Society exercised some of the functions which are carried out by the Students' Union now.

I must just quote one passage from his address, which reveals all sorts of strange things that we know so little of to-day.

"I can remember the time when many a student's life was wretched and led to deplorable results. After a healthy country life among his relations, or at school or at one of the Universities, the student of forty years ago found himself on coming to London, in a miserable position. When his day's work at the Hospital was over, he went, so to say, into outer darkness—his lodgings were dirty, his food badly cooked and there was a complete absence of anything in the way of pleasant surroundings or healthy recreations.

"What followed depended on the temperament of the individual. Many bore the weariness of their sordid life and worked on in dreary discomfort. Others, however, found their relief by casting in their lot with some kindred spirit and thus were formed, as is so often the case among companions in hardship, friendships which neither time nor separation could efface.

"But, in other instances, men threw themselves into all the amusements of the town. Once turned in this direction, they met with ever ready and sympathetic assistance. In the forties and fifties and even somewhat later, there

were at the Hospital men of a very peculiar order now happily extinct. They were students of eight or ten years standing, who had never passed or even presented themselves at a single examination, but they were past masters of music halls and billiard rooms. They walked the Hospital that is, the Hospital Square—one, or, perhaps, two days a week when they came to look for recruits. Some men obtained from their relations preposterous fees for bogus examinations or for an assortment of surgical instruments. One student obtained from his father five pounds for the purchase of a Eustachian tube for, as he said, all his colleagues had one."

But Howard Marsh is able to end in a much happier vein. "But the times are changed now and a man after an honest—that is a hard day's work turns to the recreation most to his taste and which our system amply provides and will find, when the years have rolled past, that his Hospital days were the happiest in his life."

As you have heard, at a later meeting of this session, Mr. Geoffrey Keynes is to talk to you of the Great Abernethy, and he is, indeed, much better qualified to do this than I am.

Of your famous Society, I would recall that though it is not the earliest, it was one of the very first of Medical Societies. When founded in 1795, it was called the Medical and Philosophical Society. There were six Presidents, a Librarian and a Secretary and a Council. It was, at its inception, that Abernethy was its mainstay.

After his death in 1827, the Society languished until 1832, when it took on a new lease of life "as a Society of the medical pupils of the Hospital to be called the Abernethian Society."

From that time, with one or two gaps—during wars, the Abernethian Society has carried on truly and well. Clinical Meetings have always been a great feature of its activities and it is excellent to think that they are to be revived.

The Society has often been addressed by famous people—members of our own profession and from other walks of life. I can well remember the welcome visit of Mr. George Bernard Shaw—to which he has himself referred in a review of a recent book of medical interest. At that meeting, he launched an attack on the General Medical Council and described our profession as the greatest Trade Union of all time. Mr. E. V. Lucas gave us a most entrancing address on Vermeer of Delft. And Sir Edmund Gosse—one of the greatest literary critics of all time and friend of Robert Louis Stevenson—talked to us

of "Doctors of the Seventeenth Century."

And many, many others too numerous to mention. And so we pass down the years and come to 1945 and your 150th Birthday.

I have chosen as the subject of my address "The Changing Face of Bart's," and I trust that, from my title, you will have guessed that I wish to speak in a somewhat lighthearted vein.

I am not able to cover the whole fifty years in my own personal experience, but hope that I may be able to give you some sort of picture of Bart's during the last forty years—during which I have spent a large part of my working life in the service of the Hospital—except for the years 1914 to 1918.

It has been thought by your Presidents that what I saw may serve as some sort of an introduction to Bart's for those many men who, owing to the war, have only recently begun to know the Mother Hospital, most unfortunately having had to work either at Cambridge or at one or other of the Sector Hospitals.

I have noted that, in an earlier address given to this Society, reference has been made to the vast changes which took place in the years 1795 to 1895—but they are as nothing compared to the changes which have taken place in the last fifty years.

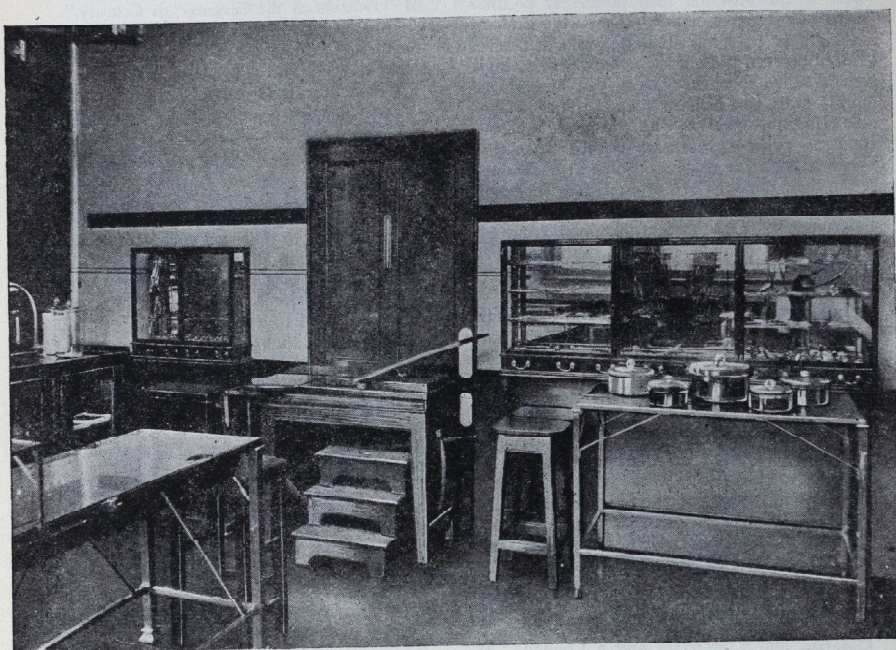
So great have been those changes that it is difficult to know where to begin. Perhaps it is natural to start with the actual structural changes and changes in the internal economy of the Hospital.

Forty years ago, the Outpatient Department functioned in the Surgery, which was then situated on the North East corner of the Hospital site, and has now for many years been used as the Nurses' Dining Room. The arrangement was primitive in the extreme. At each end of the Hall was a Duty Room—male and female—and between them a middle room where dressers came to make fomentations and exchange gossip.

Towards the end of the morning, this room was used by the Dental Surgeons for the extraction of teeth and the shrieks of the sufferers rang through the hall. Local anaesthesia was unknown and the administration of "laughing gas" consisted in producing a state of asphyxiation up to jactation and was often followed by a rough house when the patient was coming round. As far as my experience went very few of these patients laughed at all, and most of them had an appalling headache afterwards.

The firms on duty occupied the duty rooms and the other firms were accommodated in Boxes on the floor of the surgery. These were merely spaces on the floor of the hall, sur-





*Bart's Operating Theatre about 1895*

rounded by inadequate screens. Each firm had its own coloured board and we all moved round at the end of each duty period. It is interesting to think that the rooms in the Surgery to-day are still called Boxes.

At the end of the morning the boxes were vacated, one of the benches was moved into the centre and minor operations began.

I would like to remind you that, in these days, the poor of London were not only poor but destitute and had an aroma all their own.

The medical firms occupied rooms on the other side of the Hall, and these in turn were used by the Special Departments in the afternoon.

Specialization was almost unknown. The Eye Department and the Ear Department and the Throat Department existed as separate entities. The Orthopædic Department was run by a General Surgeon—Mr. McAdam Eccles.

It was not until 1908 that the New Surgery, as we know it to-day, or rather did in 1939, threw its doors open to the public.

The Pathological Department occupied two

rooms near the Museum. The Post Mortem Room was a small shed near where the Incinerator now stands.

The Resident Staff Quarters were behind the East Wing and were part of the Residential College, which was always full of students.

The Nurses were housed in buildings beyond the Residential College. All these houses were then 200 years old and the rooms were very small and lit by lamps and, later, by a form of gas, which spluttered and hissed in the taps and was so poor a form of illumination that one often wondered whether it was on or off.

In the cellars beneath the College was a strange bath and the mice and rats scampered through them and sometimes ate the gas pipes, when they were particularly hungry.

The catering company had, of course, not been heard of and most of the students fed out—in the various hostels near the Hospital, at the Express Dairy and at another clean little shop at the corner of Little Britain, whose staple article of diet you may guess when I tell you that it was familiarly known as the Nipple.

Lunch was also served in the College in a hall on "E" staircase and in a room on the site where the Pathological Department now stands called the Inquest Room. I never remember attending an Inquest in the same room.

The East, South and West Wings were the Hospital. The Wards were, according to modern standards, too small and their windows not large enough. But they used to look very comfortable, especially in winter, when huge coal fires burnt in each side.

And now, something about the people who lived their lives in these buildings.

Ward discipline was, I think, stricter than it is to-day and the senior dressers and even some of the housemen were somewhat afraid of the Sisters.

All the Sisters wore frilly caps with bows under the chin and the senior nurses wore strange handkerchief caps—also with bows under the chin. The nurses' skirts were longer and they all wore long capes almost to the ground.

Nurses and students were not supposed to associate with one another and such a thing as a nurses' dance, to which students were invited, was unknown.

The number of students was smaller than it is to-day and there were not more than six dressers or clerks to each firm.

The formal lecture still held its sway and the type of "Question and answer" teaching, which we now know so well in the Practical Surgery and Medicine classes, was just starting.

I think it cannot be denied that this latter form of teaching, now so characteristic of this and many other medical schools, is a great advance on the older type of lecture, though these cannot be done away with altogether.

A considerable amount of coaching went on in the Museum and was a very valuable source of income to badly paid Demonstrators.

The teaching collection had not been thought of and students often wondered in a state of bewilderment around the galleries of the Museum.

In 1909, the Pathological Block was opened and it is amusing to think that there were some quite knowledgeable people who imagined that it was far too large for its purpose.

The practice and teaching of Pathology advanced by leaps and bounds with these greatly increased facilities.

Ward rounds were as much as they are to-day. The custom of allowing students to sit down on a teaching round has been attributed, of late years, to a certain Director of the Medical Professorial Unit but I can well remember that

in the firm, in which I was a dresser, we always sat down to be taught.

The operating Theatres were five in number not counting the Outpatient Theatres. Theatre "A" was as lecture Theatre as well as an operating Theatre. And Medical and Surgical consultations were held in the same theatre. In fact, there was once almost a row between the Physicians and Surgeons of the Hospital, because the surgeon on duty was operating in this theatre, when the physicians wanted it for their consultations and the Clerk to the Governors had to be called in to settle matters.

Theatre "B"—apart from the fact that it was filled with all sorts of junk-jorums of lotions, salines, etc.—was thought to be up to date.

Theatres "C" and "D" were small, most inconvenient buildings, on the site where the Deep X-Ray Therapy Department now stands. They were temporary Theatres and only functioned for thirty years.

The Gynaecological Theatre was at the top of the South block and had handsome brown marble walls.

There are still members of the Consulting staff who can remember the surgeons' operating coats, which hung up stiff with blood in a cupboard in Theatre "A," they were discarded frock coats and were used to save the surgeons' clothes when operating.

In 1930, the magnificent New Surgical Block was opened. Its inception and its planning owed a tremendous amount to the energy and drive of Sir Holburt Waring.

In 1938, the New Medical Block was opened and full advantage was taken of the experience gained in the building of the surgical block.

In the planning and arrangement of this block, Dr. George Graham played a large part. The Lucas block became the Gynaecological Wards and housed the Eye Ward as well, and the Etherington Smith Theatre was built.

The other Special Departments were housed in the East and West wings. The Septic Wards—Coborn and Radcliffe—were at the top of the East Wing. And, for many years, on View Day at the Annual Inspection by the Treasurers and Governors, the Treasurer never entered these wards for fear of infection.

And this, we may say, was Bart.'s in 1939. And now let us turn to the Staff.

The Senior Surgeon in 1906 was Mr. Harrison Cripps. He wore a beard and used to drive in to the Square in a carriage and pair.

His clinical lectures were so Elizabethan in character that one had to queue up for them.

Sir Henry Butlin was a consulting Surgeon



and used to ride to the Hospital from Harley Street on a black horse.

One of his great contributions to surgery was his energetic insistence on the enormous importance of early diagnosis and drastic treatment of Carcinoma—as illustrated by Carcinoma of the tongue—in those days a more terrible scourge than it is to-day.

There is a famous story about him which must now be forgotten. He was once going round with about eighteen dressers and showed them a patient with an early carcinoma of the tongue and asked for a diagnosis. The first dresser said he thought that it was innocent—and all the others, as sometimes happens to-day, followed suit. Butlin said, "Gentlemen, you are all wrong—this is a Carcinoma and I am going to remove this patient's tongue to-morrow."

And the patient piped up and said, "Here, I'm not so sure, Gynnor, it's eighteen to one."

I believe I am right in saying that Mr. C. B. Lockwood was the first surgeon to drive into the Square perched high in the back of a car.

No member of the Assistant staff was allowed to drive into the Square. In fact, it was better for him to conceal the fact that he had a car or a practice.

The Assistant Physicians and Surgeons only had beds by the courtesy of their seniors. At one time, no Assistant was allowed to discharge his own patients—that was done for him by his senior. And there is even a story that one Physician would not allow his Assistant any beds at all as he did not consider him fit to look after patients.

The dress of the staff was rigid. Many of the Senior Staff wore frock coats and top hats. The morning coat as we know it—or, rather, don't know it—to-day, was just coming into fashion.

Most members of the Staff, even down to the Junior demonstrators, wore morning coats and gleaming top hats.

My Chief, of revered memory, Sir D'Arcy Power, used to bicycle to the Hospital when on night duty.

The motor car age had begun but hansoms and four wheelers still trundled along the streets. One unforgettable memory was the smell of Little Britain, down which all day and night passed the horse-drawn vans to the Meat Market.

At a somewhat earlier time, the surgeon on duty used to be brought to the Hospital by a Hospital porter, sent for him in a fourwheeler.

(It is interesting to recall that the last of the Box Carriers—the porters who carried the in-

struments round the wards, when the surgeons actually operated in the wards—only died some time after this last war began.)

Needless to say, all this was changed by the advent of the telephone and the motor car. With the arrival of the car, the days of the top hat were numbered. Of course, this was a great relief, but people did look well turned out in a tail coat and top hat.

And what shall we say of the men themselves? Bart.'s has had so many famous men on the Staff that it would be impossible to mention most of them.

C. B. Lockwood—the apostle of the aseptic as against the antiseptic technique.

Sir Anthony Bowlby, President of the Royal College of Surgeons—the most sagacious of clinicians—whose wise councils in surgical consultations were of inestimable value to younger generations.

Sir D'Arcy Power, one of the greatest medical historians of all time and author of one of the most readable histories of the Hospital.

Sir Norman Moore, President of the Royal College of Physicians—author of the standard History of the Hospital.

One remark of his well worth handing down to posterity was made when he was in the chair at Saint Bartholomew's Cambridge Graduates' Club dinner—a function we hope to revive next year—and it ran as follows:—

"Etherington Smith and Donaldson must remember that, though we are not Trinity men, we are yet God's creatures."

Sir Wilmot Herringham—a very great orator and the last member of the Staff to wear a beard.

He lectured in what was sometimes called the Oxford manner—and one sentence, oft repeated—I remember well, "You think, in what you are pleased to call your minds."

Sir Archibald Garrod, first Director of the Medical Professorial Unit and, later, Regius Professor of Medicine in the University of Oxford, whose work on the "Inborn Errors of Metabolism" brought about a revolution of ideas on the chemical origin of disease.

I venture now to mention some of the members of the Staff still living. Our first, and at the present moment only member of the House of Peers, Lord Horder, one of our greatest teachers and clinicians and the author of many famous sayings.

And here I would recall one of Dr. Gee's aphorisms—now almost forgotten—"There are only two classes of patients—the ones to whom you give Hst. Gent cum Rho and the others for whom one can do nothing."

One saying of Horder's that I never tire of

repeating is to this effect, "If a man over 40 complains of indigestion for the first time, you must assume that he has a carcinoma of the stomach, until you have proved that he hasn't."

Sir Walter Langdon Brown—still another Bart.'s Regius Professor of Physic at Cambridge—has very often entertained this Society by his amusing and polished addresses. He has proved again and again that he can talk entertainingly on most things.

But I might go on like this for ever.

Bart.'s has been the home of many famous

(To be continued)

## HÆMOLYTIC DISEASE OF THE NEWBORN

*A case report with an interesting family incidence.*

K. M. BACKHOUSE — G. B. CHAMBERLAIN

On June 7th, 1945, Mrs. S—, aged 34, was admitted to Dartford County Hospital, in the 38th week of her 8th pregnancy, having been sent for investigation by her doctor in view of her previous obstetrical history.

### *Obstetrical History*

With the exception of the sixth child, which was delivered as a healthy male breech, the seven previous pregnancies and deliveries were normal though somewhat precipitate.

*1st Child* (by first husband). Born March, 1928. Healthy normal male child. No jaundice. It has been found impossible to obtain blood from this child for examination and hence no information is available.

*2nd Child* (by second husband). B. August, 1930. Male. Jaundiced soon after birth. Died on fourth day.

*3rd Child*. B. October, 1931. Healthy female child, breast fed, not jaundiced. Blood group—B. Rh+ (R<sub>1</sub>, r).

*4th Child*. B. December, 1933. Healthy female child, breast fed, not jaundiced. Blood group—O. Rh+ (R<sub>1</sub>, r).

*5th Child*. B. October, 1935. Female child. Jaundiced soon after birth. Died seventeenth day.

*6th Child*. B. May, 1937 (Breech). Healthy male child. Bottle fed, not jaundiced. Blood group—O. Rh+ (R<sub>1</sub>, r).

*7th Child*. B. March, 1941. Female child, breast fed, jaundiced soon after birth, very ill for two days, but condition improved following

doctors. The ones I have mentioned are amongst those who have influenced my generation and many others.

I think that the students of those days were more in awe of the Staff than are the students of to-day and that the Staff of that day were more aloof from the students.

Now I am happy to think that—partly as the result of living together more in the war—our relations are more intimate. And, surely, this is as it should be.

an intramuscular injection of 15ccs. of maternal serum. Survived. Blood group—B. Rh+ (R<sub>1</sub>, r).

No information is available on the blood of the first husband. The second husband, father of the second and subsequent children, was blood group—B. Rh+ (R<sub>1</sub>, R<sub>2</sub>).

### *Previous Medical History*

1924 (aet. 13). Scarlet Fever (no sequeke), Diphtheria.

1930 (aet. 19). Six weeks after delivery of second child she developed cerebro-spinal meningitis.

1931 (aet. 20). Albuminuria of Pregnancy. Subsequent to this—good health throughout.

### *Present Condition*

During pregnancy she complained of fainting attacks on three occasions at the 34th week, and was found to have a hæmoglobin of 46 per cent. (Salite) and treated with Iron and Hydrochloric acid.

On admission (38th week) she was found to have a hæmoglobin value of 50 per cent. (Salite—7 gms. per cent.), to be of blood group A and Rh—ve. Anti Rh agglutinins were present in the serum to a titre of 1 in 64. W.R. was negative.

Transfusion with group O, Rh—blood was therefore commenced. After delivery of 350 ccs. the patient complained of retrosternal pain and had a rigor. Transfusion was therefore stopped and the patient rapidly recovered.

Although an explanation of the reaction is not available, it was considered advisable not



to continue with attempts at transfusion but to treat with Iron.

With the exception of the anaemia, the general condition was satisfactory.

As previous labours had been rapid and uncomplicated, with children alive at birth, it was decided to deliver the patient per *vias naturales*. Group O. Rh— blood was made available for transfusion of the infant if necessary.

#### Infant

During the evening of June 13th a male infant weighing 6lbs. 7½ozs. was delivered. Blue asphyxia was present at birth but disappeared after clearance of the air passages. There was no evidence of jaundice. On examination the following morning the infant was found to be markedly jaundiced with slight hepatomegaly and splenomegaly. The blood was found to be compatible with group O. Rh— blood and had haemoglobin 130 per cent. Sahli (18.2 gms. per cent) and a Red Cell count of 6.5 million cells/cubic sum.

100 ccs. of group O. Rh— blood were therefore delivered into the left internal saphenous vein above the ankle, over a period of 1½ hours. The blood in this case was given as a prophylaxis against anaemia and so was given according to the generally accepted rate of 10-15 ccs./lb. body weight, rather than the rate recently described by Gimson<sup>1</sup> (1943).

Transfusion recommended if R.B.C. is below 3.5 million cells/cmm. Transfusion estimated upon % rise in H6 required × blood volume. Blood

100

volume × 88 cm/kilo body weight (40 ccm per lb.) calculated on expected weight for age from birth weight.

On the first day four-hourly feeds of 5 per cent. glucose were given until breast feeding was instituted on the second day. The haemoglobin level was maintained for two days and then fell to 102 per cent. on the sixth day.

This was accompanied by increasing jaundice, lethargy and bile pigments in the urine. In view of this half-strength Trufood was instituted in place of the breast milk.

Witebsky *et al.*<sup>2</sup> (1942) have shown that the Rh antibody may be present in breast milk and hence advise avoidance of breast milk in affected children. It appears, however, difficult to appreciate how the antibody can get into the infant circulation.

Following this, there was a slight improvement in the general condition.

The haemoglobin continued to fall slowly to a figure of 60 per cent. (8.4 gms. per cent.) and 3 million cells/c.m.m.s on the 16th day. The stools were clay coloured and somewhat offensive and the urine still bile stained. The clay-coloured stools, suggesting some obstructive jaundice being present, can only account for

part of the jaundice and certainly not for the anaemia, and other symptoms of icterus gravis neonatorum, and is due to the plugging of the bile ducts and damage to liver cells. After this date there was a general improvement and he was discharged at the 8th week in a satisfactory condition. The haemoglobin was 88 per cent. (12.3 gms. per cent), R.B.C. 5.1 million cells/c.m.m. The jaundice had cleared and the stools were normal, and no bile in the urine.

During the period in hospital the blood picture showed only a few primitive red cells and a slight leucocytosis (22,000 cells/c.m.m. on the 10th day).

In addition to the jaundice and lethargy, there was some spasticity and neck rigidity, with marked irregular ocular and limb movements. As jaundice decreased so also did these signs of kernicterus, and on discharge there appeared to be no signs of permanent involvement of the basal nuclei.

Rustin McIntosh<sup>3</sup> (1941) quoted a 10% kernicterus incidence in cases of icterus gravis neonatorum, but Allott considers that this figure is far too high.

Before discharge a further sample of blood was taken and shown to be group O. Rh+ (R<sub>1</sub>r).

It can be stated, therefore, that this was a moderately severe case of icterus gravis neonatorum and that on the evidence available it is reasonable to assume that the previous affected children were also affected by this disease.

#### Discussion

Haemolytic disease of the newborn is found in one of four forms—Icterus Gravis Neonatorum, Anaemia Haemolytica Neonatorum, Macerated still born fetus with a damaged fibrosed liver, and Hydrops fetalis (with lipid infiltration of the suprarenal cortex). In a survey of the ratio of the various forms Henderson (1942)<sup>4</sup> gave a figure of fifty cases of Icterus Gravis to eight of each of the other three forms.

Deinst (1905) first noted that when the mother's serum contained an agglutinin that was incompatible with the infant's erythrocytes the potency of her iso-agglutinins increased considerably during the fourth to eighth day after delivery.

Levine and Stetson (1939)<sup>5</sup> first suggested that the presence of atypical agglutinins in the serum of a recently delivered woman might be the result of immunization to an antigen in the fetus. They later showed that their cases were due to the Rh factor.

The Rh factor, found in the erythrocytes, was first discovered by testing samples with anti-rhesus sera, prepared by injecting the blood of rhesus monkeys into rabbits. That the blood

group antigen responsible for the disease is usually the Rh factor was shown by Landsteiner and Weiner (1940 and 41).<sup>6</sup> Race and Taylor showed that the distribution of the factor in a total series of 4,618 subjects was 84.37 per cent. Rh+ and 15.63 per cent. Rh—. Landsteiner and Weiner showed that there are marked racial differences in distribution. The Rh+ figure is much higher in leucodermes and melanodermes than in xanthodermes, and they found only one Rh— in 120 Red Indians. There is no variation in the sexes and it is independent of other groups. The prognosis is more grave, however, for affected male children.

Ninety per cent. of mothers of erythroblastosis cases are Rh— and the others appear to have some antibodies to A, B, O, M, N, and P agglutinins. So far (1944) ten anti M and one anti N cases are reported. A number are reported in which the mother is Rh+ and the infant either Rh+ or Rh—. Some of these may be misdiagnosis of such conditions as acholuric jaundice in Rh+ mothers. There are, however, at least seven Rh genes, with twenty-eight possible genotypes (Rase *et al.* 1944)<sup>7</sup> so that in order to produce antibodies the mother need not be Rh—.

That the combination of an Rh— mother with an Rh+ fetus does not necessarily lead to the disease is shown by the fact that this combination is present in 9.46 per cent. of pregnancies (Haldane) but haemolytic disease occurs in only 0.25 per cent. It is therefore necessary to consider some explanation for this low incidence. The occurrence of an immunizing pregnancy in which the disease is not manifest in the fetus will account for a number of these cases.

It must be pointed out that if the immunizing factor Rh, A, B, M, N, or P, is present only in the erythrocytes, it is necessary to assume the actual entry of fetal erythrocytes into the maternal circulation for immunisation to occur. Levine and Katzin (1941)<sup>8</sup> made tests with numerous specimens of saliva, a few tests with sperm cells and seminal fluid which indicated that the Rh factor is not present.

Boorman and Dodd (1943),<sup>9</sup> however, have shown that the Rh factor is present in body fluids and the cells of a number of tissues, though in much smaller amounts than in the blood cells.

With antibodies present in the maternal circulation with an Rh+ fetus the effect is probably in relation to—

1. Ability of mother to produce antibodies.
2. Titre of agglutinins in the mother's serum.
3. Permeability of the placenta.

4. Amount of extra-corporeal group specific antigen present.

There appears to be very little relationship between the titre of antibody in the mother's serum and the severity of the disease in the fetus. It is not usually possible to forecast the condition of foetal disease in utero by estimation of maternal serum antibody, as the antibody in the maternal circulation may be due to a previous pregnancy or other immunising cause (for example, incompatible blood transfusion). What appears much more important, however, is the fact that late in pregnancy there may be a tendency for antibodies to go out of the maternal blood stream, suggesting that the fetus absorbs them and hence is a bad prognostic sign.

It is generally agreed that the low incidence of A and B haemolysis is due to the absorption of maternal antibodies by the A and B group specific substances in the foetal tissues and body fluids before they can affect the red blood cells. Boorman and Dodds (1943) have shown that the quantitative distribution of Rh group specific substance is similar to those for A and B groups but whereas the latter substances in the tissues are readily soluble in secretors (water soluble), the Rh substances are not usually water soluble. Some cases of Rh+ individuals, however, carry very small amounts in the saliva and other fluids, suggesting that some slight amount is soluble in these cases. It is therefore possible that only males who secrete Rh antigen in the saliva have the antigen in a water soluble form which allows it to pass easily through the animal membranes.

Hence a fetus which carries on Rh genotype which results in its developing Rh antigen in this form so that it can pass easily into the mother's circulation via the placenta, will be affected. This theory will discount the necessity for the passage of red cells from fetus to mother, which had to be assumed previously.

Whatever factors are considered to explain the unusual incidence in this family, it does not appear possible to consider it in the light of different Rh genotypes. All the children who are living, including those affected by the disease, carry some genotypes which are exactly as would be expected by the simple mendelian rules of inheritance. It would be reasonable to assume, therefore, that the two children that died of the disease were also of this genotype. Since the degree and genotype of the antigen would appear uniform it is hardly possible to consider a variable response in the mother in the production of antibodies, and similarly the variable permeability of the placenta could not be invoked as an explanation.



There is no doubt that a much larger percentage of affected male children die of the disease than of female, but in this family of the four affected children (two of each sex), one of each sex died. There is, however, no apparent variability in the actual incidence of affection between the sexes and so that also can be discounted.

It would appear possible that the earlier children could have been affected by immunization to other groups, leaving only the last children to be affected by the Rh group antigens. This can also be discounted in the light of subsequent response to these groups in the later children.

No satisfactory explanation of this peculiar behaviour can be put forward. All that can be said in the light of present knowledge, is that even when the mother has already been immunized and the genotype of the child is such as to be agglutinated by her antibody, some other factor, as yet not known, is involved which very occasionally gives this type of result. It is, however, of such rarity (two other series are recorded by the Galton Serum Unit (Mourant) that from a prognostic approach this effect can be neglected.

#### Summary

A family history is recorded of a standard genotype being carried by all the eight children but a marked variability in antibody response being shown by the infants.

The obstetric history and mode of treatment of the last (affected) child is given.

A revue of the pertinent points in the literature of erythroblastosis foetalis is made but no explanation of the phenomena in this series can

be given.

We would like to express our thanks to the Kent County Council and Dr. T. S. Cochrane for permission to publish this case; to Dr. F. Bachner and Miss M. V. Gantry for much assistance in collecting clinical material; to Dr. E. N. Allott for permission to publish his pathological reports and for technical assistance, and to Dr. A. E. Mourant of the Galton Serum Unit, Cambridge.

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## CORRESPONDENCE

### THE MARRIED EX-SERVICEMAN

To the Editor, *St. Bartholomew's Hospital Journal*.  
Dear Mr. Editor,

Captain Cooper, whose letter was published in your November number, and other serving Bart's men will, I feel sure, be interested to know that plans are being made under the scheme for "Post-Graduate Education of Medical Officers on release from the Forces." Up to date 18 Supernumerary Chief Assistant appointments embracing Medicine, Surgery and Special Subjects have been made by this Medical College in addition to the "routine" ones; these supernumerary appointments are reserved for Service Medical Officers on release, are in general for six months and with a salary at the rate of £450 to £650 per annum (including allowances if

non-resident) depending on experience, etc. In addition, similar appointments are available in non-teaching voluntary hospitals to suit individual requirements; parallel with these are Refresher Courses carrying with them financial assistance by certain allowances.

Captain Cooper mentions the example of men who were mobilised after only a brief period of House job; he and his brother medical officers may rest assured that this group stand high in eligibility under the scheme, indeed, other things being equal, their chances of a supernumerary appointment are greater than the man who was fortunate enough to do B2 and B1 appointments before being called up.

May I use your journal as a means of bringing this scheme to notice and to ask that any Bart's man wanting one of these "jobs" either at Bart's or in the other hospitals has only to write to this

Medical College as soon as possible or, in the case of the higher age release groups, at least three months before his release date; all further action will then be taken by the College to help these returning Medical Officers in getting the new start in civil life

which they certainly deserve.

Yours sincerely,

A. E. UNDERWOOD,

Sub-Dean of the Medical College.

17th November, 1945.

The Students' Union Ball will be held on Friday, January 25th, 1946, at the Grosvenor House. Double Tickets, at 27/6, may be obtained from C. Parker Bradfield, The Students' Union, St. Bartholomew's Hospital,

E.C.1. Applications, written or *viva voce*, should be accompanied by the requisite sum of money. Cheques should be made payable to the Students' Union and crossed.

## SOCCER

*Bart's v. Maysfield Athletic Club, October 20th. Home. Won 6-4.*

Team: Watson; Pine, Elliott; Amos, McClusky, Winstone; Pilling, Blackman, Thomas, Mangan, Burns.

Mayfield pressed at first and we were lucky to prevent them scoring, but after ten minutes the game swung the other way, and Thomas, seizing on a through pass, beat the goalkeeper easily. Bart's continued to press and three quick goals followed—Blackman and Burns (2). Mayfield, however, quickly recovered and scored their first goal.

Bart's scored first after half-time through Pilling, but Mayfield had the better of the second half, our big lead seeming only to spur them on. Our defence was continually pressed and Pine did well to keep their dangerous left wing in check. We scored once more through Thomas, but Mayfield added 3 goals to their score before full time.

*Bart's v. St. Thomas' Hospital, October 27th. Home. Won 7-0.*

Team: Watson; Pine, Elliott; Amos, Murley, Mangan; Jordan, Thomas, Mangan, Burns.

This was a one-sided game, we scored 3 goals in the first half, and in the second settled down to demonstrate to ourselves and our opponents that short passes, anticipation and quick shooting, good football in fact, are more effective than just sheer determination to get the ball into the net, and in doing so added 4 goals to our score.

Goals: Burns (3), McClusky (3), Thomas (1).

*Bart's v. Imperial College, November 3rd. Home. Won 5-2.*

Team: Watson; Pine, Elliott; Amos, Murley, Mangan; Jordan, Blackman, Thomas, McClusky, Burns.

We were lucky not to have had a goal scored against us in the first five minutes, an opposing forward hitting the crossbar, but we soon settled down, and after Burns had hit the upright, McClusky scored with a neat header from a centre by Thomas. A second goal came quickly when Thomas followed up a shot and headed past the goalkeeper, and a third was scored by Jordan, who made a sensational appearance from the wing which completely non-plussed the goalkeeper. Burns then put across a long-low dangerous centre, and Thomas put the finishing touch, for our fourth goal.

The second half was rather lifeless. McClusky scored for us, and Imperial scored twice while we were resting on our laurels, amidst the gathering gloom.

*Bart's v. Borough Road College, November 7th. Home. Won 6-3.*

Team: Watson; Pine, Elliott; Amos, Mangan, Weston; Pilling, Kirby, Goodrich, McClusky, Burns.

This game was a sweet revenge for a long series of defeats. It was particularly creditable as we had nothing like our full team out. We soon established a strong lead by scoring 4 goals in ten minutes—Burns, McClusky (2), and Goodrich. This spectacular start shook our opponents considerably, and they took a time to recover, but they scored a goal before half-time.

They started the second half by attacking strongly, and quickly scored; however, a determined dash and a skilful centre by Pilling enabled Kirby to re-establish our lead. This caused Borough Road to withdraw their dangerous centre-forward into the defence, and after this, although our goal was in peril once or twice, the result was never in doubt. Burns scored our sixth goal after dribbling past five men. The defence played well together, Mangan doing well at centre-half and McClusky and Burns did splendid work in the forward line.

*St. Mary's College v. Bart's, October 17th. Away. Lost 3-1.*

This being our first Wednesday game, it was not surprising that our team was not completed until the last moment. However, the spirit of the soccer team prevailed and our absent members managed to board the moving train at Waterloo.

The game itself was keenly contested, but owing to the pressure of examinations and the pressure of our opponents' forwards it was apparent that the game would not go as we wished. Mary's scored after ten minutes' play through their inside-left and the failure of our defence to mark their opposite numbers. We, however, retaliated and after a scrimmage in the goal mouth Burns shot hard into the far corner of the goal. Mary's scored again before the end of the first half, and this score remained until the middle of the second half when they added a third goal.

The Bart's team is to be congratulated on its spirited play, especially the hard tackling of the defence, and although our captain lost one of his boots during the game it did not interfere with his later play. The motto of the game was: Hard tackling is essential, but to win accurate marking is essential.

Team: Watson; Pine, Elliott; Winstone, McClusky, Amos; Burns, Mangan, Thomas, Goodrich, Pilling.



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EXAMINATION RESULTS  
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Johnston, I. H. D.

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Peck, I. A. W.  
Osborne, P. F.  
Jordan, J. W.  
Fyfe, A. E.

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Dawson, D. A.

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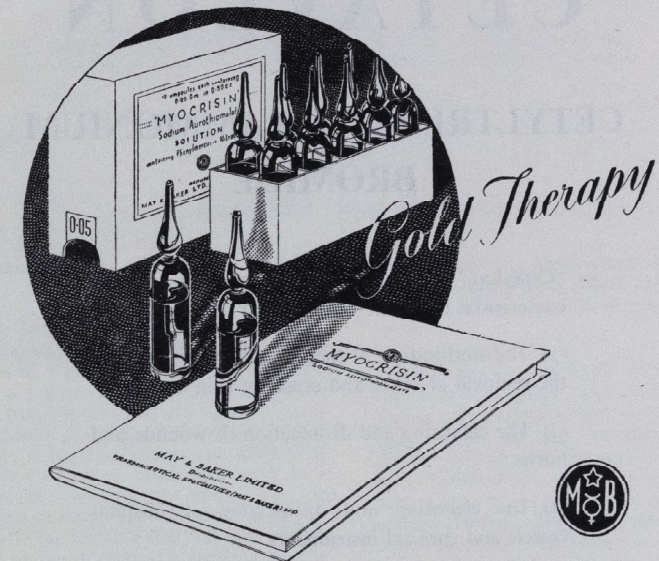
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| Allison, R. C.  | Dawson, D. A.    | Dunlop, E. M. C.      |
| Ellis, E.       | Ellis, R. H.     | Grant, M.             |
| Jackman, C. C.  | Jukes, W. R.     | McGregor, R. C.       |
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## HOSPITAL JOURNAL

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### RANDOM REFLECTIONS

A famous professor of physiology once told one of his more promising pupils, who asked him whether he should take up research work at once or proceed to qualify as a doctor, that, medicine apart, there was more to be learnt in the wards of a general hospital than could be learnt in a journey around the world. This is probably true, but we could still wish that every student should, as a part of his training, spend a few days in his own hospital as a patient. It is possible to learn as much in a week as a patient as by "walking the wards" for the same length of time—and this said with all due deference to the teaching staff. It is as well to know the routine of the wards (and incidentally to remember when you breeze in at ten o'clock, still with shining morning face, that your patient has already been awake for four hours). But the most important lesson to be learnt is about the nursing staff. Firstly about the importance of their work in the treatment of any case, an importance that it is impossible to over-emphasise. Secondly, to realise at first hand their easy, human efficiency and unfailing good humour. It is common to praise nurses as being "wonderful" and "angelic" and then to dismiss the subject to the back of one's mind, but in fact both adjectives are fully deserved. No praise can be too high for those who after a long and hard day's work can still keep their temper with the querulous and dyspeptic grumbling of a patient with a duodenal ulcer. They continue to smile long after an ordinary human being would have lost patience. What is the secret of their astonishing devotion? Presumably it is partly the temperament of the individual and partly a long tradition of devotion and discipline. Possibly a tradition dating from the time when all nurses were sisters in a

religious order. At all events, without being either sanctimonious or patronising, it can truthfully be said that no praise or thanks can be too great.

When one lives or works in a hospital and has become familiar with its building, its routine and its personalities, it is easy to lose sight of the fact that for the less educated patient their admission to hospital is one of the major events of their lives. Almost as significant as winning a football pool or the death of a near relative. There are still people who regard hospitals as mysterious and even slightly sinister places, smelling of antiseptics and staffed by white-gowned figures who spend their time manipulating gleaming chromium machinery. And there are still old countrymen who think that the hospital is where you go to die. It is time some propaganda was done to counteract this. Very little is ever written in praise of modern hospitals while so-called exposés are common enough: and if a surgeon is unfortunate enough to leave a large swab inside a patient, the press will find room to report that. A hospital would be an ideal subject for a documentary film, and yet all the cinema ever gives us is something about the drama of the operating theatre or American films about glamorous interns and tetchy old physicians with advanced rheumatoid arthritis. Will anyone take the hint?

\* \* \* \*

Contributions for the February Issue should reach this office by January 15th.



## THE CHANGING FACE OF BARTS

By Reginald M. Vick

*The Second Part of his Address delivered to the Abernethian Society at the opening of the 150th session of the Society*

I should like next to deal in a broad way with what I consider some of the greatest advances of the last forty years.

It is natural that I should deal mainly with advances in the science and art of surgery.

I would put first and foremost the advance in Anaesthesia. For, from this advance have proceeded in large part the improved methods and technique of surgery.

In most cases speed has ceased to be an essential and, therefore, much more complicated operations can be performed peacefully and successfully.

When I was a student, anaesthetics were very primitive. The Senior Honorary Anaesthetist was called and was the Chloroformist to the Hospital. Chloroform, except in expert hands, was a dangerous and inferior anaesthetic. The patient passed through the most violet stages of excitement during induction and often arrived on the table either not under at all or half dead.

I did once see a patient pop his finger into an appendix incision just as it was made. It was usual in those days and indeed later to strap the patient down, not to prevent him from falling off the table, but to control his struggles.

One cannot help but be filled with admiration for those great pioneers who initiated major operations under these difficult conditions.

For example, we all know now that the proper treatment for stones in the gall bladder is to remove the organ—much better than to open it, empty it and drain it—but, in those earlier days, the surgeon was only too glad to be able to see and seize the fundus of the gall bladder and perform the simpler operation.

But soon Ether came into general use and, combined with alcohol and Chloroform, produced an advance in anaesthesia.

And then came Gas and Oxygen and, in this connection one must remember Boyle—a Bart.'s man after whom the first Gas and Oxygen apparatus was named.

Some time later, endotracheal methods were adopted.

And so we pass on to the present—the peaceful anaesthesia of Avertin by rectum, or of Evipan and Pentothal intravenously—the more

perfect technique of Spinal anaesthesia, Splanchnic anaesthesia—local anaesthesia—and Curare.

Nowadays, we can tell patients with confidence and truth that—once and for all—the bad old days of inefficient anaesthesia are over: that they will feel a prick in the arm and when they wake up, they will find themselves back in bed and the operation happily over.

Even post anaesthetic vomiting is not the fierce and forcible thing that it was.

For some inexplicable reason, post anaesthetic chest complications are still with us.

With this steady improvement in anaesthesia, and in no less degree the perfection of the aseptic technique, surgery on the grand scale is possible and there are few parts of the body that the surgeon cannot attack with impunity.

We associate with the name of a Bart.'s man—Sir Harold Gillies—some of the great advances in Plastic surgery.

In 1906, the senior Gynaecologist did not operate on the abdomen but called in the Senior Surgeon to deal with his abdominal cases.

But this soon passed and the Gynaecologists became surgeons and developed to the full their own speciality.

In 1906 and for some time afterwards, most students learnt their Midwifery on the district and only the most complicated cases came into the Hospital. Going out on the district was one of the very first jobs that a student did on his own. And it was with a thrill of pride that one set out with the little black bag to deliver the mothers of London, and with even greater pride that one returned to report the successful arrival of a baby.

The wonderful advance in all forms of transfusion is well known to you all. The discovery of the Sulphonamides and, later, of Penicillin, have led to untold improvement in dealing with the hitherto dreaded complication of infection.

In the fields of both medicine and surgery, X Rays, both in diagnosis and treatment, have opened up wide areas of advance.

In the diagnosis of Gastric disease, the gastroscopist has come to stay. As to the cure of Cancer, one must say, in all honesty, that even with the use of Radium and Deep X-Rays, we

are not much nearer to our goal.

Over and over again, great hopes have been raised only to be dashed to the ground. And it is still true that only by the early diagnosis and the drastic surgical eradication of the disease can cure be assured.

Of advances in the practice of Physic, I speak with diffidence. Of the outstanding discoveries—one must mention Insulin and again the Sulphonamides and Penicillin—the exhibition of Iodine in the treatment of Thyrotoxicosis—of the use of artificial pneumothorax in the treatment of Tuberculosis of the Lungs—of the importance of investigating the Chemistry of the body in disease—of the importance of Vitamins—these are just a very few of the many great advances.

But to return to our own family circle.

In the war of 1914 to 1918, many sons of Bart.'s gave their lives for their country. You pass by their Roll of Honour every time you enter the Hospital by the Smithfield Gate.

Although the Hospital was hit by bomb fragments from a Zeppelin, the buildings remained unchanged, the normal working of the Hospital went on though considerably upset.

The East Wing became Military under the charge of Sir Girling Ball. And Bart.'s ran a large Military Hospital—the First London General—at Camberwell. The Senior Staff became Colonels, Majors and even Captains.

As soon as the war finished, Bart.'s quickly returned to normal, much more quickly than is possible now. We almost bounded back into full life.

In 1920, I was appointed Warden of the Residential College, which post I held until 1936, although, most unfortunately, the Residential College closed in 1923 and has never re-opened.

The Medical College obtained its Royal Charter in 1921 and became a constituent college of the University of London.

The Professorial Units were established in October, 1919. The first Director of the Medical Professorial Unit was Sir Archibald Garrod, followed by Sir Francis Fraser, Professor Witts and now Professor Christie. The first Director of the Surgical Professorial Unit was Professor Gask and the second Professor Ross.

From the point of view of medical education, one of the greatest reforms is that now all students enter as University students—most of them of London University—and a very large proportion take a University Medical degree.

Prior to 1914, nearly all the members of the Honorary Staff came from one or other of the

older Universities of Oxford or Cambridge—though why they are put in that order I have never been able to understand.

More recently, this predominance has been less marked. Our entry of students from Oxford has never been great. Our entry from Cambridge has fallen off—at one time it was on the fifty mark, it is now more like fifteen a year. This is a most lamentable thing, in my opinion, and we must make an earnest endeavour to put it right.

And so from 1918 to 1939, the old world rolled quietly along—with a few eruptions, it is true, but still on the whole peacefully.

And then on that fell day, the holocaust of war burst with all its vigour around us.

This time everything was different. Bart.'s was rent asunder at once. The Pre-clinicals went to Cambridge to enjoy the hospitality of Queen's College, to whose President and Fellows we must be eternally grateful. The Clinical students went some to Hill End and some to Friens.

The phoney war passed and the bombs began to rain down on and around our ancient hospital. Our Medical College was well nigh destroyed.

The East and West Wings were damaged grievously. The Treasurer's house with its beautiful staircase completely destroyed. The old Warden's house and all the buildings of the old Residential College and the old Nurses' Home were gutted.

The Outpatient Department had to move down into the Dungeon, but the Hospital main buildings survived and the work went on.

Night after night, the City of London was strafed and, on more than one occasion, the Hospital was ringed with fire.

Then came a time of quiet—then the short blitz of February, 1944. And then we made the acquaintance of the Flying Bomb and, later, of the Rocket. One rocket—almost the last to fall on London, exploded in Farringdon Market while it was packed with shoppers.

And within half an hour, the Hospital was filled with air raid casualties—grave and light—and soon became so crowded that—a rare happening—patients had to be sent elsewhere.

And then, quite suddenly, all that was over. And, in the midst of mild rejoicings, the Sun of Peace began to shine mistily through the clouds and, once more, we all have to readjust ourselves to a new and difficult world.

And what a changed world, indeed. With our Medical College in the Charterhouse in ruins. With a battered Hospital.

With a staff which must change rapidly—as



so many of the senior members have been carrying on over the retiring age of 60.

And looking ahead, what do we see in the future? Of course, we see the Staff landing from the helicopters on the roof of the surgery—we see the development of the greatest invention of Radar—helping the deaf to hear—even, perhaps, by a small instrument carried in the pocket, helping (by its vibrations) the blind to know where they are and whether they are passing a telegraph post, a tree or a post box, a cat or a dog.

Radar, perchance, enabling one to look right into and through the human body—so that X-Rays are no more needed and the stethoscope becomes an interesting relic of a bygone age.

You will live, maybe, to see the cure of Tuberculosis, and even of Cancer.

And looming ahead other great changes. A State Medical Service—judging by what the Prime Minister said at the Harveian Banquet it seems likely that this great reform will not be introduced without the co-operation and advice if the medical profession.

But it may well mean the passing of the Voluntary Hospital as we have known it.

The admission of women students to Bart.'s—a controversial subject, but one which, apparently, has been settled for us.

Well may the Great Men of the past turn in their graves—and well may the great men of the future shake in their shoes. But enough of prophecy.

And now may I end with a few words of advice to you, who are young in this place. First of all, I would like to quote the words of Sir Thomas Vicary (1490 to 1562). Although it is advice to a surgeon, it will be good for all of us.

Thomas Vicary's Requirements of a Good Surgeon.

That his bodye be not quaking and his handes steadfast; his fingers long and small and not trembling; and I doo note four things moste specially that every Chirurgion ought to have. The first that he be learned; the second that he be expert; the third that he be ingenious; the fourth that he be well mannered.

"Also, they should do their diligence as well to the poore as to the riche. They may not chide with the sick but be always pleasaunt and merie.

"Likewise that they despise no other chirurgion without a great cause; it is meete that one chirurgion should love another."

And to you Bart.'s men, I would say, don't be cast down. Bart.'s is a Great Old Lady—

older than the Old Lady of Threadneedle Street.

Since 1123, the Healing Art has been practised within these Ancient Walls without fear or favour.

Thousands and thousands of patients have blessed the name of Bart.'s. I have yet to see a patient unkindly treated here.

Hundreds and hundreds of good doctors have passed out under the Henry VIIIth Gateway, since that forceful monarch first bestrode it.

And I can give you as my own private opinion, after considerable experience, that you very rarely find a better doctor than a Bart.'s man and rarely a better nurse than a Bart.'s nurse. Of course, I may be slightly biased, but I say this in all sincerity.

But to you who come anew, I would say in all seriousness, you have got the most tremendous traditions to live up to—traditions of kindness to the sick and the poor. Traditions of hard work and faithful service to humanity—of courage, and cheerfulness and of the researching mind.

It is no good my saying to you: don't hurry, don't hustle, contemplate. This is a far different world from the one of which I have tried to give you a picture. It is a world of speed and movement.

But I would hope for all of you that—and again—and, perhaps, when the simmering misery of a war weary world dies down—more and more—you may be able to stop in your tracks and think of those gracious days, when the world was a peaceful place.

When people walked and talked quietly.

When people drove through the quiet countryside to the music of the horses' hoofs.

When people sailed the sea in ships—instead of ripping through the sky at six hundred miles an hour.

We all see these great changes—but I believe that the spirit of this Hospital is unchanged.

The war and all its horrors and its separations may have dimmed it, but it will live again and it is for you to keep it alive and strong.

Of course, you will have great burdens to bear, great anxieties to suffer, great researches to carry out to uphold the reputation and character of the Hospital.

But, if you will absorb these traditions, spare time to study their origin and meaning, you will not fail.

And may I end by wishing you every conceivable success in your high endeavour.

## LOUVAIN 1914-1940

By PROFESSOR L. P. GARROD

"Our trouble in Louvain," said Prof. Hoet to me, "is that our city is destroyed every twenty-five years." This picturesque hyperbole refers to the fate of Louvain in the two great wars, consequent on its position astride the great highway, both rail and road, from the Pas de Calais and Brussels to Germany. The destruction of the University Library in 1914 has passed into history as an outstanding example of German vandalism. Between the wars the Americans re-built it—on its former plan and scale but without any of the beauty of the neighbouring Hotel de Ville, which mercifully has survived both wars—and re-stocked it with a million books. They also furnished the lettering of an inscription to be placed on the façade, the Latin of which, freely translated, meant something like "Destroyed by the Brutality of Germany, Restored by the Munificence of America." This inscription, which seemed a little tactless, was in fact never displayed, but when the Germany army invaded Belgium in 1940, that lettering in the cellars had generated as much animosity as if it had been facing the city for years. Whether for this reason or because the library was by far the most prominent building in Louvain, it was deliberately shelled and completely burned out. Most of the other destruction in Louvain is unfortunately of our doing: so vital a traffic centre had to be bombed—particularly the bridge over which the main road crosses the main railway. Our day bombing was superb—the populace could watch it unscathed—but some of the heavy night raids made the whole city unsafe, and most of its inhabitants left it early in 1944.

They bear us no grudge: indeed the joy of their miraculously rapid liberation when the B.L.A. advanced from the Seine into Belgium was so overpowering that it must have obliterated any of their former sorrows. Nothing in our English experience approaches this: only four years of occupation, ending with the appearance of a British Armoured Division right on the heels of the departing Germans and many miles ahead of any news of its advance, can produce the emotion which these people experienced. I heard an account of that memorable evening in the house of a surgeon in Brussels which stands on the Ruc de la Loi, the route by which the Germans retreated and down which British tanks roared only a

hour later. Even his grand-daughters, neither of whom can have been more than ten years old, were seized by the impulse which left no female in Brussels content until she had kissed a British soldier: small wonder that the men's faces were soon a blotchy red.

To be the guest of the Medical Faculty of the University of Louvain on the occasion of its first re-union since 1939, and to hear the thanks of Belgium for what Britain has done to make such a meeting possible again, was an undeserved experience for someone who had simply undertaken to discourse for a while in French about penicillin. Some four hundred medical graduates came from all parts of Belgium for a celebration which began in Church and proceeded through a morning of speeches to a dinner which lasted, with intervals, for four hours. Although this feast was said to be a substantial advance on previous gastronomic evidences of post-war recovery, it should be made clear that food in Belgium is not scarce: some things, such as poultry, are much more plentiful than with us. So, in passing, are wine and matches. Belgium is incomparably better off than France, where in the cities at least, the black market has been the only source of any food more interesting than bread and potatoes.

Good work has been going on quietly in their medical schools, and just as they need to be supplied with all our medical journals for the four years of their isolation, so we shall do well to try to acquire theirs. I came away with a bunch of reprints of papers which can be got in no library in England. Some of these were by Maisin, whose work on the effect of diet on cancer is among the most original lines of recent cancer research. He combines experimental work employing large numbers of very fine white rats with the direction of radiotherapy in the hospital. The contents of their 11 gramme radium bomb have now been restored: one should perhaps say most of the contents, because the Germans who emptied the bomb (for purposes supposed to have been connected with a bomb of another kind) left his finger-prints on some unexposed X-ray film which he also handled, and must therefore have spilt some of the radium on his hands. Whether he is now dead of aplastic anaemia, according to expectation and his deserts, is not known.

Penicillin—American, of course—is rather



more freely available in Belgium than in England, although their experience of its use is necessarily less. I saw the only patient with bacterial endocarditis known to have been treated with penicillin in Belgium after giving a lecture in Govaerts' clinic in Brussels in which I was able to relate that 132 cases have now been treated in Great Britain with 69 at least temporary recoveries. This young man, who was treated—presumably with American Army penicillin—just after the liberation, has been well for nine months, and was produced somewhat dramatically by a member of my audience who evidently knew that this disease was to be part of my subject. His name might have been

Lazarus: no one else present had ever seen a recovered case of bacterial endocarditis, and the treatment of this disease is still prohibited by the regulations governing the distribution of penicillin, just as it was with us until last January.

It is a privilege to have an excuse for visiting the Continent in these days: the warmth of one's welcome, both in Paris early this year and in Belgium now, will always be something to remember. It is also highly revealing to look on our own country through the eyes of a recently liberated people: I can recommend it as a treatment for pessimism.

## JOHN LYLY AND BREAST FEEDING

By WILFRED SHAW

*John Lyly lived in the parish of St. Bartholomew the Less, perhaps within the boundary of what is now the hospital. The parish register shows that two sons and a daughter Francis were baptised in the church and that a daughter Elizabeth, was buried in the churchyard between the years 1596 and 1606. John Lyly himself was buried in the churchyard on the 30th November, 1606, and the register also shows that in 1608, Robert Langly was married to Anne Lyly, who may have been John Lyly's widow. The daughter Francis was married in the church in 1617, at the age of fourteen.*

*There is no record of the place of burial of John Lyly and it is a matter of very great regret to all interested in Elizabethan literature that the church contains no monument to his memory. Lyly lies buried somewhere near the old Maternity and Gynaecological block. Lyly is overshadowed by Shakespeare, Marlowe and Jonson, but he showed much originality.*

*I have thought it fitting to draw attention to the following passage from Euphues, so that a member of the obstetrical department may honour his memory. The passage shows good examples of Lyly's Euphuistic style.*

### "OF THE EDUCATION OF YOUTH"

For is there anyone more meet to bring up the infant, than she that bore it? Or will any be so careful for it, as she that bred it? For as the throbs and throes in childbirth wrought her pain, so the smiling countenance of the infant increaseth her pleasure. Is not the name of the mother most sweet? If it be, why is half that title bestowed on a woman which never felt the pains in conceiving, neither can conceive the like pleasure in nursing as the mother doth? Is the earth not the mother of all things only because it bringeth forth? No, but because it nourisheth those things that spring out of it: whatsoever is bred in the sea, is fed in the sea, no plant, no tree, no herb, cometh out of the ground that is not moistened

and as it were nursed of the moisture and milk of the earth: the lioness nurseth her whelps, the raven cherisheth her birds, the viper her brood and shall a woman cast away her baby? I account it cast away which in the swathed clothes is cast aside and little care can that mother have, which can suffer such cruelty: and can it be termed with any other title than cruelty, the infant yet looking red of the mother, the mother yet breathing through the torments of her travail, the child crying for help which is said to move wild beasts, even in the self-said moment it is born or the next minute, to deliver to a strange nurse, which perhaps is neither wholesome in body, neither honest in manners, which esteemeth more thy argent

although a trifle, than thy tender infant, thy greatest treasure? Is it not necessary and requisite that the babe be nursed with that true accustomed juice and cherished with his wonted heat and not fed with counterfeit diet? Wheat thrown into a strange ground turneth into contrary grain, the vine transplanted into another soil changeth his kind. A slip pulled from the stalk withereth, the young child as it were slipped from the paps of his mother either changeth his nature or altereth his disposition. It is prettily said of Horace a new vessel will long time savour of that liquor that is first poured into it and the infant will ever smell of the nurse's manners having tasted of her milk. Therefore, let the mother as often as she shall behold those two fountains of milk as it were of their own accord flowing and swelling with liquor, remember that she is admonished of nature, yea commanded of duty, to cherish her own child, with her own teats, otherwise when the baby shall now begin to tattle and call her mamma, with what face can she hear it of his mouth unto whom she hath denied Mamma? It is not milk only that increaseth the strength or augmenteth the body, but the natural heat and agreement of the mother's body with the child's, it craveth the same accustomed moisture that before it received in the bowels, by the which the tender parts were bound and knit together by the which it increased and was succoured in the

body.

Certes I am of that mind that the wit and disposition is altered and changed by the milk as the moisture and sap of the earth doth change the nature of that tree or plant that it nourisheth. Wherefore the common byword of the common people seemeth to be grounded upon good experience which is: This fellow hath sucked mischief even from the teat of his nurse. The Grecians when they saw anyone sluttishly fed, they would say even as nurses: whereby they noted the great disliking they had of their fulsome feeding. The etymology of mother among the Grecians, may aptly be applied to those mothers which unnaturally deal with their children, they call it *meter a meterine*, that is mother of not making much of, or of not nourishing, hereof it cometh that the son doth not with deep desire love his mother, neither with duty obey her, his natural affection being as it were divided and distraught into twain, a mother and a nurse: hereof it proceedeth that the mother beareth but a cold kindness towards her child, when she shall see the nature of her nurse in the nature of her child. The chiefest way to learning is if there be a mutual love and fervent desire between the teacher and him that is taught, then verily the greatest furtherance to education is if the mother nourisheth the child and the child sucketh the mother, that there be as it were a relation and reciprocal order of affection.

## PRESENTATION TO H. G. ADAMSON ON THE OCCASION OF HIS 80th BIRTHDAY

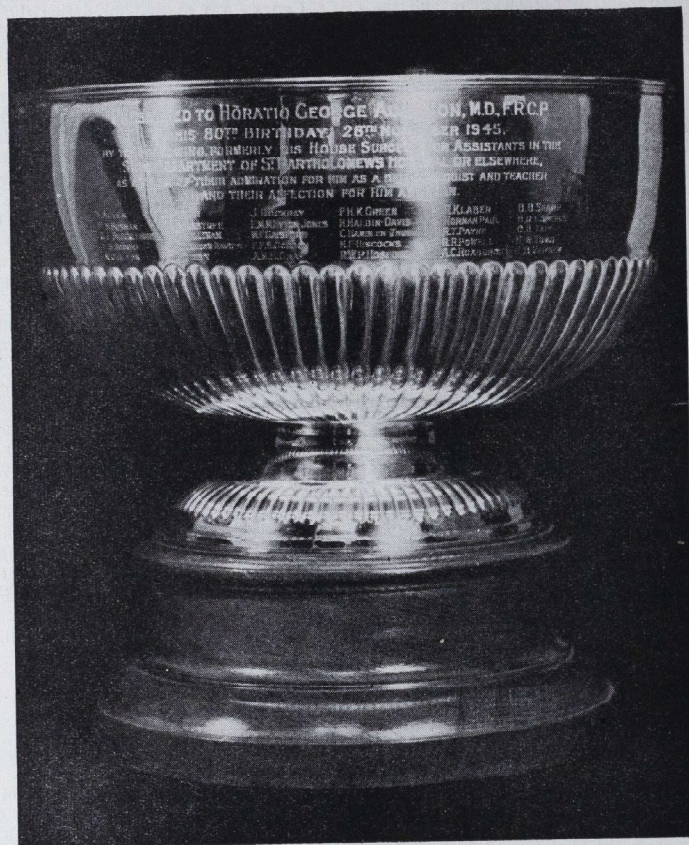
On his 80th birthday, November 28th, 1945, a silver rose bowl was presented to Dr. H. G. Adamson by thirty of his old Assistants and House-surgeons in the Skin Department of St. Bartholomew's Hospital, at a sherry party held at Dr. Henry Corsi's house, 95, Harley Street. Subscriptions had been sent by his old pupils from places as far apart as Australia, South Africa and East Africa. In spite of the difficulties of the present time some sixteen of the subscribers attended the party to pay tribute to their old teacher, whom they were glad to see looking hardly a day older than when he retired from St. Bartholomew's eighteen years ago. The inscription on the rose bowl was as follows:—

Presented to  
Horatio George Adamson, M.D., F.R.C.P.,  
on his 80th birthday, 28th November, 1945,  
by the following, formerly his House-surgeons

or Assistants in the Skin Department of St. Bartholomew's Hospital, or elsewhere, as a token of their admiration for him as a dermatologist and teacher and their affection for him as a man.

|                      |                   |
|----------------------|-------------------|
| F. Allen             | F. H. K. Green    |
| H. M. Bosman         | H. Haldin-Davis   |
| G. L. Brocklehurst   | C. Hamblen-Thomas |
| E. B. Brooke         | H. F. Hiscocks    |
| N. Chilton           | R. W. P. Hosford  |
| H. Corsi             | R. Klaber         |
| J. B. Crabtree       | Norman Paul       |
| E. R. Cullinan       | R. T. Payne       |
| J. H. Twiston-Davies | R. R. Powell      |
| J. C. Dixey          | A. C. Roxburgh    |
| J. Dockray           | B. B. Sharp       |
| F. M. M. Eyton-Jones | H. D. L. Spence   |
| W. F. Gaisford       | G. B. Tait        |
| E. F. S. Gordon      | H. W. Toms        |
| A. M. H. Gray        | E. B. Verney      |





### THE CITY FIRE

It was a dull and bleak December night;  
The year was slowly ebbing to her close;  
Great London stood beneath the wintry sky  
With darkened streets and heavenly stars  
above;  
And at that fateful hour, the sirens wailed,  
The A.A. guns sent out their bursting shells,  
Whilst high above the city's ancient towers  
The moanful drone of German 'planes was  
heard.

And all around from Cheapside to the Bank,  
The cursed Huns released their flaming bombs  
Upon the city's ancient, sacred shrines.  
From East and West the fire-fighters came—  
These valiant men who fear not flames nor  
death;  
They fought with Mars from dusk to early  
morn,  
Some lost their lives on that most fateful night,  
Yet they live on in spirit unsubdued.

### MEDICAL INSPECTION A.T.S.

*Extract from a complaint. (Pediculosis missed  
at medical inspection.)*  
"I do think it is a waste of time sending girls  
for medical inspection, as they are often barely  
examined."

JR. COMMANDER, A.T.S.

ADMS to M.O. i/c ATS.

When young auxiliaries parade  
For routine health review,  
The allegation has been made  
They're barely seen by you.  
It's doubtful if the ladies arc  
In such a serious huff  
Because you go a bit too far,  
Or don't go far enough;  
Whether you overlook them quite,  
Or see them in the nude;  
The former would be impolite,  
The latter downright rude.  
The details of the strip-tease act,  
With which you must comply,  
This regulates the proper wear:  
Shorn of inconsequentials  
You'll find that "shorts and brassière"  
Cover the bare essentials.  
I think perhaps your critic meant  
Most probably to say  
That you have been too negligent  
About these negligécs:

Be stricter then with A.T.S.,  
And treat them more austerely,  
And if you find they overdress  
Then dress them down severely.  
Let not your admiration fond  
Denounce it as ridiculous  
That some superb peroxide blonde  
Should harbour the pediculus:  
Be not intimidated by  
That exquisite coiffure,  
And fail to notice what may lie  
Beneath its false allure:  
Do not from delicacy shirk  
To take the plunge: be brave!  
Explore what deep-sea monsters lurk  
Beneath the permanent wave.  
In jungle war you know how hard  
To wrinkle out the Jap it is:  
With equal guile you should regard  
Pediculosis capitis.  
Let not inspection be confined  
To timid search for Scabies—  
Bear other parasites in mind—  
For instance: Nits and Babies!

R. B. P.

### CORRESPONDENCE

*To the Editor, St. Bartholomew's Hospital Journal*  
Dear Sir,

Moved by the appeal in your issue of October, 1945, on behalf of the Dutch medical students, I brought to Bart's a collection of clothes on November 13th. My reception led me to believe that I was the first and only answer to the appeal. Anyhow, nobody knew what to do with them. To solve the problem I took the liberty of dumping them in the Editorial Chair—then vacant—and left my name. Since then I have heard nothing. Now, Mr. Editor, if this appeal is more than a good intention committed to print, what has been done about it? From what I have myself seen of liberated Holland I know the need is urgent. If they are being sent across, good; if not, I would like them back to send by

more certain channels. If you think your appeal requires more publicity, perhaps you will print this letter.

D: A. LANGHORNE.

Burfield,  
Bosham, Sussex.  
November 28th, 1945.

*We thank you for your contribution. At the same time we should like to make it clear that although we publish appeals made by the Students' Union Council we cannot be held responsible for the reception and distribution of the fruits of such appeals. Books and old clothes for Dutch medical students should be left in the students' cloakroom and not in the Editorial Chair—which is reserved for the Editorial Seat!*



## G.B.S. AND G.M.C.

To the Editor, St. Bartholomew's Hospital Journal  
Sir,

In your current issue you commend Mr. Bernard Shaw's claim that laymen should sit on the G.M.C. "to represent the patients." But why? It will be conceded, I think, that the only aspect of the G.M.C.'s function which concerns the layman is the disciplinary one. Now, by the time a poor wretch of a doctor appears before the Council, the laymen have already had a whack at him, either in the Courts or through the Insurance Committees with their huge preponderance of lay members (the one of which I am a member has three doctors to 40 laymen). At the proceedings the patients are fully represented, and if subsequently a doctor appears before the Council, it has before it the evidence given at the previous lay proceedings. Further, the patients can be represented

by lawyers at G.M.C. sittings. Cannot the G.M.C. be trusted to weigh the evidence impartially? Mr. Shaw's unpleasant implication is that they cannot, and that lay members must be present to ensure that no mercy is shown to one who has already had his punishment at layman's hands.

Does Mr. Shaw want lay members on the Disciplinary Committee of the Law Society to represent victims of legal malpraxis? The Law might indeed prove a more fruitful field for Mr. Shaw's pleasantries; or haven't his legal friends taught him as much about the Law as his medical friends have about doctoring.

M. MUNDY,  
Capt. R.A.M.C.

November 20th, 1945.

## BOOK REVIEWS

PRINCIPLES OF HUMAN PHYSIOLOGY (Starling). By C. Lovatt Evans, D.Sc., F.R.C.P., F.R.S. Ninth Edition. J. and A. Churchill, Ltd. 36s.  
APPLIED PHYSIOLOGY. By Samson Wright, M.D., F.R.C.P. Eighth Edition. Oxford University Press. 30s.

New editions of Starling's "Principles of Human Physiology" (now rightly attributed to Professor Lovatt Evans) and Samson Wright's "Applied Physiology" have recently appeared. These, together with the slightly less well-known "Physiological Basis of Medical Practice," by Best and Taylor, constitute the three standard text-books on the subject.

Both the new editions have much to recommend them. They are both excellent and reliable books which cover more than adequately the syllabuses of the second M.B. and Primary Fellowship examinations. Starling is the longer and more detailed work, with 1,155 pages to Wright's 944. It contains more detailed information and covers a slightly wider field. Starling is also more attractive in appearance, the pages larger, the print larger and clearer and the margin wider, the diagrams more numerous; trivial advantages which nevertheless add to its readability. Starling also has references for many of the facts and figures quoted at the bottom of the page as well as a bibliography at the end of the chapters. One of its outstanding features is the section on the special senses written by Professor Hartridge. It is invaluable as a reference book and for any one reading for an honours degree in physiology.

Samson Wright is probably more useful for pre-clinical students than Starling. It is somewhat shorter and the author admits in his preface that he has paid some attention to the requirements of various examining bodies. This is not to imply that it is in any sense a "cram" book. It is, on the contrary, a most scholarly work. There is a greater proportion of applied physiology than in Starling, which besides being very useful sustains the interest. Professor Wright, in order to save space, has omitted description of the peripheral mechanisms of vision

and hearing—this is to be regretted as it detracts from the completeness of the work. It is to be hoped that this will be remedied in future editions, of which there are certain to be many.

MICROBIOLOGY AND EPIDEMIOLOGY. Edited by Prof. E. B. Babsky, Prof. I. G. Kochergin and Prof. V. V. Parin. Pp. 158, London Medical Publications, Ltd. Price 15s.

Language and other difficulties restrict our knowledge of what goes on in the U.S.S.R., and such accounts as have appeared in English of medical achievements in that country during the war have been few and inadequate. Something is being done to remedy our general ignorance by the publication of a series of books entitled "Achievements of Soviet Medicine in the Patriotic War." This volume deals with the prevention and treatment of microbial infections, whether by immunisation, the destruction of disease vectors, the use of bacteriophage, or some form of chemotherapy. Many of the problems facing the authors of the fifteen papers in this book are unknown to us: we see no cholera and little typhus, nor have we to build ice walls several kilometres long to check the mass migration of rats from which people may get tularaemia. Tetanus and dysentery we know, and whether the methods described here of producing immunity to them are worthy of adoption there is no real means of deciding in the absence of more precise information about methods and results. The prevention and treatment of gas-gangrene with bacteriophage tests the reader's credulity severely, and the use of "phytoncides"—volatile and highly antiseptic substances emitted by crushed onions and other plants—for treating wound sepsis is another method on which judgment should perhaps be reserved. Gramicidin and penicillin are also described—the latter briefly—and methods of diagnosis are considered in connection with typhus, tularaemia, and epidemic encephalitis. The book gives an interesting general picture: judgment on the merit of at least some of its component parts must be deferred until we hear more of them.

## SPORTS

## SWIMMING

At long last, the Club, dormant through six years of war, has been restarted. Although there were spasmodic efforts to start swimming at Cambridge and at Hill End, the Central London Club remained quiescent. Now the Club has been reconstituted as it was in pre-war days. Mr. R. M. Vick was elected President, Professor Hopwood, Mr. Hume and Mr. Hosford Vice-Presidents, and a committee consisting of members from Bart's, Cambridge and Hill End was formed. K. R. H. Deane, Captain; W. H. H. Deane, Vice-Captain; D. Sacks, Secretary; J. Rogers, Treasurer; L. Steinberg, Asst. Secretary, and J. Vazifdar, committee member.

The Secretary immediately wrote to every London Hospital challenging them to matches in an effort to revive Inter-Hospitals Swimming which had lapsed during the war. It appears that most other hospitals are without teams, and very few answers were received. However, two matches have been played so far, one with Middlesex Hospital and the other with King's College. Both resulted in victory for the Bart's team.

*Match with Middlesex Hospital.*

For their first trial, the team challenged Middlesex Hospital to a swimming gala, consisting of races and a water-polo match. This was embarked on with no small trepidation, as Middlesex Hospital had a team of repute. To the cheers of Bart's supporters, K. R. H. Deane won the 100 yards free style, W. H. H. Deane the 100 yards backstroke, and L. Steinberg the 50 yards freestyle. Then the match started. Within one minute, W. H. H. Deane had scored a goal with a brilliant backflip. This must have disheartened our opponents and they were forced back on the defensive, where they remained until half-time, two more goals being scored by W. H. H. Deane after some very clever passing by the front line swimmers. After half-time, Middlesex attacked vigorously. Their forwards and the Bart's backs engaged in a fracas, and due mainly to the strenuous efforts of Steinberg, disaster was avoided. A Middlesex man was carried off groaning, and was later found to have ruptured one of his recti-abdominis, and another of their forwards almost had his eye gouged out! Play was resumed after a couple of minutes for the Bart's Secretary had to be treated for cramp after nearly drowning. . . . Orr-Hughes performed some very good tackles, and passed the ball to K. R. H. Deane, who scored. After another goal by the elder Deane, the remainder of the scoring was done by W. H. H. Deane, who once again demonstrated his prodigious throw from behind the half-way line. The match ended with Bart's winning 7 nil.

*Match with King's College.*

A large crowd turned up to watch this match. There was no racing, and after hunting around for a referee we began the game. The King's forward line, taking us completely by surprise, swept up the bath, and in a trice had won a goal against us. But not at all downhearted, the team followed their usual plan of action, and by a combination of fast swimming and passing at the right time and place, evened the score. Rosen in goal was excellent, and made some very good saves when the King's centre-forward shot many times at our goal. The second goal for Bart's was scored, when Sacks passed the

ball up to W. H. H. Deane, who was waiting at the opponents' goalmouth. Despite furious tackling by the enemy backs, Deane managed to score. After half-time, the match became fast and furious, and many penalties were awarded to both sides. Duckings became frequent, and the ball was only visible at times in the whirling spray and the thrashing limbs that caused tremendous excitement in the spectators. Our team's passing was brilliant here, special mention for Portelly, who, although out of training, played at a moment's notice, one of the regulars not turning up, and only the excellent swimming of the King's team saved them from a crushing defeat. Unfortunately, their forward line broke through, and due to fact that we were all strung out in a line, King's scored again despite our back's efforts. From then onwards the King's team showed signs of weakening, and as we pressed forward, forcing them back into their own side, K. R. H. Deane scored a third goal. During the last minutes of the match, Rogers and Steinberg managed to get the ball away from King's, and had not the whistle been blown too frequently, we might have scored some more, but the referee stuck to the rules, and even swimming over one's opponent was not allowed. The whistle blew just as Deane had his arm poised for what would have been a sure goal. . . . However, the match was ours. 3-2.

Bart's men turned up to support us, and this was very welcome, being a valuable adjunct to success. We would like an even greater support, particularly from the students in London who are able to get to the baths quite easily, for the more shouts of encouragement we hear, the more we will score! We want to have a season of successes—you can help us to accomplish this by your support.

## ROWING

In the Lent Races the 1st VIII rowed over against Jesus III each day, while the 2nd VIII succeeded in bumping Q.M.C.I. on the first day and rowed over on the remaining days.

The May Races (which were renamed "June Eights") were rowed in a clinker kindly lent by Corpus Christi College, after an unfortunate mishap on the river. The 1st VIII, despite this disadvantage, bumped Trinity Hall III in under-twenty strokes on the first day. On the last day, after a very close race between St. Catharine's II, Bart's I and Queen's II, we were bumped by the latter. The 2nd VIII bumped Sidney Sussex in ten strokes. The club broke training in the traditional manner on the Saturday evening.

The Inter-Hospital Regatta rowed at Putney in an Imperial College shell.

In the first heat Bart's was matched against Guy's and St. Thomas'. By strenuous rowing and strategic coxing Guy's celebrated their centenary in losing by three feet and St. Thomas' by three lengths over the mile course. In the final our opponent was Middlesex, who got off the start quickly and gained the lead, although Bart's was catching up rapidly towards the finish they passed the post half a length ahead. Thus the Pre-Clinical Eight succeeded in gaining second place in the Senior Eights event.



The Vice-President's Sculls Cup was rowed off at the end of last term. In the final H. S. Brown rowed over spectacularly against J. B. Coldrey, who offered stiff opposition, and only in the last few yards H. S. Brown drew ahead, finishing the course in 5 minutes 52 seconds.

## RUGGER

*v. King's College Hospital, at Chislehurst, on October 6th. Won 28—0.*

This was an auspicious start to the season, but, in fairness to everyone, it should be stated that the opposition was not so good as that which King's have produced in the past. Nevertheless, it was satisfying to avenge our defeat in the Hospital sevens last season.

Of last year's team, Gibson, Arthur Jones, Pitman and Matthews are no longer with us, so some re-organisation has been necessary. In this match Hawkes was at full back, D. I. Morgan was at stand off, Wright replaced Hawkes at scrum-half, Maitland was made Hooker, and Ralph Corbett played wing-forward again, the rest of the team being as last season.

Tries came steadily, and the only question was by how much we would win. The kicking was not good, or the score might well have been more. Tries were scored by Davy (2), Jukes, Kelly, Hacking, Morgan, Reiss and Smallwood, and Hawkes and Jukes each converted one.

*v. Old Blues, at Chislehurst, on October 13th. Lost 0—11.*

Kelly was unavailable, so Hawkes moved into the centre, and Roger Morgan came in as full back. The Old Blues were on the whole the better side, though the forwards held their own, and they had a real match-winner in D. L. Marriott, who scored a couple of real opportunist tries. Had we been a little quicker on the ball, and had the outsiders played together a bit more, the result might have been different.

*v. Middlesex Hospital, at Chislehurst, on October 20th. Lost 0—11.*

Middlesex were below strength for this game, and we were without Jukes, McMillan and Hacking, the last-named through injury. Unfortunately the referee was unable to come, and a last-minute substitute, though admirably impartial, was quite unable to control the game, largely due to lack of knowledge of any of the points, let alone the finer ones; thus it was that the match was very scrappy, glaring infringements being allowed. Neither side played well, but they took their opportunities with more ease than we did and ran out the eventual winners by two rather lucky tries and a goal to nil. This game was watched by two selectors, who must have gone away feeling very disgruntled.

*v. R.A.A.F., at Chislehurst, on October 24th. Lost 0—17.*

Getting a good side up on a Wednesday is never easy, and injuries to Davy and Kelly in the previous match didn't help, so with a rather depleted side we faced those very fit airmen from down under on a day when "gales and storms" were reliably reported to be raging throughout the length and breadth of the British Isles.

Playing with the gale, it would be inaccurate to say with the wind, in the first half we kept our opponents in their own half for most of the time, though on one of the rare occasions when they did attack they scored a try, mainly due to the grand way their

forwards backed up. Although we attacked for most of this time, we never managed to score.

In the second half, the position was reversed. They attacked and attacked, and gradually wore us down, until in the last quarter of an hour they were all over us with their quick passing movements, in spite of heroic defending by Bernard Reiss and Jock Smallwood, in particular though the whole side defended well. That they did not score more was in part due to their outsiders, who were not in the same class as their forwards, and were comparatively easy to stop once they got the ball.

*v. St. Mary's Hospital, at Chislehurst, on November 3rd. Lost 0—38.*

Injuries were still taking toll of the side, D. Morgan was in the centre with Jukes, Hawkes was scrum-half, and Wilkinson was at stand-off, the wings being Robin Jones and Hacking. This game was a repetition of the previous one, though on a rather grander scale, as the score shows. In the first half we held our own, but the speed and skill of the Mary's outsiders coupled with the intelligent play of their forwards, who when they have the ball almost invariably do something with it, told in the second half, and the score began to pile up. Tackling was bad, and time and again their centres, Bennett and Pritchard, were able to break through, while Peter Graham on the wing made the most of the many opportunities that came his way.

*v. Cambridge University, at Chislehurst, on November 7th. Lost 0—30.*

The inability of some to get away on a week-day, coupled with further injuries, made our side look very strange on paper, and we weren't helped by losing Wilkinson in the first ten minutes, although he pluckily tried returning to the field several times before finally being carried off, and D. Morgan, who managed to keep going for quite a while in an "acerebrate" condition before eventually going off. This meant bringing two forwards into the three-quarters, with Lindsay Corbett moving to the stand-off position, while of the remaining six forwards, Jock Smallwood was a passenger for three-quarters of the game with a damaged ankle.

Once again the second half proved our undoing, and the fast and fit Cambridge side were constantly attacking in our half, and, as the score shows, constantly crossing our line, in spite of the defence, which, though it never actually cracked, seemed to be a bit bewildered and certainly was outnumbered.

*v. London Hospital, at Hale End, on November 10th. Lost 5—6.*

The word injuries must recur in these accounts, as they have figured so largely in our team this year, but for this match they must surely have reached a climax—the team consisted of nine A XV men, and only six regular 1st XV men, the injured including Richards, Wilkinson, D. Morgan, Smallwood, Hawkes, Roger Morgan and Buchanan.

However, we were undaunted, and playing for the first time in wet conditions, the forwards acquitted themselves well, and for once the three-quarters were playing well together and always looked dangerous, but the opposing forwards were rather bigger and faster and got the ball from most of the scrums and line-outs. Our try was a direct result of a breakthrough by Jukes, who sent a perfect pass to Kelly, who instead of passing out to his wing, Robin Jones, suddenly changed direction, got the opposition on the wrong foot and scored under the posts, Jukes kicking the goal.

Davy on the left wing always looked dangerous, but his knee prevented him from really moving as

fast as we know he can. H. Evans played a sound and at times brilliant game at full back, and Dale and Wright combined well at half-back. This was an encouraging match, and it is to be hoped that our misfortunes are nearing their end, and that we may soon start vying with the "A" XV, who are as yet undefeated.

## ATHLETICS

The club on the whole had a very good season. Although not winning many matches, it made some spirited and enthusiastic attempts, and on several occasions won the admiration of its opponents.

The club turned out two teams for the Inter-Hospitals Cross-Country Running Cup (Kant-Hughes Cup). The first team won second place and the second team third place. Only once before in the annals of cross-country running has one hospital been represented by two teams—and that was a Bart's effort.

In a match against Middlesex in March we lost by only 2 points.

In the Inter-Hospitals Athletic Championships, held at Parliament Hill Fields, the Hospital team won third place—an improvement on last year's perform-

ance.

The most outstanding runner in our team was A. E. Fyfe, who was captain of the London University and Tyrian Clubs. He also ran for the English Universities and for the A.A.A. Fyfe was captain of the Bart's Club for the year 1944. He won many cups in the June sports.

The present captain, K. M. Backhouse, has been running well for the last few years for the United Hospitals Hare and Hounds, for the Tyrian Club and for Barts. in cross country as well as athletics. He won the mile and the half-mile in the Bart's Sports.

M. E. Glanvill, the present assistant secretary, ran for the Tyrian Club, United Hospitals and Bart's throughout the season. He was the cup for the three miles at the Bart's Sports. He is the present secretary of the United Hospitals Hare and Hounds Club.

N. E. Winstone has run for the United Hospitals and Tyrian Club on several occasions, gaining many valuable points for the hospital, and has given great support to the club.

Honours colours have been awarded to:—

A. F. FYFFE.  
K. M. BACKHOUSE.  
M. E. GLANVILL.

## ANNOUNCEMENTS

### THE ABERNETHIAN SOCIETY

The following meetings have been arranged for the session:—

December 13th. Flt./Lt. Jenkes, "Modern Malaria Research."  
January 17th. Professor Samson Wright, "Experimental Hypertension."  
February 21st. Mr. R. Ogier Ward, Esq., M.Chir., "Three Wars are Enough."  
March 14th. Dr. E. Arnold Carmichael.  
April 5th. Dr. E. Muir, "Leprosy."

### CHANGES OF ADDRESS

Col. R. A. MANCELL, R.A.M.C. to Health Department, Allied Commission, Austria (British) C.M.F.  
JOHN HOLMES, to 26, Albert Road, Southport, Lancashire.

### CORRECTION

Mr. L. E. McGee has been appointed ASSISTANT EDITOR of the JOURNAL and NOT EDITOR, as was wrongly stated in the December issue.

## RECENT PAPERS BY BART'S MEN

ABRAHAMS, Sir A. "Diet and Physique." *Practitioner*, December, 1945, pp. 370-377.  
BRADLEY-WATSON, J. (and Jones, P., and Bradbury, E. B.). "Health of Prisoners of War Evacuated from Hong Kong." *Lancet*, November 17th, 1945, pp. 645-647.  
EDWARD, D. G. FF. (et. al.). "Scrub-Typhus Vaccine." *Lancet*, December 8th, 1945, pp. 645-647.  
LEACOCK, A. "A Case of Chronic Undermining Ulceration Treated with Penicillin." *Brit. Med. J.*, December 1st, 1945, pp. 765-766.  
MANCELL, R. A. "New Lamps for Old?" *J. Roy. Army Med. Corps*, November, 1945, pp. 224-227.

ROBB-SMITH, A. H. T. "The Skin and the Reticular Tissue." *Brit. Med. Bull.*, Vol. 3, No. 7-8, pp. 172-175.

VARTAN, C. K. "The Behaviour of the Foetus in Utero." *J. Obst. and Gynaec. Brit. Emp.*, October, 1945, pp. 417-434.

WARREN, W. (and Mallinson, W. P.). "Repatriation: A Psychiatric Study of 100 Naval Ex-prisoners of War." *Brit. Med. J.*, December 8th, 1945, pp. 798-801.

WEDDELL, G. "The Anatomy of Cutaneous Sensibility." *Brit. Med. Bull.*, Vol. 3, No. 7-8, pp. 167-172.



**EXAMINATION RESULTS**  
**UNIVERSITY OF LONDON**  
**THIRD (M.B., B.S.) EXAMINATION, OCTOBER, 1945**

**HONOURS**

Watts, R. W. E. (Distinguished in Hygiene and Forensic Medicine).

**PASS**

|                   |                  |
|-------------------|------------------|
| Austin, R. N.     | Hogben, B. H.    |
| Caine, M.         | Sanger, C.       |
| Guillem, V. L.    | Youngman, R.     |
| Robinson, K. W.   | Bond, G. E.      |
| Wetherhead, A. D. | Dunlop, E. M. C. |
| Banaji, P. B.     | Holgate, J. E.   |
| Clarkson, K. S.   | Sharrod, F. J.   |

**SUPPLEMENTARY PASS LIST****Part I.—**

|                    |                      |
|--------------------|----------------------|
| Ballantyne, P. T.  | Lawrance, K.         |
| Chamberlain, G. B. | Newcombe, C. P.      |
| Fox, R. H.         | Pugh, J. L.          |
| Jordan, P.         | Molesworth, P. R. H. |

|                    |
|--------------------|
| Murley, A. H. G.   |
| Pearce, C.         |
| Williams, J. R. B. |
| Banks, P. J.       |
| Davis, P. R.       |
| Fyfe, A. E.        |

**Part II.—**

|               |
|---------------|
| Batten, J. C. |
| Pugh, D. E.   |
| Cooper, B. S. |

**Part III.—**

|                  |
|------------------|
| Backhouse, K. M. |
| Jordan, J. W.    |
| Peck, I. A. W.   |
| Timmis, P.       |
| Cocks, R. A.     |
| Osborn, T. W.    |

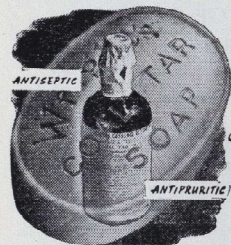
|                       |
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| Blackledge, P.        |
| Dawson, D. A.         |
| Gardiner, H. T. R. G. |
| Millichap, J. C.      |
| Paros, N. L.          |
| Rogers, J. C.         |

|                   |
|-------------------|
| Watt, I. G.       |
| Lewis, B.         |
| Williamson, T. B. |

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| Rémy, M. F.      |
| Warren, H. de B. |
| Hunter, R. A.    |
| Pearce, C.       |
| Taylor, T.       |
| Wince, W. H. D.  |

**CONJOINT BOARD****PRE-MEDICAL EXAMINATION, DECEMBER, 1945**

Physics—Gravelle, E. S. L.  
Biology—Wyner, S. E. A.



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
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