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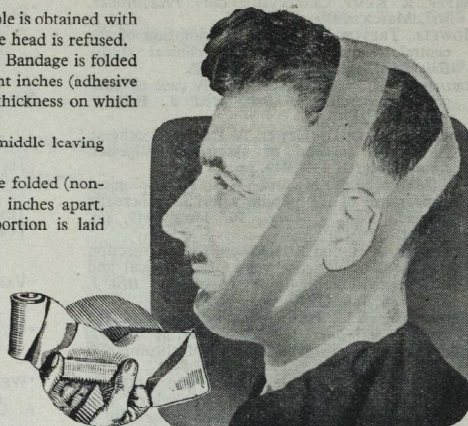
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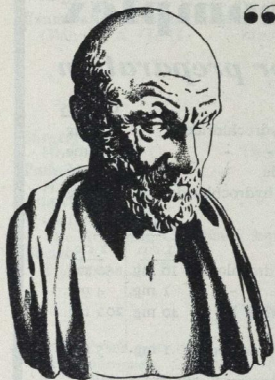
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ST. BARTHOLOMEW'S



HOSPITAL JOURNAL

Vol. LIII

JULY, 1949

No. 7

MEDICINE IN MUSIC

"Music can soften pain to ease"—so said Pope and so in a rather more prosaic manner say two dental correspondents in a recent number of *Anæsthesiology*. The horror of attending the dentist can it seems be relieved by the discreet application of a few bars of well-chosen music. Gone is the proverbial picture of the dentist as a medium through which all the most refined tortures of Hell are administered to the defenceless patient. Now we see him as a genial musician chatting airily upon the therapeutic qualities of Mr. Beethoven or Mr. Crosby. The contention put forward by these two correspondents in short is this—the amount of nitrous oxide and its attendant oxygen deprivation, prevalently practised we learn in dental anaesthesia, can be reduced by the judicious use of music. It appears that the most effective pieces have "... a smooth, even tone and contain no harsh or startling instrumentation." Debussy's *Clair de Lune*, Beethoven's *Moonlight Sonata*, Humperdinck's *Dream Pantomime*, Wagner's *Forest Murmurs* and *Evening Star* and Fibach's *Poème* are all recommended for their analgesic qualities. The advantages claimed for this delightful addition to the anaesthetist's art are that it abolishes retching and vomiting whilst at the same time facilitating recovery from the anaesthetic. One may well wonder why Mr. Frank Sinatra has no place in this impressive selection; an explanation may be sought in the fact that Frankie apparently needs no assistance from nitrous oxide to reduce his admirers to a comatose condition—and after all even anaesthetists must live.

But not only is the patient entertained with quiet music, he has at hand a remote volume control to while away his anxious moments.

Such consideration is worthy of all the great traditions of medicine. Who amongst us is not delighted with a knob or two upon which to exercise the vagaries of a twiddling nature? Indeed under such circumstances it becomes a matter of urgent necessity, for not to do so would land one back in the painful realities of the dentist's hands. "Let me die to the sound of delirious music," said the poet; if we could but resurrect him we could now lead him to the dentist's chair with the assurance that he might die a hundred such deaths whenever he so chose.

If we trace the history of music and medicine through the ages a truly remarkable revelation of its powers becomes apparent; symptoms of the most diverse nature are all vulnerable to its healing qualities. Aesculapius cured his patients with soothing songs says Pindar. What he cured or sang is unfortunately not recorded; one can but hope he had a medicinal voice of tolerable quality, for even the most abject of patients will jib at the more painful treatments. Theophrastus was of the opinion that music was a capital cure for gout and was specific against the bite of vipers. He had not, one imagines, suffered from either, and his guess after all was as good as the next man's. Cato maintained that music was good for limbs out of joint and there is no doubt that such treatment would be well appreciated nowadays by the hospital staff if not by the patients. Under such circumstances the question of holding the orthopaedic clinic at 11 a.m. in the refectory would merit serious consideration. In their delicate manners both Shakespeare and Boyle agree that music exercises a beneficial effect *super vesicam*.

It is however to Dr. Burney and his "History of Music" that one must turn to obtain an extensive review of the beneficial effects of music on diseased organs. According to this knowledgeable author "... it relieves the pain of sciatica," independently he adds of the skill of the player. "By flattering the ear, diverting attention and occasioning certain vibrations of nerves, it can remove those obstructions which cause the disorder." He even attests that it cures or ameliorates deafness. His illustration of this point however demands a considerable degree of gullibility, for he tells of one patient who could only hear when a drum was beating. To this end he employed a drummer as background music whenever he wished to enjoy the pleasures of his wife's conversation. Such incredible waywardness is a little difficult to understand. It is hard to believe that Dr. Burney has not embellished the tale for the benefit of his feminine readers, and if the truth be known it more probably served to protect the patient from a garrulous wife.

The Romance of Music in Medicine is however most forcibly brought home in a fascinating book, *Curiosities of Literature*, by Disraeli (the P.M.'s father). Here the author gives a very convincing record that Pavlov and his dogs were some 100 years behind the times and conditioned reflexes of much older vintage.

It seems that a worthy by the name of Pellison had the misfortune to be locked away in one of the less salubrious French

prisons. Here he managed to bribe the warden to obtain the services of a bagpiper to while away his enforced leisure. Another of the inhabitants of the cell in the form of a large black spider also appeared to enjoy the skirl of the pipes, for in a burst of scientific anticipation Pellison had this spider trained after several months of regular exercise—time was no object—to advance smartly at the sound of the pipes, fetch a dead fly which Pellison had placed upon his knees and return once again to its lair before devouring it. This exercise it performed only to the music of the pipes; at other times it remained stolidly indifferent to any friendly advances made by Pellison. It is only to be regretted that the hero had not the presence of mind to change the key of the bagpiper's instrument; he might then have been able to make a close study of a neurotic spider. The psychologists might try to explain the whole episode by a factor of secondary gain or "cupboard love" on the part of the trainee. This may be true, but then so it was with Pavlov and he must regretfully (this column always had a sneaking regard for Pavlov) give pride of place to the unsung Pellison from a French prison.

Unfortunately times have changed; spiders and bagpipes no longer play a part in physiology. It is heartening however to learn that music can still hold its own in these days of scientific scepticism.

ANNOUNCEMENTS

MARRIAGE

DOSSETOR—DAVIS. On January 12th, 1949, at Holy Trinity Church, Brompton. Andrew, younger son of the Rev. and Mrs. F. F. Dossetor, of Bromham Rectory, Wilts. to Jill, younger daughter of Mr. and Mrs. K. J. Acton Davis, of Bradfields, Stockbridge, Hants.

APPOINTMENT

Dr. Donald Crowther has been appointed an Assistant Editor of the Abstracting Service of the B.M.J.

THE JOURNAL

Contributions must reach the Editor before the first Tuesday of the month for inclusion in the following number. Anonymous and pseudonymous matter will not be considered unless accompanied by the author's name and address.

THE TREATMENT OF SCHIZOPHRENIA

By E. B. STRAUSS, D.M.(Oxon). F.R.C.P.

The title of this article gives rise to the same philosophical difficulty as does any title indicating that it is concerned with the treatment of a *disease*. The concept of disease, a nosological entity existing *in vacuo*, belongs to the realm of abstract ideas. Strictly speaking, there is no such *thing* as pneumonia, there is only the spectacle of a total living being reacting in a certain type of way to the invasion of pneumococci or other micro-organisms. What we call symptoms are, as often as not, positive attempts of the "sick" individual to adjust to the new situation. It is only when the total organism overdoes things in such a way that the new adjustments alter the total psycho-somatic situation in such a way that it never has time to catch up, before violent new adjustments are called for, that symptoms require to be treated. If it is important, in general medicine, to establish the principle that a physician treats a patient and not a disease, it is doubly necessary in psychiatry, a branch of medicine in which the very categories with which one deals are difficult to classify.

Another important principle in psychiatric methodology is that of multi-dimensional aetiology: in considering a psychic disorder a psychiatrist must ask himself to what extent does each of the following factors contribute to the type of reaction-formation which he is called upon to diagnose and treat—(1) psychic, (2) somatic, (3) constitutional and genetic, (4) social; and how do they interact?

It is a mistake to consider schizophrenia as though it were a single, compact disease-entity; it is more correct to talk of the schizophrenias, in the plural, in the same way as the modern neuro-psychiatrist talks of "the epilepsies" rather than of epilepsy. The term schizophrenia is derived from two Greek words—*σχίζειν* to split, and *φρήν* one of the many words for the mind; it thus indicates the cardinal morbid principle in all forms of the disorder, namely a splitting of the mind, or a fragmentation of the personality.

The principle of multiple aetiology is well illustrated in schizophrenia.

(1) PSYCHIC

The psychoanalysts maintain that schizophrenia is a psychogenic disorder, depending on a fundamental fixation of the libido at the Narcissistic level of development, i.e. that,

in the last analysis, a schizophrenic, even before his psychosis develops, is incapable of directing his sex-derived emotions otherwise than onto an image of himself or a substitute-image. The analytical psychologists (Jungians) believe that in schizophrenia there is such a profound failure to achieve integration of the personality that the most archaic psychic elements (the Collective Unconscious) spill over into consciousness, making it difficult or impossible for the patient to distinguish fantasy from reality. However true these psychological concepts may be, they are little better than more or less convenient "shorthand" accounts in analogical terms of what may be happening at certain "levels" of psychic experience. Moreover, Freud himself had the wisdom to counsel against the psychoanalytical treatment of schizophrenia—in fact, he was opposed to the use of the psychoanalytic method in all forms of established psychosis.

(2) SOMATIC

The types of physique associated with schizophrenia will be discussed under the next heading. Here it may be said that evidence is accumulating to show that, in the case of male schizophrenics, there is a fundamental failure in the proper development of certain essential elements of the testes, or a definite testicular abiotrophy. It seems likely, however, that this and other somatic anomalies may depend on a more fundamental type of pituitary dyscrasia. In certain forms of the disorder, especially in hebephrenia, the circulatory system is poorly developed, even to the extent of cardiac hypoplasia. The poor peripheral circulation of schizophrenics is often shown by cyanosis of the extremities, including the nose. It has been claimed by some that fibrous changes are found in the thyroid gland in schizophrenia, although it is possible that these changes are due to tuberculosis, a disease to which schizophrenics succumb easily. However that may be, a schizophrenic illness known as periodic catatonia is associated with a grossly defective nitrogen catabolism, and responds successfully to treatment by large doses of thyroid extract.

(3) CONSTITUTIONAL AND GENETIC

It is a well established fact that persons with a certain kind of inborn temperament are more liable to exhibit the schizophrenic

type of reaction-formation, if they should become psychotic. Moreover, there is an affinity between temperament and body-build; in other words, physique and temperament represent a man's inherited constitution. To employ Kretschmer's terminology, the kinds of physique which are apt to be associated with schizophrenia are the *leptosomatic*, the *athleticosomatic*, together with various forms of dysplasia. The kind of pre-psychotic temperament exhibited by schizophrenics is, as often as not, schizothymic. The reader who is unfamiliar with typological psychology and psychiatry will find these ideas fully worked out and described in Kretschmer's "Physique and Character" and in his "Textbook of Medical Psychology." Here it must suffice to say that leptosomatics are of slender build, athleticosomatics are, roughly speaking, of the heavyweight boxer type of physique, and that a schizothymic person is predominately quiet, reserved, sensitive, introverted and, in extreme cases, shut-in. Little of positive value is as yet known about the genetics of schizophrenia, but it can be stated with some certainty that factors of inheritance play their part in schizothymia (a normal temperamental variant), schizoid psychopathy and schizophrenia.

(4) SOCIAL

It is becoming increasingly hard for introverted schizothymes to adjust to a pattern of culture which is coming to insist more and more on extraverted patterns of thought, feeling and behaviour. Every one today is expected to be tough, "practical," "realistic," and a "good mixer." This is no world for the dreamer or poet. We must all be prepared to tell our life-histories in a third-class railway carriage, and to be "the life and soul of the party." When the outside world impinges too heavily on the sensitive type of schizothymic, he is apt automatically to beat a retreat into a cocoon of his own weaving. When he begins to find difficulty in distinguishing between the realities of his interior world and those of the world outside himself it is then that the personality-structure begins to show signs of cracking or splitting. Common parlance, which is derived from common experience, always has some light to throw on scientific psychiatry; and the term "cracked" is a singularly happy one. A schizophrenic is essentially "cracked"; but fortunately, as we shall see later in this article, much can be done nowadays to cement up the cracks, provided that they have

not led to a complete fragmentation of the personality.

Let us briefly consider an individual case-history, in order to see how the above-mentioned aetiological factors interact and interpenetrate: Walter Z. is aged twenty five and was discharged from the Brigade of Guards on medical grounds. The symptom-picture is as follows: He sits gazing into space. Every now and then he smiles foolishly to himself. He sometimes turns his head sideways, as though he were listening to someone, and starts talking to himself. He says that he is called upon to set up the New Jerusalem and establish the reign of peace on earth. Nevertheless, according to his parents, he is sometimes violent, and quite recently, on impulse, half-strangled his mother, of whom he used to be very fond, but towards whom he now adopts a most hostile attitude. He is a lanky, long-legged man of extremely youthful appearance. His fair hair, *en brosse*, grows low on his forehead. His nose is small and snub, his chin somewhat receding. He was a docile, almost a model, child, quiet, studious and fastidious. In the early days of the war he was a conscientious objector, but quite suddenly one day informed his astonished parents that he had resolved his doubts and had decided to join the Brigade of Guards. No other Unit would satisfy him. . . . On his return from the Middle East he became very friendly with a girl, for the first time. He never asked the girl to marry him, but nevertheless, regarded her as his fiancée. When this girl subsequently announced her engagement to somebody else, Walter began to exhibit unequivocal signs of schizophrenia—assaulting a sergeant and then bursting into tears. The family history is not too good from the psychiatric point of view: his father is moody and quick-tempered. His mother is a rather crushed little woman. One of his sisters is in a mental hospital with what she calls "religious mania." One of Walter's first cousins on the paternal side was invalidated out of the W.A.A.F.s on account of "nerves."

In this typical case of schizophrenia all four groups of aetiological factors are well-represented: the main psychic factors are his incompletely resolved conflict in the matter of his active participation in war, and his inadequate response to the challenge of love and sex. The somatic constitutional factors are exhibited in his physique and temperament—leptosomatic, with a tendency to

elongated eunuchoidism, and schizothymic. It is also noteworthy that he had infective jaundice some weeks before his "nervous breakdown." The genetic factors are brought out in the family history. The social factors are clearly important in so far as the Brigade of Guards provided a most unsuitable environment for a young man of Walter's disposition; moreover, sensitive types of schizothymes, like Walter, find it difficult to adjust to the idea and fact of war in any case.

It might be thought that, since so much appears to be known about the aetiology of the schizophrenias, treatment would be quite clear-cut and specific. However, this is far from being the case. The treatment of schizophrenia is essentially empirical and symptomatic. Since most schizophrenics find difficulty in distinguishing fantasy from reality, and are hence unaccountable and impulsive, it is usually necessary to conduct treatment in a mental hospital environment. Nevertheless, in many cases it may be impossible to grant a certificate, the relatives may refuse to act as petitioners, the patient may be unwilling to apply for admission as a Voluntary Patient, or it may be thought that a mental hospital environment might react unfavourably on a certain individual; in those and similar cases, treatment will have to be conducted under out-patient conditions.

"Shock" Therapy

(a) *Hypoglycaemic Coma Treatment.* This is a form of treatment which requires a trained medical and nursing team to be safe and effective. It can, therefore, be undertaken only under in-patient conditions in a hospital (usually a mental hospital). The technique is complicated and tricky, and unsuitable for description here. Roughly speaking, it may be said to consist of the induction of hypoglycaemic coma on five or six mornings a week over a period of some three months. If the illness is treated in this way within six months of its onset, some fifty per cent. of complete or social remissions may be anticipated. If the condition has persisted for more than eighteen months, the results of hypoglycaemic coma treatment are apt to be disappointing.

(b) *Electroplexy* (Electrical Convulsant Therapy). As the result of an extensive statistical survey conducted in the U.S.A., Electroplexy has dropped out of favour as a form of treatment likely to produce good, permanent results in schizophrenia, although it has remained the specific form of therapy

in the affective psychoses. Yet there is much to suggest that Electroplexy still has its part to play in the treatment of schizophrenia. The special circumstances which justify its trial are (i) when, for any of the reasons given above, in-patient treatment in a hospital equipped with the facilities for hypoglycaemic coma treatment is contra-indicated or unobtainable. (ii) When the disease has been present for a long while (with or without dementia), it is often possible to bring about a symptomatic improvement by repeated courses of Electroplexy, separated by intervals of from one to three months, even when insulin therapy has been tried and failed. (iii) Certain cases of severe obsessional neurosis complicated by hallucinations occurring in pre-pubescent children (usually diagnosed as juvenile schizophrenia) have been known to make an easy and uncomplicated recovery after out-patient Electroplexy. The problem of providing suitable residential accommodation for juvenile psychotics is unsolved in this country: so Electroplexy still has its uses in the handling of this type of case.

Electrocoma (Electronarcosis)

In this form of treatment a state of unconsciousness is induced and maintained for a period of seven minutes or more by the passage of an electric current through the anterior parts of the frontal lobes trans-frontally. The usual form of current is a sinusoidal wave-form produced by a stabilized alternating current, but the present writer is experimenting with other wave-forms. He believes that it is still too early to pronounce on the value of this form of treatment in any kind of mental disorder, but he has had a few striking successes in cases of early paranoid schizophrenia and in the obsessional variety of the disease. If, with improved technique, therapeutic results comparable to those obtained with hypoglycaemic coma treatment could be claimed for Electrocoma, we should have at our disposal yet another form of treatment for the mental disorder adaptable for out-patient use.

Pre-frontal Leucotomy

It would be a mistake to regard this neuro-surgical procedure as a routine method of treatment in schizophrenia. There is, however, a distressing tendency in certain mental hospitals to go through a kind of drill: if a schizophrenic patient fails to benefit from insulin coma, the treatment is combined with

Electroplexy. If this fails, the patient's brain is pithed.

If this practice continues, the mental hospitals will soon be filled with enormously fat, easy-to-manage human vegetables, demented before their time, who have not been given their chance to enjoy the possibility of spontaneous remission. Undoubtedly, however, as the records of Crichton Royal and other treatment centres show, pre-frontal leucotomy has an important part to play in the treatment of properly selected cases of schizophrenia. Ruminating schizophrenics who are tormented by hallucinations and delusions, but with an otherwise well-preserved personality-structure, respond best, even when other methods of treatment have failed. What is not quite so well recognized is that the subsequent social and psychiatric rehabilitation of the patient is of as much importance as the surgical procedure itself. This should take anything from six months to one year and can only be carried out to a successful conclusion in adequately staffed and properly equipped hospitals.

Occupational Therapy and Physical Training

Any form of procedure, which helps to direct a schizophrenic patient's gaze away from the interior psychic landscape and towards the realities of the external world is of primary importance in the treatment of the disorder. It may be said that the introduction of these methods brought about a greater revolution in mental hospitals than any other therapeutic advance. The present writer can still remember visiting old-fashioned lunatic asylums populated by literally hundreds of apparently demented patients sitting in various statuesque attitudes, or rocking to and fro all day, or performing endless repetitive antics. There is no excuse nowadays for this sorry spectacle. A large proportion of even partly demented schizophrenics can be taught a useful occupation which, in many cases, not only leads to a social recovery but assists the total economy of the institution. In the same way, by means of physical training, almost stuporous catatonic patients can be made to re-acquire the zest of using their bodies as they are meant to be used. Nowadays, one can see a company of schizophrenic patients drilling, if not as well

as the Brigade of Guards, yet as well as the Home Guard. Of course, infinite patience by a staff of specially trained instructors is required, if these desirable results are to be obtained.

Therapeutic Social Clubs

Many progressive mental hospitals have started social clubs both for their resident patient and for their out-patient population. This is not the place to give even a brief account of this form of social therapy. However, it should be evident that any attempt to re-socialize patients who have taken refuge deep inside themselves and who are existing on their own psychic break-down products is therapeutically useful.

Psychotherapy

Although, as already indicated, psychoanalysis is not recommended in schizophrenia, yet, many forms of psychotherapy are of incalculable value in the case of certain patients with a well-preserved personality-structure. If one is prepared to devote endless time to an individual patient, it is surprising how, by simple conversational methods, the patient's intellect can be re-educated to become once more the conductor of the psychic orchestra. For example, it has often happened that the present writer has enabled a paranoid schizophrenic or paraphrenic patient to lead a substantially normal life by persuading him to accept and be governed by the following formula: "although I am persuaded that the voices that I hear are real, and that my suspicions are justified, in spite of what the doctor says to the contrary; yet I am going to order my life as though he were right and I were wrong." In many cases, also, ordinary intelligent conversations about anything other than the patient's illness—history, politics, religion, games and sports, theatres and cinema—carried on *as between equals* can often yield big dividends in the long run.

Even from this very brief survey of the treatment of schizophrenia, it will be seen that we are by no means therapeutically bankrupt as regards this dread form of mental disorder, which until recently was approached with fatalistic pessimism.

[Reprinted from the *Medical Press*, No. 5740 (May 11th, 1949), by courtesy of the Editor.]

EXHIBITION OF MEDICAL PHOTOGRAPHY

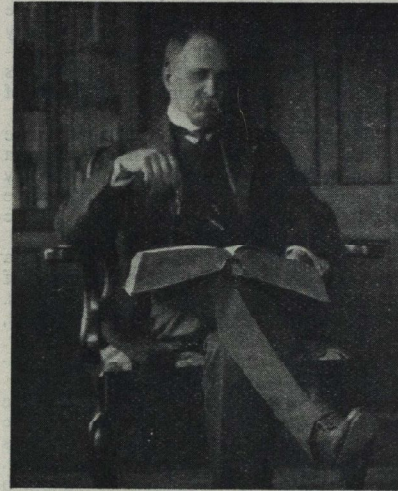
An exhibition of medical photography will be held by the Medical Group of the Royal Photographic Society at the Society's House, 16, Princes Gate, London, S.W.7, from July 4th to 16th inclusive. The exhibition will be open from 10 a.m. to 5 p.m. and admission is free.

SIR WILLIAM OSLER

July 12th, 1849—December 29th, 1919

"He was a great and rare man fit to be propounded for an example to after ages."

—P. GASSENDI, *Life of Petresk*.



"WHAT will it help me after my death," wrote the practical Thomas Sydenham, "for the eight letters which make up the name of Sydenham to pass from mouth to mouth among men, who can no more form an idea of what I was than I of what they will be?" The life of Osler, by Harvey Cushing, gives Sydenham an answer to his attack on history. One of the truly great biographies in literature, in its pages the men of after-ages will discover Osler and his companions and his way of life. His interests and his influence live here and will continue to live and to inspire and to uplift the spirit of the reader as long as the printed word is read. De Bury, the book-lover, is more apt than Sydenham. "In books I find the dead as if they were alive."

In this month that marks the hundredth anniversary of Osler's birth, why should we remember him? Mindful of Sir Thomas Browne's warning—"every man is not a proper champion of truth, nor fit to take up the gauntlet in the cause of verity"—the author's wisest advice would be—"Go and read Harvey Cushing. See for yourself the measure of the man. And then read some of

what he wrote. If an aeroplane flight over the delectable mountains of medical history appeals, read 'The Evolution of Modern Medicine' and the essays in 'The Alabama Student.' Is it books that hold you in thrall? Do you intoxicate to the delicate aroma of old calf and of the dust of libraries? Then contemplate the majestic plan of 'Bibliotheca Osleriana,' the catalogue of Osler's own collection that is more than a catalogue, revealing a man and his books and what they meant to him. Do you need a dose or two of philosophy of living? Then a course of 'Aequanimitas' would be the very prescription."

Perhaps this slender centennial tribute may whet the reader's appetite to ask for more. William Osler was born on July 12th, 1849, at Bond Head, in Canada—"born seventh in a missionary's family, in the backwoods of Ontario with twins ahead." His father, the Rev. Featherstone Osler, had emigrated from Falmouth with his newly married wife in 1837. After a childhood spent in the stimulating surroundings of a developing community, happy, busy and not lacking its escapades, he went in 1866 to Trinity College School, Weston, where he came under the influence of the first of the three teachers who meant so much to his student life. The Rev. W. A. Johnson—Father Johnson—warden of the school, was a keen field naturalist of the Gilbert White type, who spent whole days out in the country collecting and sketching, and whole evenings in preparing and mounting microscope slides. Here was encouragement for Osler's natural bent for observation and a beginning of his lifelong interest in the protozoa.

In due time Osler passed to Trinity College, Toronto, to the charge of Dr. James Bovell. A doctor with a broad philosophical outlook, his was a stimulating personality, diffusing its interests too widely for accomplishment, but able "to talk pleasantly upon anything in the science of the day from protoplasm to evolution." Bovell held his pupil in high regard, taking him to live in his house and granting him the precious privilege of freedom of the library—"the best the human mind has afforded was on his shelves." Here the young Osler browsed among the green pastures of English literature, and here he turned from

the idea of entering the Church towards medicine.

In 1870, at the age of 21, he entered McGill University and the orbit of the third of his triumvirate of teachers, Palmer Howard, Dean of the Medical Faculty. "With him," wrote Osler, "the study and the teaching of medicine were an absorbing passion." In the Summer of 1871 the problem of tuberculosis was under discussion, stirred up by the epoch-making work of Villemin (1864) on the transfer of tuberculosis. "Every lung lesion at the Montreal General Hospital had to be shown to him . . . an ideal teacher because a student, ever alert to the new problems." Palmer Howard believed in Osler, encouraging him to continue in academic study and helping to secure his first McGill appointment.

His official education over, Osler travelled to London at his brother's invitation and for 15 months worked in Burden Sanderson's laboratory at University College, studying among other things the microscopic appearances of blood and especially of the third corpuscle of the blood, the blood platelet. Although he did not discover these elements Osler was the first to watch them closely. Abandoning the idea that they might be bacteria, he realised their relationship to the clotting of blood. There followed six months in Berlin and Vienna, at that time dominated by Rokitansky and the morbid histologists. After a short spell in London to polish his laboratory studies, which were communicated to the Royal Society by his Professor in 1874, he returned with cobwebs in his pockets and no immediate prospects to Canada.

The Medical Faculty of McGill to their credit rose to the opportunity and offered Osler on his return the Lectureship of the Institutes of Medicine (Physiology). With some misgivings, because didactic lectures were to be given and he had only hoped to be assistant, Osler accepted. The next year (1875) he became Pathologist to the Montreal General Hospital with charge of the post-mortem room, and he started a medical society for the discussion of cases. Now he had his opportunity to make those careful post-mortem studies on which his medical work was so securely based. As he wrote in his M.D. thesis (unpublished): "To investigate the causes of death, to examine carefully the conditions of organs, after such changes had gone on in them as to render existence impossible and to apply such knowledge to the prevention and treatment of disease, is

one of the highest objects of the Physician."

And so the young professor is successfully launched—"if success means getting what you want and being satisfied with it"—on a career that will take him in 1883 to the chair of medicine in the University of Pennsylvania, now an F.R.C.P. of London, in 1887 to be the first professor of medicine in the newly founded Johns Hopkins Hospital in Baltimore, and finally in 1905 to the Regius Professorship of Physic in the University of Oxford.

Mark in his training the powerful influence of serious men, men with hobbies and a keenness for hard work, for orderly study and, not least, men prepared to develop the minds and characters of their pupils. These lessons Osler learned well.

He was above all things a teacher and a server of his fellow men. He left a trail of devoted students and worshipping patients. Medical societies, student and post-graduate, for medical and for medico-historical study, bloomed under the warm sun of his personality. His house in Baltimore, like 13, Northham Gardens, in Oxford, earned the name of "The Open Arms," and in each place "latch-keys," the favoured among his students, had the run of house and library. Editors and secretaries of societies found him ready of pen and speech, and he could be relied on to support promptly subscription lists for the hard hit and the retiring.

Many of Osler's addresses to students and nurses have been published in "Aequanimitas" and "The Student Life." His manner had nothing in it of the orator's arts, but his words and thoughts were simple and his speeches were inlaid with gems from the books that he read. His own advice is often expressed in sentences that stick. Of medical reading he wrote: "Read with two objects: first to acquaint yourself with the current knowledge on the subject and the steps by which it has been reached; and secondly, and more important, read to understand and analyse your cases." He himself always read notebook in hand, jotting down quotations that appealed to him and the ideas to which they gave rise. The newly qualified should "try in the waiting years to get a clear idea of the history of medicine." Osler usually had some piece of historical work in hand and he saw in history not antiquarian interest so much as the proper approach on humanistic lines to a body of knowledge and practice that was ever changing and ever growing.

He had in his dining-room a library of reference books—the D.N.B., the Library Catalogue of the Surgeon-General's Library, biographical dictionaries—and this he called the "flighty purpose library" because "the flighty purpose never is o'ertook unless the deed go with it"—vital advice to anyone who tries to "live in day-tight compartments."

He always read in bed for half an hour at night, never professional reading and often from his bedside library of old friends. Sir Thomas Browne, Burton, Montaigne, Rabelais, Plato, Oliver Wendell Holmes. Browne occupied a special place in his affections and the *Religio Medici* was his life-long companion. Burton's "Anatomy of Melancholy" was a favourite to dip into and a typical act of Oslerian piety was to gather together in the library of Christ Church the books left by Burton to the College. But he worked hard for the Bodleian as for all the libraries with which he came in contact.

Osler's medical writings (the first incomplete bibliography recorded 730 articles) contain no important original discoveries. He first described polycythaemia rubra vera and he spread to the profession a wider knowledge of bacterial endocarditis and of hereditary telangiectasis as well as much that was thought-provoking about tuberculosis and typhoid fever. The "Text Book of Medicine," first published in 1892, became at once the standard work for English speaking medical students. He introduced those aetiological ideas, particularly in the bacteriological field, that followed from Pasteur's discoveries. With his literary and historical allusions and the personal touches he succeeded, as Falconer Madan said, in making a scientific treatise literature. If the book's weakness lay in therapeutics, it was a weakness not of Osler but of his time. To recognise and to make clear the therapeutic poverty of the day, hidden as it was beneath much traditional medicine-taking, was a necessary first step towards the remedy. The Text-book is said in this way to have contributed to the foundation of the Rockefeller Institute.

A curious fellow of the name of Egerton Yorrick Davies of Caughnawaga must not be forgotten. A retired surgeon of the American Army Medical Corps, his exploits were often mysteriously laid at Osler's door and his lucubrations on customs among the Indian tribes of the Great Lakes and even

odder subjects discomfited unwary editors. Osler and E.Y.D. seem, at least, to have shared a somewhat wicked sense of humour.

Through all this life of intellectual and physical activity, with the manifold demands on his time, on his skill as doctor and on his human sympathies, he had the blessing of a happy home. Married late, in his early forties (had he not said "Keep your affections on ice") he found in Grace Revere Gross, the widow of a Philadelphia colleague, a wonderful stay and support. The tragedy of the death of their one son in the 1914-18 war strained their courage to the uttermost.

Osler was short of stature, swarthy of skin, with a straight carriage and a lithe gait. His nature, balanced and helpful, sloped towards the sunny side. In a few moments he had learned the hobbies and the interests of a new acquaintance, and he remembered. Sooner or later would arrive a post-card of encouragement, a reference to some work or a pamphlet bearing on a pet subject. For wide as were his pursuits and busily used as was his time he could focus his personality on each person that he knew, big enough in heart and mind to give something of himself to all.

He believed firmly in the real goodness of his fellow men and had a blind spot for their deficiencies. Occasions of carelessness or meanness in men's behaviour would draw from him some general mutterings about the Sons of Belial, but soon he would be found arm-in-arm with the villain of the piece, all forgotten and forgiven. He had that intelligence of the heart, that quality that drew men to him, to follow his advice, to interest themselves in the things that he did and to live better because they had known him. The effect of all this on his students in the four Universities where he taught was revealed in their appreciation of him when in 1919 two fat volumes of "Contributions to Medical and Biological Research," by 150 of his pupils and friends, were presented to him by Sir Clifford Allbutt on his 70th birthday. The medical journals of two continents flowered into Osler numbers; it was as if everyone medical was bent on paying tribute to and giving thanks for his life and influence.

Here truly was a man gifted with intellect, enthusiasm, understanding, humour, who took life's opportunities and striving to use them fully, kept faith with his destiny. Here truly is a man to be remembered.

A. F.

'DITES - MOI'

Now tell me, Sir, please tell me do,
Your age, your trade, your state;
Exactly what is troubling you:
Oh please elucidate
The whereabouts of all your pain,
And when the trouble started,
And has your weight shown loss or gain
Since from good health you parted?
Have other docs been treating you
For better or for worse:
And what, good Sir, compels you to
Come here, your health to nurse?



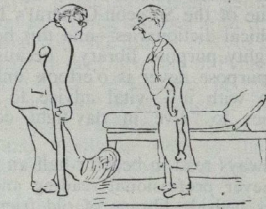
How many in your family
Depend on what you do?
And are they living healthily,
Or any ill like you?
And those who've sadly passed away;
What ages did they touch?
All well at home from day to day
Or is your work too much?
And do you smoke, or drink perhaps?
Some worries on the mind?
And now if you'll remove your traps
We'll see what we can find.

VIEW DAY

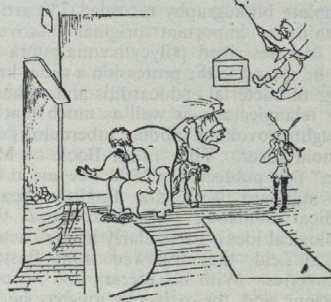
To the Editor, St. Bartholomew's Hospital Journal
Dear Sir,

With some surprise and indignation I noted that this year's View Day in the Hospital had not been publicised among the Pre-clinical students of Charterhouse Square. Some heard about it accidentally, many did not know and went home on the same Wednesday afternoon. I belonged to those who did not know; the man who sold me an evening paper near Aldersgate Tube Station asked me "what special occasion was on at Bart's—whether Queen Mary was paying a visit to the hospital." He was rather shocked when I, whom he expected to be a "member of the Bart's family," could not furnish him with any reply whatsoever. I felt rather awkward. On making enquiries the following morning I did eventually find out what had been going on in my hospital

By F. WINSTON
Illustrations by J. S. Bunting



Now are you sleeping very well
Or troubled by a cough,
Disorders of the bowel to tell:
Your waterworks gone off?
Completely lost your appetite—
Temptations fail upon it?
Or are you short of breath at night
And is it blood you vomit?
And have you, Sir, been ill before:
Or spent some time abroad?
A wife at home whom you adore
And kids you can't afford?



CORRESPONDENCE

the previous day. I understand that a notice concerning View Day had been up in the lady students' cloakroom—nowhere else. I feel certain you will agree with me that this place is not, under normal circumstances, accessible to the less fortunate student who happens to be male.

I believe the above-mentioned to be only one of the many symptoms of the existence of a very deep gap between Charterhouse Square and the Hospital. Nothing is done in order to bridge this gap—on the contrary, its existence seems to be welcomed. Surely Second M.B. puts up a sufficiently high barrier between Pre-clinicals and Clinicals. Further barriers are unwanted and unnecessary.

I am, Sir,

Yours faithfully,

H. A. ULLMANN.

Charterhouse Square,
E.C.1.

22nd May, 1949.

THE GREEN TURBAN¹

A VISIT TO AMERICA

WHEN I decided that I must somehow get to the United States it never occurred to me that my hospital² might give me a grant for this purpose. My first duty and extreme pleasure is then to express to the hospital authorities my gratitude for helping turn a dream into reality.

During the voyage the seafarer has some of the gilt taken off the gingerbread. The airborne traveller, who is immediately pitchforked into luxury and abundance, gets this untarnished. For the food on the boat is something that staggers the contracted English stomach. Moreover he who flies presumably misses that most memorable of sights, the Manhattan Skyline at dawn. It has been described by many but it has to be seen to be believed. On the other hand he is spared the unmitigated boredom of five days at sea. I know some like it. I, however, read most of a textbook of radiotherapy.³ Need I say more?

The first impressions of New York are of huge automobiles and loud neckties, the latter so loud and numerous that the occasional one seen in London is only as worthy of note as snow is upon the equator. I subsequently found that many American's automobiles are larger than their apartments and of course very much cheaper. The logical development is clearly that people will eventually live in their cars.

Every doctor I met without exception and most laymen asked for my views on the National Health Service. Consequently any intending visitor should have a short speech prepared which he can deliver as the occasion arises. They seem to me to be in much the same position as we were in 1947, determined to oppose State Medicine but realising that if a Social Security programme is introduced it will be very difficult to keep out. They therefore watch our developments with the greatest interest and not a little anxiety.

The man-in-the-street is aware of two things that seem to occupy a disproportionate amount of space in the daily and weekly papers: Communism and Cancer. Of the first I will not write. Of the second I would say, albeit with some hesitation, that he knows too much, or at least too much about

¹Worn only by those who have made the pilgrimage to Mecca.

²The Royal Cancer Hospital, London.

³It would be libellous to give its title.

the unimportant aspects of the disease. A distinguished surgeon whom I heard lecture said that it came as a shock to many of his patients to be told they required an operation. They had thought that surgery was out of date and that cancer could now be cured by chemotherapy. This is not of course the fault of the profession, but of the popular Press which almost every day reports new successes for various drugs. The idea of Cancer Detection Clinics is also very much in the public and medical eye, but for the most part these are based on the idea (which is by no means new) that practitioners should refer to such clinics cases in which doubt exists as to diagnosis. The alternative idea, that patients should attend of their own volition for periodic check-up also finds favour but is expensive and time-consuming. At the Memorial Hospital for instance, there is a six months' waiting list for an appointment at the Cancer Prevention Clinic. In general, the aim is, as always, to secure earlier diagnosis by educating the public in early symptoms and the doctors in earlier reference of their patients to these clinics.

Hospitals and Surgery

The modern hospital is a stupendous undertaking. If I describe the George Washington Hospital⁴ it is because it was the first I saw and therefore the most memorable. One's immediate impressions were of spaciousness and heat, almost intolerable heat, though the day was cool and spring-like. To serve about 150 surgical beds there were six major and four minor operating rooms, and there were, it seemed, almost as many laboratories and X-ray machines as there were patients. The telephone exchange occupied a whole room of generous proportions and the clerical staff must have been vast. Much emphasis here as elsewhere was laid on Research and I observed with some amusement at one hospital a woman and a small monkey in adjoining cubicles having electroencephalograms taken. I saw a dog which seven weeks previously had had its cervical oesophagus replaced by a polyethylene tube and which was feeding normally. At the George Washington too, the most admirable facilities existed for out-patients. I observed with envy comfortable cinema-type tip-up seats, a first-class canteen, even a shop where

⁴Washington D.C.: 400 beds.

almost anything seemed available. The presence of a canteen is a very great boon to the visiting doctor and I found one in every hospital I visited.

Not all hospitals are so impressive in regard to appearance. The operating rooms at the Temple Hospital could only be described as poky. Nevertheless the general standard of equipment and resources seemed to me in a different class from that found in England. It was with considerable surprise therefore that I heard that so many hospitals were financially hard up. It may be that the ratio of Staff to Patients (analogous to the number of ground staff to air-crew in the Royal Air Force) is of some consequence in this respect. Obviously it is enormously greater than in England.

The surgery I saw performed was magnificent. But one has to appreciate the principle that speed in America (with some exceptions) is at present at a discount. Small wonder they start operating at 8 a.m. when a surgeon may do only two operations a day. It must not be thought that I am necessarily criticising this method: I am reporting facts.⁵

The surgery was most meticulously performed, and watching it I was reminded of the Mills of God which "grind slowly, but they grind exceedingly small." (On occasions too, I could not help but think of glaciers whose progress is recorded in years rather than in feet and inches!) But it is also a fact that in terms of blood-pressure and pulse rate these same patients left the table in excellent condition.

Of anaesthesia it is not my place to write, except possibly to record that continuous spinals seemed to be fashionable, that too many patients were awake for my liking and that the plexus of pipes and taps and electro-physiological apparatus without which no up-to-date patient dare face a major operation seemed even more complicated than it is at home.

Black Silk and Steel Wire

Johns Hopkins⁶ is of course world-famous and as soon as one passes the doors one is conscious of an aura of tradition such as exists in many English hospitals. The spirit of Halsted and Osler pervades the place and the demonstration "theatre" in which Hal-

sted performed his operations reminded me very much of the old lecture theatre at St. Bartholomew's, happily destroyed in the blitz. The international reputation of the hospital no doubt accounts for the number and variety of the visitors who throng the corridors and operating rooms. In the latter the call-over was like a premature view of the Day of Judgement:—

"Smith: California"
 "Schmidt: Vienna"
 "Smythe: Sidney"
 "Smidt: Amsterdam"
 "Psmith: London" . . . and so on.

This was no Surgical Congress, but an ordinary day of the week and I marvelled. My taxi-driver, however, who took me from the station to the hospital, held other views. "They're not doctors at Hopkins," he said, "they just experiment. My Old Man," he continued, "was a surgeon, but he chucked it in. Took my appendix out—would you like to see the cut?" In vain I protested, and at the next traffic light he pulled up his shirt to reveal a pararectal scar.

So I visited the experimenters. I saw laboratories which looked like physiologist's nightmares and also the new Isotope Research Department. I was surprised at the youthfulness of their workers. I was most charmingly taken care of by Dr. Rienhoff and wish that others besides myself could have enjoyed the spectacle of the Senior Surgeon climbing out of a skylight on to the roof in order to give me a bird's-eye view of the hospital and of Baltimore.

I saw Dr. Blalock perform a spleno-renal shunt in a baby girl, between veins of minute size. Here, surely, was the apotheosis of the surgeon's art! And I saw a considerable number of other major operations executed with great skill but (I thought) far too slowly.

I attended a lecture on cancer of the rectum by Dr. Tom Jones, of Cleveland, who was most emphatically in favour of the Miles' operation and against conservation of the anal sphincters, a procedure which I was to see performed a few days later. He reported a mortality of 3 per cent. in 803 cases, having consecutive series of 137, 148 and 169 cases without a death. Fifty per cent. survive five years where the disease is localised to the bowel. He and some others I met had scant regard for the modern tendency to perform vast excisions of viscera and parietes, leaving, as someone remarked, "little more than a heart-lung-kidney preparation."

At Johns Hopkins everybody used black silk and I hardly saw a tube of catgut. In Philadelphia under the influence of Dr. Babcock it was steel wire all the way. At Temple University Hospital I had the pleasure of watching Dr. Bacon operating on several rectums and saw him demonstrate three different methods of resection, namely: the classical Miles' abdomino-perineal excision, the anterior recto-sigmoidectomy with open anastomosis, and the sphincter conserving "pull-through" operation which he himself first described. The name of Chevalier Jackson will always be coupled with this hospital and although Dr. Jackson senior has practically retired, his son carries on the great tradition. Since my own father also occupies a position of considerable repute as a laryngologist it was satisfying for me to meet Dr. Jackson junior and to see him perform two laryngectomies. In one of these he used the special clamp which he has invented (and which is regarded with grave disfavour elsewhere) for closing and oversewing the pharynx. I saw more men without larynxes in the United States than I ever hope to see again, for radiotherapy is seldom used except in palliation. In the Follow-up Clinic here and later at the Memorial Hospital they appeared to pass by in droves—a tribute indeed to the survival rate, but at what a cost!

Americans have always been health-conscious and theirs is unquestionably the cleanest country in the world. The railroad stations, most of which seem to be built exclusively of marble, look more like operating theatres than the horrors of Liverpool Street or Snow Hill to which we are accustomed. Everything edible is naturally wrapped in cellophane, but I could not help feeling that when postage stamps from an automatic machine are delivered in a "sanitary container" it is going a bit too far. The *pièce de resistance*, however, was found in my hotel in Philadelphia which was fitted with self-sterilising lavatory seats. The sputtering ultra-violet light which was switched on by raising the seat seemed to me to put the total eclipse of the moon (of which I had a splendid view) literally in the shade.

Virginian Interlude

Good friends in Washington insisted that I should spend a week-end in Virginia and accustomed as I am to the tradition of the English week-end I was a little shaken to find that this started on a Thursday. We set off on a perfect spring day, leaving the cherry trees of this lovely city in full bloom, and

hurled along one of the astonishing arterial roads that seem to cover the whole of the eastern States with fly-over and clover-leaf intersections, until we came to Mount Vernon, country home of George Washington. This fine house, situated on a hill overlooking a bend in the broad Potomac river, was the first of many which I saw built in the Colonial style, of white wood with pillared portico and surrounded by numerous smaller "cabins" in which the slaves once lived and looked after the affairs of House and Estate. From there we travelled south through pine woods gay with the pink and white of Red Bud and Dogwood trees until we reached Williamsburg, the original Virginian capital of the early settlers. I do not suppose there is anything else quite like this in the world, for the whole town which had fallen more or less into decay as a result of the March of Civilisation has been restored by the munificence of the Rockefeller family to its 18th century condition.

Books could be, and indeed have been, written about Williamsburg but it is enough to say that except for the inevitable swarm of automobiles one might have been back in the Georgian Age. Many buildings have been rebuilt and furnished according to plans and inventories found in the Bodleian library at Oxford and the lady guides who took us through the Governor's Palace were dressed in the costumes of the period with full skirts and tight bodices. Even some of the wall-paper had been transported, goodness knows how, from buildings which were being demolished in London, Bath and elsewhere. The gardens are laid out according to original plans and no flowers grow but those which have been brought from England. Over the Capitol there flew a flag suspiciously like the Union Jack, though this it appeared was in reality Queen Anne's Standard. (Incidentally, one of the first pictures I saw in the Palace was an etching of St. Bartholomew's Hospital.) The William and Mary College is said to be the only building in the United States designed by Sir Christopher Wren and The Tavern at which we dined on oysters and fried chicken was lit by candle-light, in style reminiscent of Stone's Chop House, off Leicester Square, and which was destroyed by a bomb.

It was near Williamsburg, on the banks of Chesapeake Bay, that the British were finally defeated and Lord Cornwallis surrendered. This War of Independence, or the Revolution

⁵Some operation times observed:

Abdomino-perineal excision of rectum with repair of ventral hernia—5½ hours.

Radical mastectomy—3 hours.

Anterior recto-sigmoidectomy—3½ hours.

Partial gastrectomy—3 hours.

⁶Baltimore, Maryland: 900 beds.

as Americans prefer to call it, must have been at times rather in the nature of a "free-for-all," for the Americans were fighting the British; the British, in addition and as usual, were fighting the French, and the Indians were skirmishing around the outside fighting anybody they could find.

Charlottesville is the home of the oldest American University, which was designed by President Thomas Jefferson. His house, Monticello, superbly placed on the very top of a neighbouring hill, commands a view of the town and university, of the plain towards the sea and of the West Virginian Hills inland. It was to these hills, immortalised in the song concerning the girl "who stayed up in the mountain," that we bent our steps—or rather depressed our accelerator. Here genius of the American engineer (to whom expense is no object) is given full scope. For close on one hundred miles the road runs along the ridge of the Blue Mountains, two to four thousand feet high, and is appropriately named the Skyline Drive. The views are superb and the Shenandoah valley lies below one to the west. Along this ridge, which is a segment of the Allegheny Mountains bordering the whole of the eastern seaboard of North America there also runs a part of the Appalachian Trail, a footpath which commences at the Canadian border and stretches to the Caribbean Sea. Anyone who enjoys a walking holiday might do worse than consider this six-month constitutional.

These hills are made of limestone and like others of similar formation (in Derbyshire, for instance) they contain numerous caves. It is said that those which we visited were discovered when someone fell down a pothole into one of them. All the artifice of skilful lighting has certainly produced the most fantastically impressive sights. Here indeed are caverns measureless to man, bearing stalactites almost a hundred feet in height. No one seems to know whither they extend and, oddly enough, no one seemed to care, though the suggestion that these particular caves might communicate with a rival concern further down the valley shocked our guide into indignant silence. Did not the guide-book *guarantee* these to be the "largest and most beautiful in the whole of America?" Even the man-made masterpieces of Manhattan seemed trivial by comparison.

And so to New York City.

The Memorial⁷

To come from the Royal Cancer Hospital is to be *persona grata* at the Memorial Hospital and I was, therefore, allowed to observe a goodly part of the workings in the week that I spent in New York. A list of operations does not make very exciting reading and I must be content with noting a few odd facts. As before, I found the surgery most thorough if sometimes a little finicky. American blood must be very precious when it is not unusual to use 300 artery forceps for a radical mastectomy. I saw a deal of major work including such high lights as a beautifully executed duodeno-pancreatectomy for an ampullary carcinoma (Dr. McNeer), an excision of the upper jaw (Dr. Hayes Martin) and the much discussed "All (or Pan) American" operation (Dr. Brunswick) in which the pelvis is eviscerated and a "wet" colostomy established in advanced cases of cancer. In Boston I was to see a woman in good health who had had this considerable undertaking performed over a year previously.

One of the excellent features of this hospital is the daily schedule of clinics and other activities with which the visitor is provided. The spaciousness and organisation of the Follow-up Clinics makes one most envious and it is only green jealousy that prompts me to mention the disgruntled patient who I found waiting for a bus outside the hospital. "They keep me," he muttered, "all day in this b hospital." I feel sure he was exceptional. In Dr. Martin's Head and Neck Clinic I saw some most spectacular results of really radical surgery of the face and jaws, though I feel bound to put on record my disappointment that radium is so little used. In several different hospitals I heard it said that "radium can do nothing that X-rays will not do better, and that surgery is superior to either," but it struck me as strange that a hospital with as many patients and all the resources of the Memorial should actually have sold their radium "bomb" because there was no occasion to use it. Even interstitial radium is not employed to any extent. At the weekly Staff meeting of the Head and Neck department (which took place, ghastly to relate, at eight in the morning) and subsequently at a meeting of the New England Cancer Society which was devoted largely to

⁷The Memorial Hospital, New York City: 250 beds (plus 300 building).

cancer of the mouth, I found myself in the unusual position for a surgeon of defending and justifying radiotherapy. And since I was on both occasions in a minority of one I feel I should have been given a medal for this service. There seems, on the whole, a lack of co-operation between surgeons and therapists which is not to the credit of American medicine.

I also spent a couple of hours in the Statistical department of the hospital which is conducted on very similar lines to those employed at the Royal Cancer Hospital. As might be imagined this department is of considerable size and importance and it was a matter of surprise not to find cancer more clearly "staged." For until surgeons are prepared to group their cases according to the extent of the disease and, furthermore, until they all agree to employ the same staging for individual sites, any comparison of results may well be interesting but will remain largely profitless.

New York is an intolerable city to live in. Even New Yorkers admit this. Nevertheless it contains many beautiful buildings and none more so than the New York Hospital itself which points a white and graceful tower toward the sky immediately across the road from the Memorial. Endowed by a gift of over £7,000,000 this vast edifice is built on the most elaborate scale imaginable. Nevertheless it contains only a few more beds than St. Bartholomew's. It is constantly "in the red." Another fine hospital, Mount Sinai, overlooks the Park and here I saw Dr. Garlock operating with great skill and *speed*. He has performed about 200 abdomino-thoracic explorations for carcinoma of the stomach and oesophagus and has been able to perform radical resections on more than half of these growths. Although his results are not yet published I gathered that the five-year survivals⁸ had been somewhat disappointing.

New England

I moved northwards with the spring and near the coast in Connecticut the magnolias were so astonishing that one felt sorry for Kew. The American Fall is well-known but now I have to admit, and it pains me much, that Springtime in Old England has no advantages over that in New England. The country, in fact, was at its best.

⁸The Americans employ the term "salvage" for the group of cancer patients who survive a stated period, usually five years. I cannot help feeling that this word has a rather depressing sound about it.

In Boston I was most hospitably entertained by Dr. Charles Lund, a surgeon of merit and fame, especially in regard to the treatment of the unfortunate victims of the disaster of the "Cocoanut Grove," a night club in Boston which burned with frightful results during the war. The oldest hospital in New England⁹ wears the same air of distinction as Johns Hopkins in Baltimore. It was with some sense of the historical importance of the event that I stood upon the spot where one hundred years ago Dr. Morton first administered sulphuric ether to the patient who was to have "a tumor removed from below the jaw." I was taken to the huge City (Municipal) Hospital and to the State Cancer Hospital situated some twenty-five miles out of Boston in deep country. On the way I speculated upon how the patients could possibly come so far to Follow-up Clinics. I need not have worried. As we entered the car park the usual sea of automobiles met the eye.

Having met Dr. Francis Moore, youthful professor of surgery at the Peter Brigham Bent Hospital,¹⁰ I was invited to see over his department. Here is something which I doubt exists in England, if size and number of workers (and dogs to experiment upon) are any criteria. Indeed it is a complete physiological department and under the leadership of Harvey Cushing and Elliott Cutler produced a wealth of important work. Considerable interest arises from experiments on the use of inert plastics such as polyethelene and "teflon" in reconstructive procedures of various sorts. At other hospitals I was privileged to see Dr. Lahey operating and also Dr. Catell, who has resected the pancreas and duodenum upon what appears to be a phenomenal number of occasions and for the last twenty-three times without a death.

I have already made brief mention of a meeting of the New England Cancer Society. This was held at Worcester, about forty miles from Boston, and was a whole-day affair with morning and afternoon sessions and in the evening, cocktails and a dinner. A number of short papers were read in addition to the main symposium on cancer of the mouth. A novel feature was the discussion of interesting and unusual cases by two or three surgeons who had been given some of the details of a case, including, for instance, the fact that

⁹The Massachusetts General Hospital, Boston: 800 beds.

¹⁰Hospital of the Harvard Medical School: Harvard University.

an abdominal operation had been performed, but to whom the actual diagnosis was unknown. It was as if the examiners for the Fellowship were themselves under examination. And what could be more entertaining than that?

One last visit was paid to the Chemotherapy Clinic of the Massachusetts General, and here some most spectacular successes were to be seen, mainly in cases of advanced breast cancer. It was interesting, however, to observe that oestrogens and androgens were being administered often in vast doses and juggled about apparently without logic. A cynical observation of Sir Walter Langdon Brown's came to my mind concerning endocrinology: the giving of unknown chemicals to credulous patients by even more credulous physicians. But it is only fair to add that the physicians in this case admitted the empiricism of their treatment.

Envoi

Although I saw but a fraction of this vast country and although it would be both absurd and disastrous to attempt any conclusions after so short a visit, certain impressions inevitably remain.

First, Efficiency—but coupled paradoxically with Waste. The former is, of course, a by-word of American life and I was able to see a non-medical example close-up in a visit to the factory of a Canning Firm, justly famous for the Number of Varieties which it produces. Here, amid the clatter of conveyor belts, millions of tins marched in orderly progression along the benches, walls and even the ceilings of lofty rooms. It was all most impressive. Waste one encounters on every side. It is calculated and deliberate: it may even be justified. I cannot tell. The motto of this country should be "Expendable," its slogan "Chuck it away and buy a

STUDENT'S UNION COUNCIL MEETING

Held on June 8th, 1949.

Mr. M. Cohen was elected Senior Secretary.

Mr. P. D. Matthews was elected Junior Secretary.

B.M.S.A.—it was decided to send two impartial observers to the next meeting of the B.M.S.A. so that the council might know more about the activities of the Association before considering affiliation.

The revised constitution of the Squash Club was accepted.

THE "BART'S" FAIR

It is to be regretted that owing to the construction of the new residential block now in progress at Charterhouse Square, it will be impossible to hold the Bart's Fair on the dates already announced.

It is hoped however to hold it in conjunction with the opening of the block when the latter is completed.

new one." The surprising thing is that they take so much trouble with their patients.

Second, enthusiasm for Research; and this by no means limited to those who wish to make that subject their life work. The training of a doctor allows time for a man of about Registrar Status to do a period in a research laboratory which is not necessarily concerned with the routine daily work of the hospital. And this must surely be of value to him later on.

Third, towards the Cancer Problem, an interest among laymen upon which I have already commented. Among medical men there is a beaver-like energy and enthusiasm which is both impressive and infectious. If I say that they write and talk a great deal it is only to add the excuse that it is impossible to keep abreast of all of it. But then in the States, Publication has ever been a necessity.

Fourth, a kindness towards visitors which beggars our poor efforts. One is conducted around hospitals and clinics and passed from doctor to doctor even unto the seventh generation. And they never appear to get tired of helping and entertaining. Nothing is too much trouble.

But what stands uppermost in the mind? Friendships renewed and new ones made: boundless hospitality. Above all, a determination to go back again. But now with Home once more in sight, what could be more appropriate than the words of the great American poet?¹¹

Thus in silence in dreams' projections,
Returning, resuming, I thread my way
through the hospitals.

HOGARTH

R.M.S. Queen Mary: May, 1949.

¹¹Walt Whitman. Leaves of Grass: The Wound Dresser.

THE HENRY VIII GATEWAY INTO SMITHFIELD

By GWENETH WHITTERIDGE, M.A., D.Phil.

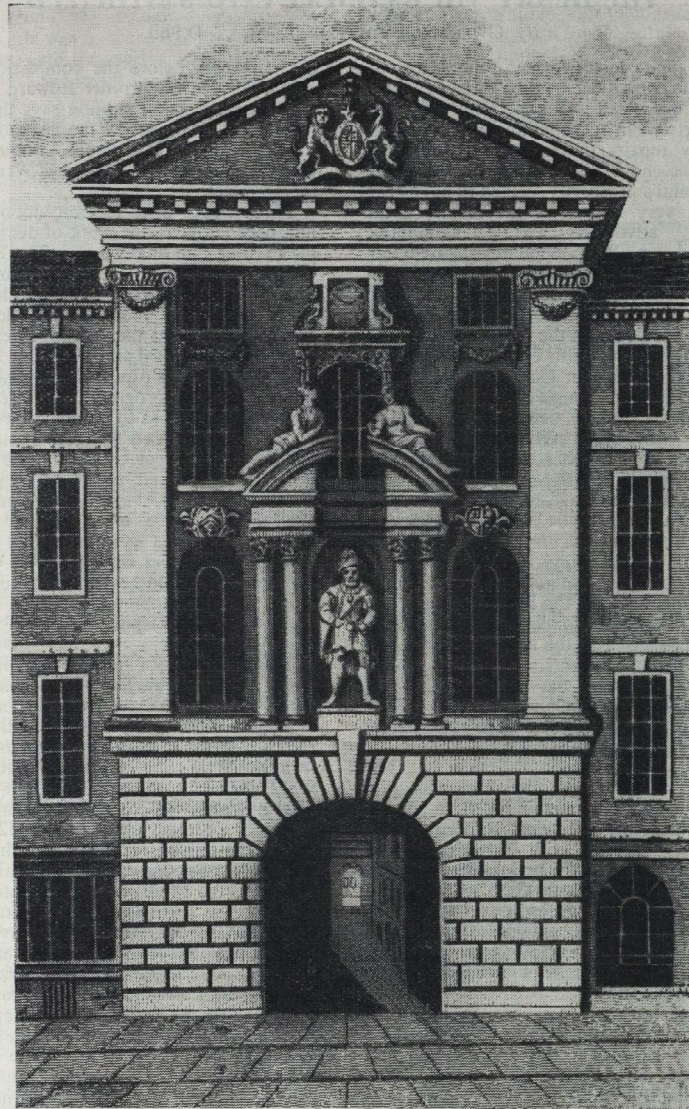
The great losses which the Hospital suffered in consequence of the Fire of London in 1666 prevented the undertaking for the next thirty years of anything but the most necessary repairs to the existing buildings. But, at the end of the century, the decline in the Hospital's prosperity seemed to have been checked, very largely as the result of the measures advocated by a Committee appointed on 24th September, 1696, to enquire into the Hospital affairs. As part of the scheme for improving the financial situation, the Governors ordered the amelioration of tenements on the Hospital site. The street between the South Gate of the Hospital and the Little Britain Gate was paved and given the name of King's Street. Tenements were altered and a new way was made between Well Yard and the Little Britain Gate. These enterprises were followed by a plan to rebuild the North Gate of the Hospital on Smithfield, and to construct new tenements on either side of the new gateway. The first indication of this project was given at the Court of Governors held on 1st August, 1701, when it was ordered that the building of the North Gate of the Hospital and of the several tenements adjoining it, "according to the model shewed to this Court," be referred to the Hospital Viewers. The leases of the tenements adjoining the old gateway were due to expire at Michaelmas, 1701. New tenements would mean new leases at higher fines and higher rents and, therefore, be beneficial to the Hospital's finances. The plan was not put into immediate execution and is not referred to again until 5th March, 1702, when the following resolution was adopted: "Agreed with Edward Strong, junior, mason, to erect and build the front of this Hospital's North Gate in Smithfield with purbeck stone according to the model drawn by the said Edward Strong and approved of by the Governors appointed Viewers of the revenues of this Hospital for the sum of £550."

Edward Strong, junior, would appear to have been the son of Edward Strong and nephew of Thomas Strong who was the chief mason of Sir Christopher Wren. The Strong family came from Staying, near Burford, where were quarries which contributed stone for the rebuilding of London and of St. Paul's Cathedral. Thomas Strong

died in 1698, before the completion of the cathedral, and his brother Edward inherited all his contracts. Tradition says that it was he who, in 1708, carried the last stone to the top of the dome of St. Paul's, although others give this honour to Christopher Wren, son of the architect.

Three weeks after the resolution to build had been adopted, the work of demolition of the existing buildings began. The Hospital's Carpenter and Bricklayer, Abraham Wilkins and John Phillipps, were put in charge and were ordered to preserve the old timber, boards, bricks and tiles within a fence to be erected in Smithfield and to put the lead, iron and glass in the Hospital storehouse. While the work was in progress on the new gate, a convenient way was to be made through part of the old tenements for persons to pass to and from the Great Cloister. The Hospital Porter was ordered to "keep a particular account of the workmen and labourers that shall be employed in taking down of the aforesaid premises and prevent the materials thereof from being embezzled." Contracts for the new buildings were made on 18th April with Phillipps and Wilkins by which they provided the labour and the Hospital the materials.

The first lease of the new tenements was granted on 12th May to Mr. William Crossfield. He was to have the tenement on the West side of the Gate together with half the rooms over the gate and the shop underneath it on the West side. He was granted a lease for 21 years to begin on the first quarter's feast day after the completion of building, at a rent of £60 p.a. and a fine of £200. The Governors agreed to line the kitchen below stairs and the shop with slit deal, and to wainscott the rooms on the first storey, one room on the second, and the staircase. (A comparison of the fines paid shows that this was a much larger tenement than any of the others.) On 6th June a similar lease of the shop on the East side of the gate and of half the tenement over the gate was granted to Robert Forster, citizen and turner, for a fine of £50 and a rent of £25 p.a. The same day the new building in the passage leading from the North gate to the Cloister, and next to the tenement intended for the Porter, was let on the same terms and for a fine of £50 and a rent of £27 p.a. to a Mr. Ellis, Symon Peter,



Prattent del.

Designed and Engraved for Lambert's History of London.

Owen Sc.

Principal Gate of St. Bartholomews Hospital (1755)

citizen and goldsmith, received a lease of the tenement next to that of Mr. Crossfield for a fine of £60 and an annual rent of £30. Thomas Fletcher, citizen and tiler and bricklayer, received a lease of the single tenement situated in the passage between the Gate and the Cloister and North of that granted to Ellis, for an annual rent of £20 provided that he himself lined the kitchen with slit deal, wainscotted the stairs and put in the chimney pieces at his own charge. Finally, on 20th June, Mathew Tombs, citizen and merchant-taylor, received a lease of the tenement to the West of that granted to Mr. Peter, for a fine of £60 and an annual rent of £30. Various contractors were selected to do the joiner's work, the plastering and the glazing in these tenements. One of the Governors, Mr. Dodson, gave "the painting in and about the several houses . . . at his own proper charge for the benefit of the Hospital." But none the less costs were high. By Michaelmas, 1702, the bills for materials and labour amounted to £1,493 6s. 0d., and a further £1,320 1s. 9d. was spent before the gateway and the adjoining houses were finished.

Building continued throughout the summer and autumn of 1702. In August, Thomas Fletcher asked for leave to use the shop for which he had contracted, during the next Bartholomew Fair, and declared his intention of entering on the property at Michaelmas. On 7th September it was agreed with Richard Horton, clockmaker, to make a "dyall in the front of the New Gate in Westsmithfield and a small dyall in the Coffee Room over the same," for the sum of £18. And on 10th October it was ordered that the President's and Treasurer's names and the year when the gate was erected "together with such inscription as shall be agreed upon," be written above the gate. John Everett, paviour, received a contract to "pave such part before the new buildings in Westsmithfield as shall be ordered" on 23rd November, and five days later it was set down that the hearths in the new buildings should be of 16" marble square and the chimneys of Coven stone, except in the tenement let to Mr. Fletcher. Water was to be brought from the New river in a leaden pipe from the conduit in Smithfield along the passage at the North Gate and Fletcher, Ellis and Foster were given leave on 19th December to bring the water into their houses by laying branches to this pipe at their own cost.

There are few references to the new buildings in 1703 and most of the bills were paid by the summer of that year. On 5th May the Porter, John Middleton, asked for a rise in salary, as, by the pulling down of the old houses to improve the Hospital revenues, he had lost £15 p.a. which he used to get by letting part of his house for shops. The Governors agreed to his petition, and his salary was raised from £21 to £40 a year. The Hospital Carpenter, Abraham Wilkins, received a further £25 from the Governors as he complained that he had spent most of his time while the buildings were being erected "in surveying and keeping the account of the day's work, it being done by the day," and he had "no allowance for his loss of time and pains taken therein."

From this statement it is evident that the building of the Henry VIII Gate was, in fact, completed by May, 1703. The thanks of the Governors are then formally expressed to Mr. Dodson "for his pains and benefaction in giving the painting of the tenements," and to Mr. Greene, another of the Governors, "for his pains and care in surveying and directing the buildings." The name of the Treasurer inscribed on the Gate is that of Mr. Nicoll who died on, or shortly before, 27th May, and no one could be found willing to take on the duties of the office until July.

As far as can be ascertained the Henry VIII Gate remained with the tenements adjoining as it is shown in the print of 1755, until the reconstruction of the Smithfield frontage of the Hospital in 1845 and 1866. The surrounding tenements were then demolished and the main entrance of the Hospital assumed its present appearance.

I am indebted to Rupert Gunnis, Esq., for the following information concerning Edward Strong: Edward Strong, Junior, was born in 1676. He was employed on a lanthorn of St. Paul's in 1706 and was partner with his father in building part of Greenwich Palace (1698) and Blenheim (1705-1712). By himself he laid the marble pavement beneath the dome and in the cross aisles of St. Paul's, and built the towers of St. Stephen, Walbrook, St. Michael Royal, and a lanthorn of St. James, Garlickhythe. In 1715 he was employed by Lord Chandos at Cannons. With Edward Tuffnell he built St. John's, Westminster, and the churches of Wapping (1712-15), Deptford (1713-15), Limehouse (1715-16), and St. George's, Bloomsbury (1718-23). He was also employed at Marlborough House (1712). In 1699 he married Mary Beauchamp, by whom he had four daughters, the eldest of whom married Sir John Strange, Master of the Rolls. He died in 1741. After 1700 it is difficult to distinguish between his work and that of his father.

HEALTH ON ACTIVE SERVICE

By E. GREY TURNER, M.C.

sometime Regimental Medical Officer 2nd Battalion Coldstream Guards.

THIS is an account of the health of an infantry battalion during two years of active service overseas*. The Battalion first met the Germans in Tunisia on the 11th December, 1942, and remained in the Front Line practically without interruption until the conclusion of the campaign five months later, fighting in every type of country, from mountains to desert. After taking part in the seizure of the Italian islands of Pantelleria and Lampedusa in June, 1943, we spent the rest of the year in reserve and concluded it at Carthage, guarding President Roosevelt and Mr. Churchill on their way home from Teheran. Early in 1944 the Battalion was transferred hurriedly to Italy and immediately went into action on the Gustav Line in the Mountains of the Abruzzi. In the course of the year the unit fought its way up the 250 miles from Cassino to the Gothic Line, and 1944 ended in the high Apennines overlooking the Plain of Lombardy.

The strength of the Battalion varied from 650 to 1,000 men, with an average of 800, including 35 officers. No claim is made that these statistics are free from inaccuracies. It is extremely difficult to keep exact records under battle conditions, but wherever a doubt has arisen, the higher figure has been chosen in order that the statistics might not be accused of flattery. Battle casualties are excluded, the figures relating solely to sickness.

	1943	1944
New cases	9	9
Unfit for Duty	16	11
Evacuated	2	2
Total	27	22

A good picture of the state of health of a unit can be obtained from the following three figures:—

- (i) the number of new cases reporting sick daily;
- (ii) the number of men unfit for duty (i.e., marked "Attend B," "Attend C" or "Hospital"); and
- (iii) the number evacuated to hospital.

The sum of these three figures gives a rough and ready index of the sickness as a whole. A man who suddenly falls severely ill will, of course, be included under (i), (ii) and (iii) and will thus be counted three times, and certain

others will be counted more than once, but this weighting is justified in these cases as a reflection of their greater severity. Daily averages of these figures in the two years and in certain particular periods are shown in Table (I).

It will be seen that the new cases averaged 1% of the Battalion. In addition the old cases attending at the Regimental Aid Post for inspection and treatment (not shown in the Table) averaged 2% daily in both years. There was, therefore, a total daily attendance for all purposes of 3%.

The winters in both Africa and Italy were severe. Snow was encountered even in Africa, and in the Italian mountains frostbite was not uncommon and Trench Foot distressingly prevalent. In the Apennines Arctic clothing was necessary. In spite of the rigours of the cold weather, however, it will be observed that the Battalion stood up to the winter better than to the dry, scorching summers. The rate of sickness was higher in Africa (1943) than in Italy (1944), probably on account of the less exacting hot season in the latter.

The relatively low sickness rate during active operations is striking, but is no new observation. The explanation is probably threefold:

(i) In battle, men who might otherwise have fallen sick are continually being wounded and

	Hot season	Cold season	In the Line	Out of the Line
	9	8	7	11
	19	12	5	19
	2	2	2	3
	30	22	14	33

replaced by healthy reinforcements. The unit receives repeated transfusions of healthy blood, as it were.

(ii) In battle the Medical Officer naturally keeps to a minimum the number of men excused duty.

(iii) Most important of all, in battle the soldier has less opportunity to notice his ailments and, moreover, makes every effort to carry on. An insignificant minority, of

* I owe an apology for the late appearance of this article. The material on which it is based lay buried in a drawer until accidentally unearthed a few days ago.

course, take the opposite line and regard sickness as a heaven-sent avenue of escape from unpleasant responsibilities.

The incidence of sickness in the six companies of the Battalion was roughly equal. The relative incidence of different ailments was interesting. Ailments were classified as: traumatic (excluding war wounds); alimentary (mainly simple diarrhoea); skin; inflammation of areolar tissue; respiratory; and remainder (including gingivitis, which was much less common than in the U.K.) This may strike some readers as a curious classification. It was largely inherited from my distinguished predecessor in the Battalion, C. P. Blacker, and it proved a good practical classification for a body of comparatively fit men. Table (II) shows the incidence of these various conditions. The almost exact similarity of the figures in two

Table II.

	1943	1944	Percentages	
			Cold season	Hot season
Traumatic	13	13	16	11
Alimentary	17	18	9	23
Skin		18	} 32	} 23
I.A.T.	27	9		
Respiratory		8	} 43	} 43
Remainder	43	34		

different years, two campaigns and two continents is remarkable. The high proportion of alimentary disease in the hot season merely reflects the prevalence of flies and the epidemics of diarrhoea which they caused. The figure for skin disease and I.A.T. illustrates the heavy incidence of septic scratches, sores, boils and skin infections of all kinds, which were easily our principal scourge. This must be attributed to the impossibility of keeping clean on active service and (to some extent) to the effect of the Mediterranean sun upon the skins of fair-haired, blue-eyed north-countrymen, of whom there were a majority in the unit. A battalion of the Welsh Guards, who were brigaded with us and who were predominantly dark, were much less troubled in this respect.

Table III shows the incidence of certain important diseases. There were no cases of

Table III.

	Cases per 1,000 men per annum
Diphtheria	13
Bacillary Dysentery	18
Infective Hepatitis	53
Malaria	35
Venereal Disease	13

smallpox, enteric fever, tetanus or typhus (although these diseases are endemic in the civilian population of North Africa), probably because the troops were protected against them by inoculation. The cases of diphtheria occurred in a small and fortunately very mild epidemic. Nearly a quarter of the cases of infective hepatitis occurred amongst officers. The relatively high incidence of this disease amongst officers was noticed in all units, and a variety of explanations were suggested of which two appeared more convincing than the rest:

(i) Apart from active operations, officers feed together in messes and use communal utensils.

(ii) Again except in battle, officers sleep in pyjamas and may catch cold while dressing and undressing. I subscribe to the belief that chilling of the abdomen is a danger

in the tropics. Investigations into the causes of our worst epidemic of diarrhoea led me to the conclusion that chilling of the abdomen was an important causative factor and I regretted that British troops were not issued with body-belts, as were the Germans and Italians.

In the hot season bursitis in various sites, conjunctivitis and balanitis were common, and when sea-bathing was possible there were many cases of otitis externa. Amongst comparative rarities there occurred cases of erythema multiforme, battledress dermatitis, angioneurotic oedema (due to sensitivity to opium), heat-cramps, surgical emphysema of the eyelids of the right eye (after boxing), osteochondritis dessicans and spondylitis ankylopoietica. The highest temperature recorded in the Regimental Aid Post was 105°F. in a case of malaria. Surgical emergencies of the abdomen were conspicuously rare.

SPORT

CRICKET CLUB

May 5th, v. Romany C.C.

RESULT: DRAWN.

After their 8-wicket defeat last year Romany were out for our blood. In spite of the forecast the weather was glorious when Biddell and May opened the Hospital innings. Four off the first ball was comforting, but Biddell was run out at six—a purely Bart's affair—and Tomlinson left at 22, finely caught at mid-on. Cairns made his mark carefully and was very confident, but lost May shortly afterwards. The Cairns-Braimbridge partnership which followed was a stimulating example of stroke play tempered with watchfulness. Afterwards Vazifdar and Clappen delighted the eye with strokes to every part of the field. Cairns was eventually caught close in for 87 most entertaining runs, and our innings closed shortly after, leaving Romany to score 88 an hour to win. They started well, Smith hatting magnificently, and the game was very interesting when with 15 minutes left the scoreboard read 181—8—6. However, the last over arrived with no more than 13 required to win, with Ross to bowl it, and two wickets standing. Twelve runs were scored off the first five balls, and then Clappen took a catch off the last, with the scores level. Ross and Haigh bowled both intelligently and well for Bart's and Peter Smith's innings for Romany was beyond praise. The game itself could not have been bettered.

SCORES:

Bart's: 224 (Cairns 87, Braimbridge 40).
Romany C.C.: 224—9 (Smith 133 not out).

May 7th, v. Old Millhillians

RESULT: DRAWN.

On losing the toss, Bart's were sent in on a plumb wicket. After Biddell had spent some time scrambling around for his run, Hawkes and Tomlinson took command of the bowling, making fine scoring strokes all round the wicket in a century partnership. The latter went on to complete his century with May.

The innings being declared the visitors were left the same time to get the runs. This proved beyond their power. The Bart's bowling did not impress, being sadly lacking in length and direction. Train was our most successful bowler and put in a very fine spell towards the end of the game.

SCORES:

Bart's: 211—2 dec. (J. D. W. Tomlinson 104 not out, P. H. R. Hawkes 73).
Old Millhillians: 166—5 (D. V. Saunders 68).

May 8th, v. R.N.V.R. C.C.

RESULT: WON BY 109 RUNS.

After some interesting batting by Tomlinson and May, the Hospital dismissed their last opponent with the last ball of the day.

SCORES:

Bart's: 229—8 dec. (Tomlinson 75 not out, May 59).
R.N.V.R.: 120.

May 14th, v. Middlesex Hospital

RESULT: LOST BY 3 WICKETS.

SCORES:

Bart's: 146—7 dec. (Hawkes 74 not out).
Middlesex Hospital: 147—7.

May 21st, v. Crofton Park C.C.

RESULT: DRAWN.

SCORES:

Crofton Park: 197—9 dec.
Bart's: 193—8 (Tomlinson 41, Braimbridge 37).

May 22nd, v. Buccaneers C.C.

RESULT: WON BY 58 RUNS.

SCORES:

Bart's: 186 (Braimbridge 77).
Buccaneers C.C.: 128 (Clappen 5 for 27).

May 25th, v. Incogniti

RESULT: WON BY 7 WICKETS.

This was a grand all-day match played at Chislehurst in delightful conditions.

Incogniti batted first on an easy wicket. Thanks to fifties by Jory, Kennedy and our own Braimbridge, the visitors were able to declare at 217—8. Foy (5—60) bowled extraordinarily well against a strong batting side and showed that, when he can keep a length, he is a very dangerous bowler.

Bart's started disastrously and had lost 2 for 12 when Tomlinson and Cairns set about retrieving the position. At first they went cautiously, but gradually gained ascendancy. When Cairns left at 98 for a valuable 23 Tomlinson was in full cry and the writing was on the wall. Clappen proved a most adequate successor to Cairns and the game was won with 15 minutes to spare, Tomlinson and Clappen being undefeated with 161 and 34, respectively.

Tomlinson scored 50 out of the first 60 and altogether smote 23 boundaries. He gave one chance near the sight-screen when 130. It was a brilliant innings, the like of which can seldom have been seen in Club cricket. All the shots were there and he was particularly severe on anything at all short of a length. Despite a field scattered about the boundary he was largely instrumental in the score being taken from 33 to 218 in 90 minutes after tea.

SCORES:

Incogniti: 217—8 (declared).
Bart's: 218—3.

May 29th, v. Stanmore C.C.

RESULT: WON BY 61 RUNS.

SCORES:

Bart's: 209 (Clappen 66 not out, Braimbridge 48).
Stanmore C.C.: 148 (Clappen 4 for 50).

R.U.F.C.

SEASON 1948-49

The results—WON 15, LOST 18, DRAWN 1—were a vast improvement upon the previous season, and we hope Bart's rugby has seen the last of the lean years for some time. Most of the members of the 1st XV will be available next season and, with a few suitable additions, we should have a good side. The standard of play in the junior teams has been higher than of recent years. This and the greater enthusiasm throughout the Club have been most encouraging and bode well for the future.

At the Annual General Meeting the following officers were elected for next season:

President: DR. E. F. SCOWEN.

Captain: D. G. DICK.

Vice-Captain: A. H. JOHN.

Secretary: A. J. THIRD.

Treasurer: A. P. WYNNE-JONES.

Pre-Clinical Representative: B. FOY.

ATHLETIC CLUB

MATCH RESULTS

May 4th—

1st MIDDLESEX & MARY'S ... 113 pts.
2nd IMPERIAL COLLEGE ... 62 pts.
3rd BART'S ... 45 pts.

May 18th—

1st MIDDLESEX & MARY'S ... 61 pts.
2nd KING'S COLLEGE ... 58 pts.
3rd BART'S ... 27 pts.
4th LONDON SCHOOL OF ECONOMICS 22 pts.

May 25th—

1st BART'S ... 47 pts.
2nd SURREY A.C. ... 41 pts.
3rd WESTMINSTER BANK ... 11 pts.

June 1st—

1st BART'S ... 72 pts.
2nd GOLDSMITHS' ... 40 pts.

Owing to calls by the University team upon members, and the conflicting attractions of Friern Hospital on Wednesdays, only in the match which Bart's won against Surrey A.C. and Westminster Bank were we able to put out anything approaching our full strength; but it is pleasing to note that the teams have contained a number of pre-clinical men—a fact which augurs well.

D. L. Bee is a promising newcomer in the field events where he has already produced the good winning javelin throw of 143' 2" in the first match of the month. Carter and Lascelles have been useful in the long sprints; Matthews, that indefatigable secretary, has performed at every meeting, his versatility with hurdles, flat races and field events bringing in steady and useful additions of scoring points. As the month has advanced we are pleased to note the steady return to form of Morgan—a rate of return which is presumably in inverse proportion to the rate at which his memories of the Rotunda and the prepared waters of the Liffey fade. John Menon, a tower of strength as ever, was out there in the lead in all his three mile races.

University Championships
Motspur Park, May 14th

Almost a full team this time, although it was unfortunate that Arthur Wint from whom we had hoped for victories in the 440 and 880 yards was suffering from strained leg muscles and unable to compete, and that John, also with muscle trouble, was unable to produce his best. However, we maintained our position of 3rd in the competition, Imperial College again carrying off the Championship with 93 points, with Battersea Polytechnic 2nd with 52 points, a mere single point ahead of Bart's. In the Thierry Challenge Cup, in which the scoring takes into account the number of students, Bart's was awarded 2nd place with 306 points to Battersea's 364.

The 880 yards race saw the breaking of a record made in 1923 by H. B. Stallard who is now the President of the club, but although a Bart's man, running second, got within the old time, the record passed to H. J. Parlett, the present British 880 yd. champion. MacDonald, a first-year

student, must be congratulated on his very fine performance which brought him into 3rd place.

We must also take note of the appearance for the first time in the University Championships of a Bart's woman student who ran well to be awarded places in the 80 m. Hurdles and the 880 yards.

Scoring positions in the Finals were gained as follows:—

80m. Hurdles. Women	2nd	H. Meredith
880 yards. Women	3rd	H. Meredith
Throwing the Hammer	2nd	R. T. Heylings
One Mile Walk	3rd	G. Wallace
440 yards Hurdles	5th	D. C. Morgan
One Mile	3rd	J. I. Burn
120 yards Hurdles	2nd	E. M. Rosser
Pole Vault	5th	V. Chuck
Javelin	3rd	D. L. Bee
2 miles Steeplechase	5th	P. D. Matthews
Long Jump	4th	A. H. John
880 yards	2nd	A. E. Dormer
	3rd	A. H. MacDonald
Hop, Step and Jump	5th	A. H. John
3 Miles	3rd	J. A. Menon

Eight members—Heylings, Dormer, John, Menon, Burn, Rosser, MacDonald and Wint have represented London University, Wint, Dormer and Rosser going over to Paris to help London defeat Paris University for the first time since 1938.

In the U.A.U.-British Universities Championships at White City on May 21st, placings of Bart's men were:

Throwing the Hammer	4th	Heylings
880 yards	2nd	Wint
	3rd	Dormer
120 yards Hurdles	5th	Rosser

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M.D. (Lond.) 1901-1948	457
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ELECTION AND EXAMINATION RESULTS

ROYAL COLLEGE OF PHYSICIANS

The following Candidate is nominated for election by the College to the Fellowship:—
Gibb, W. E. April, 1949.

UNIVERSITY OF LONDON

Third (M.B., B.S.) Examination for Medical Degrees

April, 1949.

Honours

Myers, S. (Distinguished in Medicine)

Pass

Batten, K. L.	Finer, B. L.	Jones, A.	Sophian, G. J.
Brandreth, T. K.	Gai, P. N.	Linnett, M. J.	Taylor, G. B.
Charles, D.	Harris, J. W. S.	Mehta, M. D.	Watson, J. R.
Colquhoun, I.	Hindle, I. F.	Melotte, G. H. C.	Weller, M. A.
Coombs, G. A.	Hobbs, J. J. B.	Morris, V. C.	Wilson, F.
Craike, W. H.	Johnson, W.	Powell, F. J.	Wright, W. J.
Ebbing, R. N.			

Supplementary Pass List

Part I

Andrews, J. D. B.	Facer, J. L.	Leary, B. D. J.	Thomas, D. H. C.
Brown, H. S.	Ffooks, O. O. F.	Menon, J. A.	Thomas, W. C. T.
Cox, J. S.	Freier, S.	Montfort, F. G.	Tucker, D. K.
Crook, R. A.	Griffiths, J. D.	Morley, D. F.	Vercoe, M. G. S.
Davies, W. H. G.	Harrison, J. A. B.	Reading, J. H.	Wainwright, A. J.
Dickerson, R. P. G.	Hawkes, P. H. R.	Rees, J. D.	Woolf, J. C.
Drown, G. K. M.	Holland, W. G.	Rees, J. H.	Wright, R. F.
Evans, T. L.	Jones, N.	Rohan, R. F.	
Eve, J. R.	Koster, H. G.	Tannen, G. F.	

Part II

Bass, P. H.	Drown, G. K. M.	Hooper, E. R. S.	Mendel, Dennis
Crook, R. A.	Fyfe, A. E.	Leary, B. D. J.	Newman, W. T.

Part III

Bhandari, N. P.	Freier, S.	Latham, J. W.	Morgan, D. J. R.
Davies, H. F.	Kazantzis, G.	Mehta, J. S.	Timmins, W. L.

Examination for the Postgraduate Diploma in Psychological Medicine

March, 1949.

Part A

Brenman, E.	Weatherhead, A. D.
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SOCIETY OF APOTHECARIES OF LONDON

Final Examination

April, 1949

Pathology, Bacteriology and Forensic Medicine

Giri, G. A. R.

BOOK REVIEWS

SUGARS AND BACTERIA. Thomas Kerfoot and Co., Ltd.

For bacteriologists and others who are interested in the fermentation of sugars by bacteria, Thomas Kerfoot and Co., Ltd., have produced a thirty-six page monograph. In this is given the compositions of the various Kerfoot sugars, and also a short account of their uses in the identification of bacteria and in various clinical tests.

R. A. S.

PENICILLIN AND OTHER ANTIBIOTICS, by G. W. S. Andrews and J. Miller. Introduction by Sir Alexander Fleming. Todd Publishing Group, pp. 160 + 4 plates. Price 7s. 6d.

The aim of the authors of this book, who are assistants in the Wright-Fleming Institute of Microbiology, St. Mary's Hospital, is to produce a short scientific survey of the subject of antibiotics. The book is divided into four sections, dealing with antibiotics in general, penicillin, streptomycin and tyrothricin, and future research in antibiotics, each section being provided with a list of selected references. Each of the substances mentioned is dealt with in some detail, and considerable attention is paid to methods of manufacture and chemical structure. The result is in no way a clinical manual, but is a good account of the more scientific aspects of antibiotics and their preparation.

R. A. S.

ST. BARTHOLOMEW'S



HOSPITAL JOURNAL

Vol. LIII

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No. 8

GINGER POP

THE Vicar of Wakefield "was ever of opinion, that the honest man who married and brought up a large family, did more service than he who continued single and only talked of population." We will take the traditional plural to exempt us partially from his stricture, and endeavour to show that he was but literally justified in this opinion.

A Royal Commission may be compared with a thunderstorm in summer: unpredictable changes in pressure and temperature, the gathering of forces, a long-drawn muttering and grumbling, until the whole atmosphere is charged with intolerable oppression. At the last moment, when relief is despaired of, comes the Report, making a good deal of noise for a short time, and reverberating from nearby eminences; then the clouds disperse, the air is clear again, we are back where we started—until the next storm. Thunderstorms are frequent in England.

Our population, we are told, is declining, though not so fast as before the war. Then, of course, we spoke of the "Net Reproduction Rate"; now we revert to Basic English and the "Average Family Size." The Average Family is found to have 2.2 children, and should have 2.4 if a constant population is to be maintained. Not a very high aim; but the average family of "non-manual workers" is only 1.68. As they are a small proportion of the nation, and the most intelligent (axiomatic: how can a surgeon, who works with his hands, be intelligent?), so more of the cream is skimmed by infertility from the top of the population with every new opportunity for ability to rise to its own level. Conversely, the less intelligent breed more rapidly, and we shall

soon be a nation of morons. Perhaps it would be better to bring all families down to an average of 1.5 children, so that we could die out like the scholars, less and less of us knowing more and more?

The unrecognised impulse behind this insistence on the importance of maintaining the population, if not increasing it, is national pride. Just as primitive peoples judged a man's prowess by his progeny, so the civilised Western democracies feel impelled to continue expanding. How much better the Eastern negligence of such policies, the calm indifferent multiplication of brown and yellow and black! Let us emulate South-eastern Asia, which de Quincey described in horror as "the part of the earth most swarming with human life, the great *officina gentium*. Man is a weed in those regions." Not to bother about an object was always the best way to achieve it.

Malthus was before his time. The grand old March of Progress has kept food production ahead of consumption by the margin of approximately one thousand million chronically undernourished inhabitants of Asia and Africa for centuries now. Why should it not continue to do so? New food sources will be discovered as fast as new millions are saved from death and disease; contraception will gain adherents as quickly as continents are destroyed by erosion . . . the few who think otherwise are contemned for their Jeremiads.

Meanwhile, in England, "both parents and children of even medium sized families are at a serious disadvantage in material circumstances and prospects as compared with those of the very small families," and

"the ordinary economic deterrents to parent-hood are aggravated in the higher and upper-medium income ranges"—splendid periphrasis—"by an unfair incidence of taxation, and parents in these income ranges are entitled to such further tax relief as can be justified on grounds of fiscal equity." This is the substance of the Report of the Royal Commission on Population; a thunderbolt indeed to our egalitarians in

high places. But it will no more than glance off them; they will stop their ears to its echoes, and nothing will change. Would there have been more lasting effects if the Commissioners had said, with Ralph Waldo Emerson,

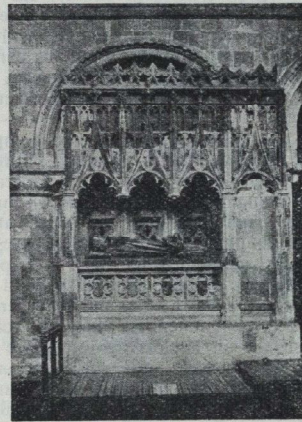
*"Earth, crowded, cries: 'Too many men!
My counsel is, kill nine in ten,
And bestow the shares of all
On the remnant decim!"*

ST. BARTHOLOMEW THE GREAT

The Priory Church of St. Bartholomew the Great, founded by Rahere in 1123 with the Hospital, is in urgent need of repair. An appeal has been made for £20,000 to carry out the work, which is additional to that classed as "War Damage."

The church is the oldest in London, and one of the finest examples of Norman building in the world. Its land and endowments, and a part of the fabric, were seized at the Reformation and its status was reduced to that of a parish church.

Contributions should be made payable to The Treasurer, St. Bartholomew-the-Great, London, E.C.1, and sent to the Rector, St. Bartholomew-the-Great, The Gatehouse, West Smithfield, London, E.C.1. Forms of covenant, and the full text of the appeal are available from the Rector.



Rahere's tomb

BIRTHDAY HONOURS

- C.B.E.**—Brooke, Charles Wartham, Ph.D.
Green, Francis Henry Knethell, M.D., F.R.C.P.
- O.B.E.**—Jayasuriya, Joseph Hulbert Fernando, F.R.C.S.
Rees, Thomas Percy, M.D., M.R.C.P., D.P.M.
Waterfield, Noel Everard, F.R.C.S.

THE CHRONIC SICK PROBLEM

By TREVOR H. HOWELL, M.R.C.P. (Ed.)

A SHORT time ago, a consultant was asked to visit the home of an elderly patient, for whom it had been impossible to find a hospital bed. The general practitioner explained that the case was a puzzling one and that he had not been able to make a satisfactory diagnosis. On seeing the patient, the consultant found no less than five different pathological conditions, two of which required further investigation which could only be carried out satisfactorily in hospital. In addition to osteo-arthritis of one shoulder, sacro-iliac strain and fibrositis in the muscles of the left thigh, there was a marked degree of hypertension, an enlarged tender liver and a painful mass deep below the left costal margin. Under the circumstances, it was decided to start the necessary investigations through the out-patient department of a neighbouring hospital, transporting the old woman from her home by means of an ambulance, then returning her home again after each test had been carried out. In the same way it was arranged to begin the physiotherapy which was necessary to relieve the rheumatic pains when regular transport to hospital could be organised. Since her age was 72 and since her condition could not really be considered acute, this was the only way in which the case could be managed, a diagnosis established and treatment given.

Now why was it not possible to get a patient of this type admitted to hospital? Technically, because she came into the category of aged chronic sick. It was unlikely that she would either die or recover completely within three or four weeks. A general hospital, wishing to admit acute cases to its medical wards, would find that patients such as this tended to stay a long time and to block beds urgently needed for younger people. Why, then, could such a patient not be transferred to a chronic hospital as soon as the investigations had been completed? Because it is difficult to get any vacant beds without waiting for them quite a long time. The position is rather like a traffic jam in a busy London street. Vehicles roll up at the end of the queue quicker than they are released at the head of it. In other words, the demands for beds in a chronic hospital is greater than the supply. Aged chronic sick seem to be manufactured more rapidly than they are being either killed or cured. But

this is only guess work, you may complain. Are there no reliable figures which support or deny this theory?

Let us therefore examine a few statistics from a large chronic hospital in London. This building had 637 beds in use before the war. At present, owing to bomb damage and shortage of staff, some 480 are occupied. Some of these, however, are filled by cases suffering from pulmonary tuberculosis or patients sent for observation of their mental condition. A recent estimate suggested that only 408 were available for (aged) chronic sick. During the year 1948, this hospital had 104 deaths among its chronic patients. The length of stay of these patients is shown in Table 1.

TABLE 1.
Length of stay before death.

Less than 2 months	...	...	39
2 to 14 months	...	...	35
14 to 24 months	...	...	11
24 months or more	...	...	18

103

Let us see how this compares with the rate of discharges in the same period. But there are two special factors to remember in this connection. The first is that nearly all cases admitted to this hospital were sent there as being incurable and past treatment. The second is that there is an active Geriatric Unit in the building of 50 beds, which specialises in the rehabilitation of chronic arthritic and hemiplegic patients. Both these factors must be taken into account when considering the figures in Table 2.

TABLE 2.
Length of stay before discharge.

Less than 2 months	...	...	36
2 to 14 months	...	...	36
14 to 24 months	...	...	12
24 months or more	...	...	6

(18 from Geriatric Unit)

This gives us a total of 193 vacant beds in a year for a hospital containing 408 chronic cases. Expressed differently, this means that about four beds are available every week. Now the hospital in question serves five hospital management committee

groups. Each gets less than one vacancy per week. No wonder that there is a traffic block!

A recent survey of the patients in this hospital revealed that no less than 70 were not in need of either nursing or medical care, but could not be discharged owing to social reasons. In most cases, this was lack of any home to which they could go. Many of these patients were infirm and only fit for ground floor accommodation. Such diseases as hypertension, chronic bronchitis, arthritis or slight strokes could have been supervised as out-patients if the old folk had a home in which to live. The result was to block beds which were needed for others, usually more infirm than their present occupants. This was another cause of the traffic jam which exists.

In 146 patients, an enquiry was made about previous hospitals to which they had been admitted before transfer to the present one. The replies were sometimes vague and unreliable, but many cases seemed to have been sent from one place to another during the war. Sometimes this had resulted in lack of continuity of treatment and a deterioration of the condition of the patient. The results are shown in Table 3.

TABLE 3.
Previous hospital admissions or transfers.

No previous admissions	14%
1	42%
2	27%
3	9%
4	6%
6	2%

100% = 146 patients

A further investigation was made of the kind of hospital to which these patients had been admitted or transferred. This revealed that some 20% of the previous attendances had concerned voluntary hospitals, 68% municipal hospitals and 12% E.M.S. hospitals. On the average each case had been in two hospitals before reaching the one

surveyed. When the length of stay was considered, the hospital in question produced some rather interesting evidence.

TABLE 4.

Length of stay in chronic hospital.	
1 year or less	55%
1 to 2 years	20%
2 to 3 years	20%
3 years or more	5%

100% = 392 patients

At the time of the survey (September, 1947) some 18% had been in the hospital less than a month, 24% less than two months. It was noted when examining the death rate, that many patients died during the first few weeks after being transferred from another institution. Once past this period, they tended to live some time before dying.

Now what lessons can we learn from an examination of these facts and figures? First of all, it is difficult to get patients into a chronic hospital because the rate of both deaths and discharges is low. This blocks the stream of traffic in acute hospitals and leads to complaints like those of practitioners in a recent *British Medical Journal* (March 5th, 1949). Secondly, it is difficult to increase the rate of discharges from chronic hospitals until there is more accommodation available for infirm persons who need supervision but no nursing. Otherwise a chronic hospital becomes a stagnant pond with no outlet, in which deaths cause the only vacancies. Thirdly, to revert to the case report with which this paper began, it is possible to investigate and treat some elderly patients in their own homes if transport to hospital and adequate domestic help is forthcoming. The key to the chronic sick problem lies more on the social plane than the medical one. A little imagination applied to logistics, and a little staff work applied to transport, out-patient clinics and domestic assistance might alter the outlook within a relatively short period.

49 YEARS OF PRACTICE

Dr. F. E. Feilden, of La Mielle, St. Saviour's is 84 today. A student of "Bart's" Hospital, London, he qualified in 1900, and thus has 49 years of medical and surgical practice and experience to his credit, besides active service both in the Army and Navy in various wars. He is still conducting his private practice and hopes to continue to do so.

From the *Guernsey Evening Press*, June 13th, 1949.

THE LIFE AND WORKS OF SIR ARCHIBALD GARROD

By C. J. R. HART

Based on the Wix Prize Essay, 1949

PROLOGUE

ARCHIBALD EDWARD GARROD was born in Harley Street on the 25th of November, 1857. If there was anything momentous or spectacular about the event, no record of it has come down to us. Indeed, on this as on other details of their personal affairs, the family retained a reticence which is at once the admiration and the misfortune of the would-be biographer.

Proud, talented and successful, the Garrods came from East Anglia, where they owned a thriving estate agency in the county town of Ipswich. The move to London was made by Archibald's father, Alfred Baring Garrod, who had shown no inclination for the family business. Choosing instead the profession of medicine, he served the usual apprenticeship to a local surgeon and completed his studies at University College, London, where he gained the gold medal at the M.B. examination in 1842.

Soon afterwards he married into the Sparrow family, who were well known in Ipswich, having inhabited for centuries a house in the Butter Market there, one of the most beautiful surviving specimens of Tudor domestic architecture. Dr. Garrod was appointed to the staff of his teaching hospital, and the couple set up house at No. 9 Charterhouse Square, a pleasant Regency building on the site now occupied by a large modern block of flats. He was fortunate, as well as clever. His hospital was newly founded, and the Governors sought to fill the teaching posts with the most promising of the pupils. Less than ten years after qualification Dr. Garrod became a physician and Professor of Therapeutics and Clinical Medicine there — an unusual achievement, even in those times of opportunity. His private practice, too, was growing rapidly, and before long the family was established in Harley Street, and augmented by the arrival of two sons and two daughters.

By the time Archibald appeared on the scene, his brothers were already demonstrating their talent at a preparatory school in Regents Park. What little is known of the family group suggests that it was a happy and united one, yet ambitious almost to

the point of competition among its members. Clearly, great things were expected of Archibald Garrod.

EARLY INFLUENCES

In his early years Archibald was able to watch his brothers as they made their way steadily to success. For three years running, his eldest brother Alfred obtained the medical scholarship at King's College, London, after which he qualified and gained an exhibition at St. John's, Cambridge. The following year found him performing experiments on body temperature, and suggesting improvements to the sphygmograph. In the same year, 1869, Herbert Baring Garrod, the second son of the family, gained the Newdigate Prize for English Essay at Oxford. Subsequently he became a barrister and a noted literary critic.

All this had happened before Archibald was old enough to go to school, and no doubt the boy was too concerned with exploring his immediate environs to pay much attention to such triumphs. Harley Street in the 'sixties, with all its coaches and liverymen, was not so very far from the fields of Marylebone, and if young Garrod's later travels are anything to go by, he did not neglect his early opportunities.

At home a constant visitor was his cousin Charles Keene, whose charming black-and-white sketches in "Punch" were delighting an ever-increasing public. Keene was far more than a mere illustrator; indeed his latest biographer has called him "one of the greatest of English artists." Another gifted cousin was Meredith White Townshend, authority on Indian affairs, who was on the staff of *The Spectator*. He came to live near the Garrods in Harley Street, and it was probably from Townshend that Archibald derived his life-long interest in history and geography. There were other influences, too, outside London. The family always kept a close connection with the Ipswich branch, and one of his grandmother's letters refers to a visit from "dear little Archie."

It seems probable that Garrod's first instruction, like that of his brothers, was obtained at a preparatory school. The

rising family fortunes then rendered a public school education possible, and Professor Garrod chose Marlborough, where Archibald entered Littlefield House in January, 1873, at the age of fifteen.

Whether the success of the rest of the family had overawed him, or whether he was just going through a difficult period, we do not know, but he did not show much bent for the ordinary classical education, and his reports were disappointing. Within two years, his father considered him so unpromising that he decided to remove him from Marlborough and put him to business. By great good fortune this crisis was dealt with by Dr. Farrar, later Dean of Canterbury, who was Master of the College. Farrar could not possibly have followed the progress of all his pupils in any detail—Marlborough was by then among the largest of the public schools—but there must have been something exceptional about Garrod, which the Head was quick to discern. He considered the boy to show promise in a scientific direction, and persuaded his father to revoke his decision.

Garrod always claimed he owed his career to Farrar's judgment, and there is no doubt that the following passage from his address to the Osler Club, more than fifty years later, is autobiographical:—

"We recall the schoolmaster who awakened our interest in what has been our life's work; he who by a word of encouragement spoken in good season helped to give us confidence and showed that one person at least believed that there was something in us. Another may have succeeded in interesting us in subjects for which we had no appetite—classics perhaps . . ."

Garrod determined to justify the faith his Head had placed in his ability. He studied hard in all subjects, but particularly the sciences, and when some months later he entered for the Public Schools Examination of the Royal Geographical Society, he gained the Bronze Medal for second place. The success was a timely one, and did much to restore his self-confidence and to meet the high expectations of his father. As he continued to work hard and show considerable promise, in January, 1877, he was entered at Oxford as a Commoner at Christ Church.

Of the events of the next four years, not much is known, except that he read very widely, and developed an affection for the

quiet and orderly collegiate routine. His solemn and retiring disposition masked a keen brain and a determined ambition to emulate the success of the rest of the family.

His eldest brother had become Prosector of the Zoological Society when only 25, and while still in his twenties he obtained the posts of Professor of Comparative Anatomy at King's, and Fullerian Professor of Physiology at the Royal Institution. This progress was halted abruptly by a severe pulmonary hæmorrhage, and in mid-December, 1878, Archibald accompanied him to Mentone, where he stayed until the end of January. The season was wet and dull there, and the change did him little good. His health deteriorated steadily until his death in October 1879, surrounded by his family, and mourned by many scientific friends, who had seen in him a second Darwin.

Meanwhile Archibald had returned to Oxford, where he was awarded the Johnson Memorial Prize for an essay on *The Nebulae; a Fragment of Astronomical History* in which he discussed Sir William Herschel's observations on nebulae and star-clusters. From this essay may be dated Garrod's lively interest in what he termed "the very borderland of knowledge." New discoveries in all branches of science called forth his unstinted admiration.

When the time came for a decision on his future line of work, Garrod could not have found it easy. His wide interests and natural bent for investigation suggested a research post, but financial considerations forced the choice of a more remunerative career. His father had reached consultant status some years previously, and was devoting much of his time to work on the causes and treatment of gout. Chemical pathology was then one of those untrodden pathways which enticed the adventurous spirit, and Archibald Garrod was deeply interested in his father's researches.

In 1880, having obtained a first in the Natural Sciences School, Garrod entered Bart's. What determined the choice of hospital is not easy to tell, but among the students were several known to him at Oxford; as for the staff, his father had many friends there. The physicians included Drs. Church and Gee, with Dr. Duckworth as one of the assistants. Among the surgeons was Mr. Thomas Smith, Mr. Mills was the Administrator of Chloroform, and

the (for Garrod) all-important subject of Chemistry was under the charge of Dr. Russell, F.R.S., whose predecessor had committed *felo-de-se* with the curious mixture of morphia and prussic acid. Incidentally, the standard text book of *Materia Medica* then in use at Bart's was written by Garrod's father.

While a clinical student, Garrod continued his interests in other branches of science. He rewrote his prize essay on Astronomy, and had it printed privately—his earliest work. This 44-page pamphlet is now rare, but a copy has found its way to the British Museum. In spite of this preoccupation, medicine was not neglected; in 1881 he gained a Junior Scholarship and in 1883 the Brackenbury Scholarship in Medicine. He celebrated the latter award with a trip to Norway the following summer, which he made with a fellow student, H. Lewis Jones. Part of their holiday was devoted to a survey of Norwegian medicine, and on his return Garrod described some of their experiences in a paper entitled "A Visit to the Leper Hospital in Bergen," which he read before the Abernethian Society. It comes as something of a shock to the modern student to discover that the leper population of Norway was then 1,600.

Garrod qualified M.R.C.S. in 1884, and on his father's advice spent some months post-graduate study at the Allgemeines Krankenhaus in Vienna, where there was excellent teaching, especially in the more technical branches of medicine. The lecture-demonstrations by Schnitzler and von Schrötter on laryngology—then a very poorly developed science in England—excited his especial admiration, and on his return he produced a concise and useful little book on the laryngoscope. Nor was this the only result of his stay abroad, for in after life Garrod found his foreign friendships of great help in propagating his discoveries. His father was an honorary member of the *Gesellschaft für innere Medizin*, and in later years the son achieved the same distinction.

MEDICINE AND SCIENCE

He came back to Bart's as a house physician to Dr. (later Sir) Dyce Duckworth, an old friend of his father, with whom he had much correspondence on the subject of "rheumatics." At this time there was only one house physician to each firm, and for a

whole year Garrod was responsible for the work in the surgery as well as the wards. It would be hard to suggest a better preparation for his professional career than the rigorous training at home and abroad to which Garrod submitted himself.

In 1885 he obtained his B.M., M.A., Oxford and M.R.C.P., London. He proceeded M.D. a year later. He was now 29, and the question of a home and practice weighed heavily. Thomas Smith was at this time at the height of his career at Bart's. An exponent of the old school—he was the last man to enter Bart's as an apprentice, under Paget—he was the best-loved surgeon in London, with a large and remunerative practice. Two of his daughters were already the wives of Bart's men, and in 1886 Archibald Garrod married his eldest daughter, Laura Elizabeth. The details of the romance, in common with the rest of their private lives, are hidden from our gaze.

Dr. and Mrs. Garrod settled at No. 9 Chandos Street, Cavendish Square, where they remained for the next 30 years. Together with his friend H. L. Jones, Garrod was appointed a Casualty Physician at Bart's. Ten years previously Robert Bridges had held this post, and the conditions in the casualty department had formed the subject of a powerful attack from his pen, which was printed in the Hospital Reports. By the time Garrod reached the scene, Bridges was on his way to becoming Poet Laureate, but the department was little changed, and remained so until the present building was erected in 1907.

After holding this appointment for two years, Garrod became Assistant Physician to the West London Hospital, where he stayed until 1896. Dr. Garrod desired a permanent post at Bart's, but none was then available. In those days, to quote Robert Bridges, "the only avenue to the staff was through the post-mortem room." It was possibly with this remark in mind—taken literally—that Garrod proceeded to spend part of his spare time collaborating with Wilmot Herringham and W. J. Gow to prepare *A handbook of Medical Pathology for the use of students in the Museum of St. Bartholomew's Hospital*, which was published in 1894.

During his long years of waiting for a vacancy at St. Bartholomew's, he started his life work on chemical problems. His early observations were made under the influence of his father (now knighted and a physician—

extraordinary to Queen Victoria), who placed case books at his disposal. In 1890 Archibald Garrod produced a *Treatise on Rheumatism and Rheumatoid Arthritis*. His father had previously differentiated the latter condition from gout; in later years Garrod drew a further distinction by classifying osteoarthritis separately. Throughout his life he wrote many papers on this and allied subjects, in one of which he described the rheumatic nodules known as "Garrod's Pads."

At this period the technical methods of quantitative blood analysis were yet to be developed and those interested in metabolism were still led to look for changes in the urine as a chief field for study. Garrod began to concentrate on urinary pigments, and his first paper on hæmatoporphyrin was produced in collaboration with F. Gowland Hopkins of Guy's.

Eventually a place was found within the hospital hierarchy. In 1895 the number of medical firms was increased from four to five, and this led to a rearrangement of posts. The Medical Registrarship was combined with the Department of Morbid Anatomy, and Drs. Garrod and Calvert were made the two first holders of this office. Before long he became also Physician to Out-patients at Great Ormond Street, where his father-in-law (now a baronet and surgeon-extraordinary to Queen Victoria) had been a surgeon for many years.

The Hospital for Sick Children is now nearing its centenary, and it is fitting to pause here a moment to survey the part played by Bart.'s men in its early history. Commencing with the founder, Dr. Charles West, the roll continues with such names as Samuel Gee, Francis Harris, William Steavenson and Robert Bridges. At the turn of the century, Sir Thomas Smith and his son-in-law, Dr. Archibald Garrod, were maintaining this proud connection.

Always an extremely hard worker, Garrod was now completely absorbed in his studies. His interest in urinary pigments led him to investigate Alkaptonuria, the peculiar condition in which voided urine turns black on standing. It was then thought to be due to infection, but the absence of other signs of disease rendered this explanation unlikely. One afternoon while walking home from hospital and pondering on this problem, it flashed through Garrod's mind that the condition was perhaps caused by a metabolic error, a disturbance of chemical activity in

which a different molecule resulted as an end-product. He saw that the origin of such a state of affairs could be hereditary. Fortunately the mother of one of his alkaptonuric patients was pregnant at the time, and Garrod resolved to test his theory.

The experiment, once conceived, was simple enough. The newly born baby's napkins were inspected regularly. They were found to be stained by the second day of life. Collection of urine was carried out as soon as practicable, and within a week the characteristic pigment of the condition—homogentisic acid—was isolated. The child had been born alkaptonuric.

The discovery was of far-reaching significance, for until that moment the possibility of such inherited abnormalities had not been examined. Garrod spent the remainder of his life collecting further examples of such inborn errors of metabolism. Meanwhile his work began to attract real, if limited, attention in this country. He became a full physician at Great Ormond Street, and in the first year of the new century he was invited to summarise his researches in the Bradshaw Lectures of the Royal College of Physicians.

In 1903 Dr. Archibald Garrod became an Assistant Physician at St. Bartholomew's Hospital. He was then aged forty-six; owing to the galaxy of medical talent then on the staff—most of whom had reached their posts at an earlier age—Garrod had waited longer than usual for this appointment. Little known as yet at home, he was already famous abroad, and the many foreign physicians and scientists of eminence who came to visit him during his early period on the staff gained him some notoriety.

When in the following year it was decided to start an out-patient department for the diseases of children, Garrod's experience made him particularly suited for the post of physician-in-charge, which he shared with Dr. Herbert Morley Fletcher. Together they built up a department which was handling 7,000 patients a year when Garrod left it for other activities six years later.

This period was probably the happiest of Garrod's life. His work was receiving at last due recognition, and at home his wife and four children formed a charming family circle. The veil over his private affairs is lifted for a rare moment in a description by one of his children many years later:—

"His interest in astronomy, like that in history, always remained with him. Both

these interests he imparted to his children at an early age, having a great gift for making such things interesting to the young. When I was a child, from nine years old onward, one of the great pleasures of the week was the Saturday afternoon walk, which was always the occasion for a long story, usually historical. In this way I learned the history of the Roman Emperors, and the chronicles of the Roman Emperors, which were developed in front of their busts in the British Museum, and a host of other things. If possible my father planned the walk to take in some building or statue relating to the story he told."

The account may cause modern readers to smile, but with all its stateliness and grave dignity there is something very human in this picture of the successful Edwardian physician and his children. All too quickly, however, the glimpse of the "life" is ended, and regretfully we turn once more to catalogue the "works."

In 1904 A. E. Garrod was an important participant in a move to start a medical journal of a type rather different from any then being published in England. The aim was to produce a medium for recording the results of fundamental research which had perhaps no immediate clinical application. At an early stage in the discussions the inimitable Osler was consulted by Garrod. He suggested the prior formation of an "Association of Physicians" modelled upon the American body of the same title which he had formed, and using the proposed journal as its official organ.

Osler had just accepted the Regius Chair of Medicine at Oxford, and was soon back in America settling his affairs before his final move across the Atlantic. Meanwhile Garrod was deputed to get together a few active and influential physicians, and arrange a meeting with Osler as soon as he returned to England. Garrod and Osler had been in correspondence a year or two previously on the subject of alkaptonuria, and their acquaintance now ripened into friendship.

In May, 1906, the meeting took place at Dr. Wilmot Herringham's house in Wimpole Street, where after dinner Herringham, Rolleston, Garrod (all of Bart.'s), Hutchison, Hale-White, Rose Bradford and Osler agreed to accept the latter's suggestions. This involved much activity and canvassing up and down the country by those present at

the gathering, who soon became known by their followers as "The Gang." When in due course the highly select association was formed—numbers restricted to 250—most of the members of "The Gang" became co-editors of the journal. Garrod retained his post on the Quarterly Journal of Medicine for 21 years, and devoted much time to his editorial duties.

Partly because of these activities, his researches began to receive more attention in England than they had done previously. In 1908 he was invited to give the Croonian lectures to the Royal College of Physicians. He devoted them to an account of the inborn errors of metabolism, which he published in book form a year later—his most important single work. By then he had added three more diseases to his list, and was able to generalise on the subject. A whole branch of medical knowledge had been created. In recognition of this achievement, he was elected a Fellow of the Royal Society, an honour already bestowed upon his father and elder brother. Garrod was justly proud of this remarkable family record.

Dr. R. S. Frew, who was associated with Garrod at Great Ormond Street from 1908 to 1911, has kindly supplied some details of his work there. He writes:—

"He was the greatest scientific physician I encountered during my whole career, with a great gift for imparting his knowledge. His round lasted for about 1½ hours, twice weekly, and half that time was occupied in testing urines. He said to me once, 'Clinical medicine is not really my main interest, I am a wanderer down the by-paths of medicine'—an accurate description.

"He used to love bringing his alkaptonuric patients back time and again to the ward, and a case of steatorrhœa was heaven to him. He had both a male and a female alkaptonuric and he used to get them into the ward at the same time, in the hope, as he said, that they might become fond of each other, for there was no known case of two alkaptonurics having married each other!

"He would hold forth on Mendelism and illustrate it on many occasions. He loved children, but was, I think, always a little in awe of them. He was a most distinguished man, a great pioneer, though equally a great upholder of tradition."

Sir Robert Hutchison, another of his Great Ormond Street colleagues, and a member of

"The Gang," writes similarly of this period:—

"He was not one about whom anecdotes catered for; he was in truth rather solemn—one might say ponderous without much wit or humour. He therefore did not appeal much to students for he had none of the tricks and mannerisms which they like; he was, however, a sound teacher and a good all round paediatrist."

In November, 1911, Garrod was elected Fellow of the centuries-old College Club of the R.C.P., whose select gatherings he found most congenial, and attended regularly until the war. Of the 22 members, those from Bart's then included Sir William Church, Sir Norman Moore and Sir Francis Champneys, to mention only the baronets.

In 1912 he delivered the Lettsomian Lectures to the Medical Society of London. In 1857—the year of Garrod's birth—his father had been similarly honoured. Both chose chemical subjects—the father gout, the son glycosuria. The strong similarity between their careers will have been noticed already. In one direction there was a difference, however, for Dr. Garrod never attracted as many private patients as his father, who had enjoyed one of the largest practices in London.

Earlier in 1912 Dr. Garrod had been appointed at last a Physician at St. Bartholomew's. His inaugural lecture to the Abernethian Society was entitled "The Scientific Spirit in Medicine," and he made a plea that more attention should be paid to German medical literature.

Two passages from later accounts of Garrod, written by his friends among the staff, give a somewhat forbidding picture of the newly appointed fifty-six-year-old physician:—

"In his prime of life," says Dr. Hugh Thursfield, "he was of markedly handsome appearance, with finely shaped head and face, from which looked out dark eyes of impressive brilliance, which at first sight seemed to promise quickness, vivacity and, perhaps, irascibility, yet with deeper knowledge it became clear that any such supposition was completely incorrect.

"Of irascibility there was never a trace; even by momentary irritation he was but rarely overtaken, and never possessed but for a second or two; and quickness of wit, which he had in plenty, was always subdued to a somewhat slow and deliberate utterance, the outcome, no doubt, of his lifelong habit of conscious self-criticism."

Sir Francis Fraser gives a similar description:—

"... There was no one quite like him. An able, practical physician when the need arose, patients, as he said himself, did not really interest him, and the complex problem presented by an individual who is ill did not really appeal to him for solution.

"... His was the mind of the true scientist, and one often wondered, and he wondered also, how he had come to be a practising physician. . . . Often he would spend all morning at a window in the ward testing urine that presented an unusual colour or smell. The morning's round could be left to others. . . .

"Each group of students was to him the raw material in which he hoped to find an individual who would be inspired to see a 'higher medicine' in the problems of the ward, who would perhaps be tempted to ignore the immediately practical and devote his life to 'things that matter'."

Early in 1914 Dr. Garrod was called to give evidence before the Haldane Commission on University Education in London. His recommendations for closer association between the hospital and the university were put into effect after the war, as will be seen presently. At the end of July the B.M.A. held its 82nd Annual General Meeting, in Aberdeen. While present at the gathering, Dr. Garrod received the hon. L.L.D. of Aberdeen University, the first recognition of his work to come from a seat of learning. On August 1st he delivered the Address in Medicine to the Association. It offered no hint of the storm which was to break upon the world just three days later. Indeed, the whole atmosphere of the conference was one of great calm and detachment. No doubt, like the rest of their generation, they assumed "it would all be over in six months." [To be concluded]

CANDID CAMERA

This volume of *Informal Studies of the Great* may be obtained from the Librarian, price 1s.

CORRESPONDENCE

E. E. G.

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

In his article on the E.E.G. in your June issue my friend, Dr. Aldren Turner, has described and illustrated some of the common artefacts which obtrude themselves all too easily on the tracings. I hope that, for the sake of accuracy, he will allow me to point out that his figure of the so-called flat-topped waves of psychomotor epilepsy usefully but quite inadvertently illustrates another artefact. The flat-topped effect of some of the waves of this figure is clearly due to the limitation of the excursion of the ink-writer, so that when high voltage waves are recorded their rounded summit is abruptly cut off and replaced by a horizontal line. True flat-topped waves are compound formations, each built out of two or more rhythms, one component usually having three times the frequency of the other. The summit is thus not exactly horizontal but merely flattened. The artefact in Dr. Turner's figure only slightly deforms what is in fact a very good example of a classical 3 per second wave-and-spike type of tracing.

A very erudite neurologist has said that he has "about as much confidence in the E.E.G. as in an Italian fortune-teller's budgerigar," but such views may be largely because artefacts are often the easiest things to see.

Yours faithfully,

ERIC C. O. JEWESBURY.

E.E.G. Department,
St. Thomas' Hospital, S.E.1.
June 14, 1949.

STUDENTS v. POLICE

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

It is suggested that you, Sir, have not fully appreciated the point at issue between these protagonists. It is not so much the irresponsibility of the former as their potentialities. Suppose, for example, that the members of the visiting staff together with their chief assistants spaced themselves at equal distances around the Old Bailey and proceeded to climb, the chances are that, for good or bad, a considerable body of men would be rendered unfit for further duty at the hospital. Such members of the local constabulary as might witness the performance would be fully justified in assuming an attitude of inscrutable detachment in the full knowledge that it would be abortive. If now the contest be thrown open to students, it immediately assumes an entirely different complexion. There is little doubt but that some would reach the topmost point, where they might even feel inclined to leave a token of their achievement. It is these very potentialities which the police seek to curb.

Yours, etc.,

NEVILLE OSWALD.

70, Harley Street,
London, W.1.
June 14, 1949.

[The following extract from *The Daily Telegraph*, Wednesday, December 8, 1875, lends point to Dr. Oswald's contention.—Ed.]

On Monday afternoon a serious collision took place between the students of St. Bartholomew's Hospital and the police. The former were amus-

ing themselves by snowballing each other in the grounds of the Hospital, and one of the missiles flew beyond the gates into the roadway. A City police constable went into the enclosure and ordered the combatants to desist. He was received with laughs, pelted, rolled in the snow, and ejected. The officer returned with two other constables, but they were also driven out. An inspector, two sergeants, and twenty men then proceeded to the spot, and they were met by a very large body of students who speedily repulsed them and turned them out of the precincts of the hospital amidst a shower of snowballs, in spite of the efforts of Sir Sidney Waterlow, the Treasurer of the hospital, to pacify the young men. A repetition of the scene was expected yesterday, but the police kept out of the way.

FORTY YEARS ON

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

On reading the interesting article by Ernest H. Shaw in the *St. Bartholomew's Hospital Journal* of April I remembered that I still have some old photographs, the majority of which were taken between 1900 and 1904 by E. T. Glenny. I have tried to ascertain the latter's address but can find him neither in the Medical Directory nor in the Medical Register.

Glenny is seen at the "Operation in the Surgery," with what looks like a roller towel suspended from his neck in lieu of a gown, while J. F. Trewby is giving the anaesthetic. At the door of the cubicle is Dr. Malcolm Donaldson. I cannot identify the dresser.

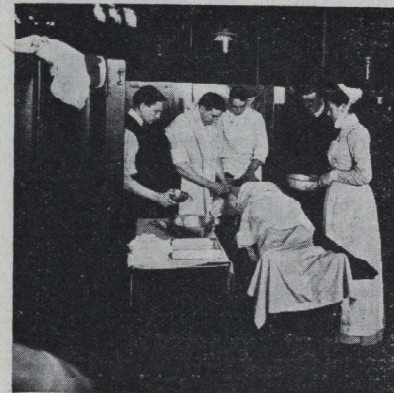
Whenever I have come across them in my bookshelf they have reminded me of much that happened in those bygone days. Perhaps others could also care to refresh their memories.

Yours truly,

M. B. REICHWALD.

Timber Hill, Ashted, Surrey. May 12, 1949.

[A selection of these photographs will appear in later issues.—Ed.]



OPERATION IN THE SURGERY

A SENSE OF HUMOUR

by DAVID CARRICK

APART from the obvious facts that the human being walks on two legs, has no particular object in his existence, and possesses what he likes to refer to as superior intelligence, one of the few truly distinguishing features that raise him from the level of the beast is his sense of humour.

The proximate cause of this peculiar quality is most obscure. Psychologists, I dare say, have a perfectly plausible explanation, but, having read some of their postulations on other characteristics exclusive to man, it is one that I have not cared to discover; it might sadden me. Physiologists, on the other hand, are not so given to letting their fancy roam, which places them at a distinct disadvantage. They must have fact, and this can only be obtained by experiment. Dead subjects are of little use to them; even the wittiest jokes would leave them cold. Living people, excluding those with hysteria or in a state of risus sardonicus, neither of which are exactly amusing, are not inclined to offer themselves eagerly for tinkering purposes which may upset their equanimity. Animals alone remain, and they are virtually useless: the only one that might be singled out for investigation is the hyena, but even his chuckle-headed laugh is indicative rather of the presence of a predatory companion than of a rollicking sense of fun.

At exactly what stage of our evolution an appreciation of the ludicrous arose is equally unknown. Monkeys have a habit of shying coconuts at passers-by, and it is thought by some that this affords them (the monkeys) great amusement, but it is a question that is open to much argument. Neolithic man may have had his sports and entertainments, he probably did, but if they were anything like some of the drawings he made on his cave walls, I feel that a present day observer would be slow in appreciating the nicer points involved.

It is to the Bible that we must turn for enlightenment. Although there is very little reference made to real enjoyment, and, in fact, one of the prophets tells his people that "Sorrow is better than laughter," the number of occasions on which people laughed each other to scorn, and at their friends' calamities, assures one that the ancient Jews were not entirely lacking in conviviality. The translators give us a

number of incidents so worded that either they or the originators must have seen the amusing side of things. For example, when a gentleman by the name of Shimei showed his dislike of King David by cursing and casting rocks and dirt at him: "Abishai the son of Zeruiah said unto the king: 'Why should this dead dog curse my lord the king? let me go over, I pray thee, and take off his head.'" On the whole, however, the Bible is singularly lacking in humour, which is surprising when one considers the number of excellent Jewish comedians on the stage today.

Both the Romans and the Greeks knew how to enjoy themselves. The former derived countless hours of contentment from watching chariot races, gladiatorial contests, or lions eating Christians: whereas the latter had a more sophisticated sense of humour as witnessed by the remarkable Greek comedies which have retained their sparkle throughout the ages.

After the fall of these two great empires, there was a similar decline in talent in all directions. Apart from some form of domestic amusement that must have existed, there were no organised entertainments until the appearance of Greek religious plays. Their popularity soon spread to England where they were presented as serio-comic dramatisations of sacred history, and the humour they contained was of a crude, slap-stick, vulgar type which displeased the Church dignitaries. There are accounts of boisterous choruses of comic shepherds burlesquing the angel choirs; Herod and Pilate playing the parts of low comedians; of extraordinary pranks being played in what are considered to be the holiest of places.

Local sports around this time were on a similar plane. Most of the nobles retained their own fools who were, for the most part, half-wits capable only of practical jokes and indecent stories: plenty of them exist today. Bull and bear-baiting were extremely popular for many centuries, and one of the favourite pastimes of boys was the throwing of stones at live cockerels suspended from posts by one leg.

It is fortunate that the crude, cruel type of humour has largely disappeared, and it is interesting to note that a more harmless

variety, namely that of nick-naming, which was very popular in medieval times, has left its mark where the other has vanished. The majority of surnames now in use date from this period. Many of them were derived simply from places or modes of life, but a great number arose from the wit of wags recognising eccentricities or peculiar misfortunes.

The brilliance of the 16th and 17th century comedists, with Shakespeare at their head, needs mentioning only as a milestone in the progress of sophistication in the art of humour and wit. This progression continued through the succeeding centuries until the cinema and the wireless greatly impeded the spontaneous brilliance one associates with the literary circles so common up to fifty years ago.

As with the past, so with the present era, humour is strictly nationalistic. The Englishman has probably as keen a sense of humour as anyone. He may be reserved, and appear slow to his more quick-witted American cousins, but it is extremely doubtful whether any people in the world could have regarded the ravages of the air-raids as did the Londoners during the worst of their ordeals. In fact, the war did much to revive the natural humour that had been blunted by seventeen years of the artificial variety blared forth from wireless sets.

The Americans, although they consider themselves far advanced with their witticisms, are, in many respects, over three hundred years behind; for what they choose to call wise-cracks, etc., are very little removed from the punning word-play so beloved of the later Elizabethans. They find English jokes as difficult to understand as we do theirs, yet they are not so ready to permit us our eccentricities. I remember an incident which happened a number of years ago that illustrates this intolerance. I was reading a copy of *Punch* in the school library when a member of a party of tourists who was being shown around the place came up to me and took the paper out of my hand. He glanced through it for a few minutes, with a look of mingled perplexity and boredom on his face; then he returned it with the remark: "You English think *Punch* is funny, don't you? . . . Well it's not!"

The Germans have their lighter moments even if they are few and far between. It is alleged that Hitler, much impressed by

the joviality of the Tommies in the Great War, ordered the military authorities to include some jokes in their regimental magazines. They thereupon reprinted some of the Old Bill strips which were considered suitable. Amongst these was the most famous of them all, namely, the one depicting the veteran showing the shell hole to the recruit and calming his nerves by assuring him that it was caused by the action of rodents rather than the enemy. This was fine, but the editor, doubting the intelligence of his readers, placed an asterisk by the caption which led to an N.B. at the bottom of the page pointing out that, in reality, the hole was made by a shell, not rodents!

It is impossible to cover every nation, so I shall content myself with the most remarkable of all the orientals: the Chinese. I have no personal acquaintance with these people and can only offer the two following little stories second-hand as given to me by a friend who was on the Burma air-lift.

He told me that in order that loading and unloading the Dakotas should be done as quickly as possible, the main doors of the machines were removed. These were soon replaced as it was discovered that the resulting gap proved too attractive to the coolies who were carried for the manual work. It seems that if there was a new coolie recruited for the job, his veteran companions would wait until the aircraft was at its maximum height, then take the unfortunate novice to the door, tell him to look at the pretty scenery, and push him out. The sight of the hapless fellow falling to his doom thousands of feet below apparently afforded the perpetrators immense amusement.

The second story is connected with the fear which many of these persons possess in connection with the belief that small, vindictive, invisible devils are continually trailing them. Fireworks are fairly efficient in dealing with the scourge but they were difficult to get during the war, and few of the coolies were trusted with hand grenades. A new method was quickly conceived. This consisted in jumping in front of fast-moving staff cars and letting the vehicle pass near enough to destroy the devil without harming its owner.

Unfortunately, these devils had a habit of coming back after a time, a state of affairs which led one bright lad, who was

working on a Flying Fortress aerodrome, to hit on what he thought was a much better method. One day he was seen regarding the revolving propellers of one of these machines with great interest, and afterwards it was considered that he had reckoned that if a staff car could remove the devil for a considerable time, a propeller might well do the job completely: so he backed slowly towards it.

The devil was killed all right, so was his master, very much so, and my friend assures me that flying operations had to be discontinued from that drome for the rest of the day because the remaining coolies could do no more work... they were doubled up with laughter at what, to them, was the funniest spectacle of their lives.

Since the war ended there has been a marked decline in humour. People do not laugh nor even smile as much as they did. This is due largely to the restrictions and the stringencies of the times, but also there has sprung into being an echo of the old Puritanism that frowned on any form of enjoyment. I am not suggesting that the vulgar story has disappeared, it will never do so: its popularity will remain so long as people exist who are incapable of moving an audience in any other way. There are only two ways open to a poor comedian who wishes applause: one is to get the audience to sing, in which case they applaud their own efforts; the other is to loose vulgarities which make people laugh, firstly because they feel that they shouldn't, and secondly because they fear that their friends will think them prudes if they do not.

But apart from this, there are too many kill-joys about today. Too many people who love the ponderous rather than the light, who prefer the dolorous to the bright. H. M. Bateman has illustrated the behaviour of stern individuals towards the man who dared to laugh where he should have maintained the dank atmosphere of some

pseudo-sacred place. In such a case, the offended are the offenders rather than the falsely accused iconoclast.

And it is not only in the old that we find this severity. Nothing is so sad as the young man, scarcely freed from his mother's apron-strings, who regards all humour as facetiousness, who views even the Times Fourth Leader with disapproval as being beneath the dignity of such an august journal; who, in the pursuit of all the stern duties of life, glowers darkly on all who seek her pleasures. One must pity him because, when he has reached crabbed old age, he has not even the consolation of looking back on a blithesome youth, which he has never known.

All who have to do with the medical profession must have a sense of humour. It becomes almost a duty. The morbid-minded layman is a nuisance only to himself and his family; his equivalent as a doctor is a menace to mankind. There is little in the student's course to amuse, yet in the past medical students have been renowned for their exceptional gaiety, as the Police records will show. It is lacking today: perhaps due to Nationalisation or to the war or both; but whatever the cause, the resulting state of mind is very pernicious, and unless something is done to encourage students to enjoy themselves in some outside interest right apart from continuous medical study, we can look forward to the day when doctors are nothing more than stiff-faced, pill-giving automata.

Perhaps it will not come to that. Let us fervently hope that since such wonderful liberties as the opportunity to gaze at the glittering Bovril advertisement, the permission to buy as many sweets as our salaries will allow, have been restored to us, the British humour will arise again, hoisting with it the cheery, laughing, light-hearted, devil-may-care State Doctor.

B.M.A. PRIZES

Prize for State Registered Nurses: Miss Winifred Hector. Commended: Miss S. M. U. Oates.
Prizes for Medical Students: the subject for 1950 is "Clinical Teaching in Relation to the Practice of Medicine." Essays must be forwarded to the Secretary of the B.M.A. not later than December 31st, 1949.

ORDER OF ST. JOHN

The Lord Prior of the Order of St. John of Jerusalem, Lord Wakehurst, held an investiture in the Great Hall on June 16th. This is the first occasion on which the Great Hall has been used for an investiture.

A THECA CELL TUMOUR OF THE OVARY

by J. WHEELWRIGHT

This tumour was first described by Loeffler and Priesel in 1932, under the term xanthofibroma theca cellulare. In the original series the tumours were described as outwardly resembling fibromata of the ovary, except that the cut surface showed a yellow pigmentation. Histological examination showed that the yellow areas consisted of cells similar to the theca interna cells of Graafian follicles. Since the original publication of Loeffler and Priesel a fairly large number of similar tumours have been described and the tumours are now called theca cell tumours of the ovary.

In 1944 Mc Goldrick and Lapp collected 74 cases from the literature. The maximum age incidence is in the two decades between 50 and 70, though they are quite common in younger patients.

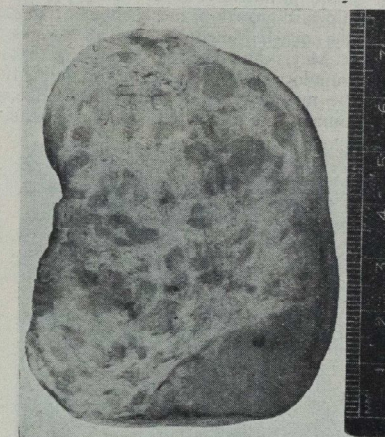
The tumours are hormonal, secreting oestrogens which stimulate the endometrium to proliferative hypertrophy and cause post menopausal bleeding. Occasionally, however, through luteinization of the theca cells, the endometrium displays secretory hypertrophy. The incidence of malignant change is disputed, and in three only of the 74 cases collected by Mc Goldrick and Lapp were there obvious malignant changes. On the other hand, the opinion of most workers is that the tumour should be regarded as of low malignancy.

The following case is fairly typical of a tumour arising in a relatively young woman:
Case Record.

Mrs. K. E., aged 31, married for 7 years, suffered from pruritus vulvae and amenorrhoea. She was referred by her doctor because he had discovered a swelling in Douglas' pouch. Menstruation had started at 13. The cycle was 28 days and the duration six days. There was severe dysmenorrhoea during the first two days of the period. Three years previously the patient had missed two periods. There was no history of previous pregnancy. The last normal menstrual period was in September, 1948, and the patient was admitted on January 18, 1949. The cervix and uterus were healthy, but behind the uterus there was an oval, firm, solid swelling. There was no ascites, and the secondary sex characters were normal. The case was regarded as one of a hormone secreting tumour of the ovary.

The amenorrhoea suggested that the tumour might be virilising in type although there were no signs of masculinization.

Operation was performed on January 19th and the swelling was found to be a solid tumour of the left ovary measuring 3 ins. by 2 ins. The uterus and the opposite ovary appeared healthy. The outward appearance



Irregular areas of pigmentation.

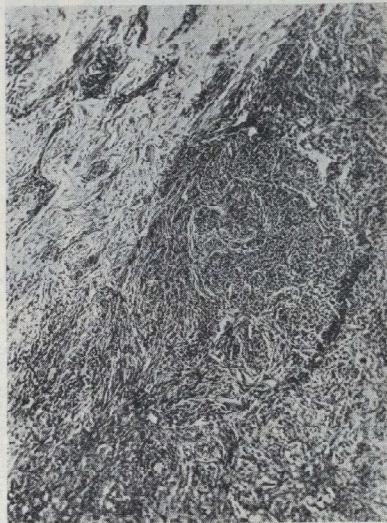
of the tumour was that of a fibroma but the cut surface showed irregularly distributed yellow areas scattered through the substance of the tumour. The tumour was examined histologically and the yellow areas were found to consist of interlacing bundles of fusiform cells rich in protoplasm. In some areas the cells were elongated, similar to those described by Loeffler and Priesel. Between the bundles of cells were masses of hyaline tissue not unlike the tissue found in granulosa cell tumours, though much more plentiful. Similar hyaline reaction is sometimes seen in Brenner tumours. The fat content of the theca cells was low.

Discussion.

It is well known that theca cell tumours produce post menopausal haemorrhage. The development of amenorrhoea has been reported with theca cell tumours and the symptom is also well recognised with granulosa cell tumours. There is evidence that the

oestrogens secreted by theca cell tumours are sometimes considerable in amount and it is possible that the amenorrhoea may be caused by the suppression of anterior pituitary secretion by oestrogens.

The main theoretical interest of the tumours is their histogenesis. The cells of the tumour correspond with the theca interna cells of the Graafian follicles. In the past it was thought that both granulosa and theca cells had a common origin in Pflügers columns derived from germinal epithelium and that segregation of the primitive follicles was produced by the upward growth of mesenchymal tissue from the ovarian medulla. Novak quotes Fischer, Meyer and Politzer as stating that both granulosa and theca cells are derived from the mesenchyme of the genital ridge, while Gilman in a recent publication suggests



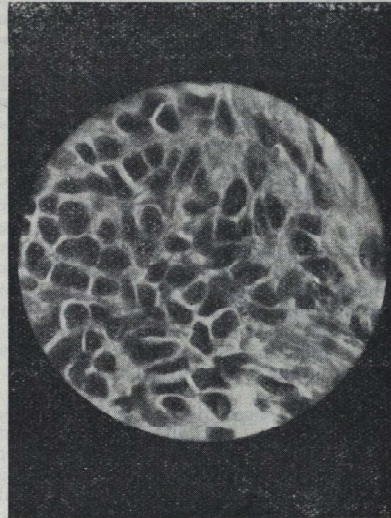
Low power: hyaline tissue and cell rosettes

that the granulosa cells are derived from the coelomic epithelium. It may be that the derivation of the theca cells from the mesenchyme will be disputed in the near future.

There is therefore probably a close relationship between the theca and granulosa cells of the Graafian follicles which would explain the common characteristics of granulosa and theca cell tumours. Both tumours are derived from ovarian mesen-

chyme, it is not therefore surprising that both are oestrogenic and that (histologically) cells characteristic of theca and granulosa cell tumours may be found in a single growth. Additional evidence of the close relationship of theca and granulosa cell tumours has been provided by Giest who produced both tumours by irradiation of mice. Gilman has recently shown that theca cell tumours can be produced experimentally in animals by macro molecules.

Nowadays while theories of cell rests are in abeyance it is difficult to explain the origin of theca cell tumours in post menopausal women, for no ripening follicles are seen in the senile ovary. It has been suggested that the cells of the ovary may revert back by division to cells which are more primitive in type. This process of degeneration and



High power: cell rosette.

retrogression can be detected in the foetal and juvenile ovaries. It may be that by degenerative division ovarian cells may revert to a foetal type and so in later years cause ovarian tumours of the theca and granulosa cell type. It is significant that no theca cell tumours have been described in a girl before the onset of menstruation.

The case has been reported because it is believed to be the first example of a xanthofibroma theca cellulare form of theca

CULPEPER'S LAST LEGACY

by G. C. H. CHANDLER

FEW people can even approach, much less equal, Nicholas Culpeper's record of having published a book which has survived for three hundred years and is still in print to the present day. In addition to his "Compleat Herbal" he also published "Semiotica Uranica," "Compleat Midwife's Practice," "School of Physick," "Physical Directory," and "English Physician Enlarged." These latter two books were published in 1649; in the former he incorporated the 1618 Pharmacopœia and incurred the wrath of the College of Physicians, while the latter, which had a wide circulation and numerous editions was a treatise on astrological botany. Culpeper was, to judge by his last work, published by his wife Alice after his death, a Galenist, and his works greatly widened the rift, started by John Parkinson in 1629, divorcing Herbalism from Medicine.

According to the title page, his last legacy contains amongst other things . . . "Sundry Admirable Experiences in several Sciences, more especially in Chyrurgery and Physick" . . . as well as . . . "two hundred Choice Receipts lately found, never published before in any of his other Works; and a Compleat Table" . . . The sixth edition, published by Obadiah Blagrove, at the Black Bear in St. Paul's Churchyard, in 1685, also has added an exact and perfect Treatise of Anatomy of the Veins and Bladder, Brain and Nerves of all parts of the Body . . ." This is not recommended as a text book for those sitting 2nd M.B. or Fellowship!

(Continued from page 171)

cell tumour obtained at St. Bartholomew's Hospital (Mr. Wilfred Shaw).

The case is also clinically interesting because of the associated amenorrhoea. The histogenesis and hormonal effect of the tumour both produce problems which are worth consideration.

I am very grateful to Mr. Wilfred Shaw for allowing me to report this case and for the assistance he has given me.

References

- Mc Goldrick, I.L. and Lapp, W.A. *Am. J. Obst. and Gyn.* 48: 409 (1944).
Giest, S.H., *Am. J. Obst. and Gyn.* 30: 650 (1935).
Novak, *Gynaecological and Obstetrical Pathology* 2nd Ed. 1947.
Photographs by the Department of Medical Photography, St. Bartholomew's Hospital.

Amongst his earliest Receipts worthy of note is a method of procuring Chastity, by taking a dram of powdered Red Nettle seeds in White wine, for . . . "it is a far better medicine to rout out Asmodeus, the lecherous devil than the liver of fish." Jaundice is regarded as a disease entity, rather than a symptom and occupies a great deal of his attention, for example. "A decoction of earth worms, sallendine and ivy berries in White wine, take equal quantities of each, is an excellent remedy for the yellow jaundice; and if towards the end of the decoction you add a little saffron tied up in a rag, 'twill be the better.'" Or again. "The roots or leaves of strawberries, eaten in a pottage, is a marvellous remedy for the jaundice. "Shell snails dried in an oven, and a drachm of the powder of it taken at a time doth in nine or ten days cure the black jaundice." It must be taken in Ale in the morning on an empty stomach to be of any use however.

The worry of prognosis, which appears to have been as major a problem to the 17th century physician as it is today was, however, easily solved by taking . . . "the grease of a hog and rub the body of any that is sick against the heart and the soles of the feet, then throw the grease to a dog; if he eat it, the sick will live; if not he will die." I've no doubt a nice compromising dog could be found if the need arose, though I doubt very much whether the practice will be introduced in Barts. as a means of gauging a patient's prognosis! If, however neither hog's grease nor dogs were available, the physician merely performed some simple arithmetic . . . "Number the days from the 26th of June to the day when the Party first began to fall sick, and divide the number by three; if one remain, he will be long sick, if two remain he will die; if none, he will quickly recover." This method appears to have the advantage of being able to give a more accurate prognosis as well as a third alternative. Pride of place must, however, be given to Culpeper's orthopaedic treatment. "For Sinews that are shrunk in the Thighs, or elsewhere."

"Anoint the place with Oyntment of Swallows; it is thus made: Take young Swallows out of their nests, by number

Twelve, Rosemary tops; Bay leaves, Lavender tops, Strawberry leaves, of each a handful: Cut off the long feathers of the Swallows wings and tails, and put them in a stone Mortar; and lay the Herbs upon them, and beat them all to pieces, Guts,

Feathers, Bones and all; then mix them with three pounds of hog's grease; set it in the sun a month together; then boil it up, strain it, and keep the Oyntment for your use." The potency of this ointment leaves very little to the imagination of the reader!

WE ARE SUCH STUFF AS DREAMS ARE MADE ON

By DAN WOODING

All men have dreams—
 Though most will ne'er admit them:
 With scornful laugh and mocking jest
 They hastily assume the cynic's cloak,
 Retreating from the field before the battle's joined,
 Fearing the barbed tongues of witless men
 Who scoff from empty jealousy:
 But dreams, ideals, and secret questionings,
 Reflect the soul of man and all his finer feelings,
 And cannot be quite utterly foresworn
 Though they be muted to a whisper.
 The happy greybeard still has dreams
 Albeit experience hath taught him some were folly;
 And younger men are moribund—nay, dead!
 If they do lack a goal to strive at constantly,
 Be it by God, a woman, or a skill
 That he must earn with sweet and patient toil,
 Man must be inspired to give his best.
 The greybeard knows this truth
 And has the courage to proclaim it
 —The younger man is still acquiring proof.

ANNOUNCEMENTS

DEATH

JOHN, A. Hilton, M.B., B.S.Lond., on June 9th, 1949, suddenly, at Sandon House, Stoke-on-Trent, aged 73.

THE JOURNAL

We announce the resignation of the Editor, Mr. J. M. L. Gilks. He is succeeded by Mr. G. C. R. Morris. Mr. M. Braimbridge has been appointed Assistant Editor. Contributions much reach the Editor before the first Tuesday of the month for inclusion in the following number.

THE JOURNAL COVER

Copies of the design made by Eric Gill for the cover of the Journal may be obtained from the Librarian, price 2s. 6d.

HOUSE APPOINTMENTS

1st July to 30th September, 1949

St. Bartholomew's Hospital

DR. BOURNE	B. J. Batt
G. E. Dower†	
DR. CULLINAN	W. P. L. Morrison
G. A. Coombs	
DR. SCOWEN	M. J. Linnett
M. D. Begley†	
PROF. KRISTIE	J. G. Widdicombe
E. G. Rees†	
MR. HUME	P. A. Freeman
P. J. A. Butcher†	
MR. CORBETT	W. G. Dawson
F. M. Shattock	
MR. HOSFORD	R. A. Struthers
H. W. Stanley	PROF. SIR JAMES PATERSON ROSS
PROF. SIR JAMES PATERSON ROSS	J. W. S. Harris
J. F. Bennett	
CASUALTY H.P.	
J. C. Graham-Stewart	
CHILDREN'S DEPT.	M. W. Partington
H. A. Evans†	
E.N.T. DEPT.	
A. L. Wells†	
SKIN & GYNÆ. DEPT.	
W. G. H. Lesliet	
EYE DEPT.	
J. Monckton†	
INTERN	
D. Rosedale†	
ANAESTHETISTS	J. Q. Matthias*
F. C. W. Royle*†	T. B. Boulton†
DENTAL DEPT.	
Miss Joyce Manning	
ORTHOPÆDIC DEPT.	
(Accident Service)	
B. E. L. Thompson	
	Hill End Hospital
DR. SPENCE	B. B. Reiss
MR. NAUNTON MORGAN	
M. W. Glossop	
E.N.T. DEPT.	
M. E. Johnston†	
ORTHOPÆDIC DEPT.	W. J. Wright
G. B. Taylor	
THORACIC DEPT.	
W. M. Keynest	
NEURO-SURG. DEPT.	
J. W. Platt†	
INTERN	
G. A. D. Lavy†	
ANAESTHETISTS	C. Todd†
I. Jackson*†	K. Orr Hughes
	Alexandra Hospital
R.M.O.	
E. B. Farrar	

*B.1. †B.2. ‡S.R.A.

SPORT

ATHLETIC CLUB

UNITED HOSPITALS CHAMPIONSHIPS

Duke of York's H.Q., Chelsea, Saturday, 11th June

On a pleasant summer's afternoon Bart's ran away with the Championship finishing some 40 odd points ahead of Middlesex, their nearest rivals. The preliminary heats, together with a few of the finals, had been decided at Motspur Park earlier in the week, and with Bart's commencing the Saturday events with a few points in hand, the result really never looked in doubt—but it must be whispered that the 1948 meeting when the Bart's. win was not decided until the final event made for a more exciting afternoon).

Our success undoubtedly lay in the all-round ability of our team for only in two events did we fail to obtain scoring points; but also contributing largely to this success must be mentioned the leadership of the captain, J. I. Burn, the organising ability of the secretary P. D. Matthews, and the encouragement of our President, Mr. H. B. Stallard and our coach Mr. J. Drewer. Support from the numerous Bart's people who were amongst the spectators was most welcome and their vociferous encouragements undoubtedly helped the Tug men to pull into second place.

Rosser, getting a bad start in the 120 yards Hurdles didn't manage to produce his usual form, but in the 440 yards Hurdles, a new event for him, he ran into first place in quite a good time. Arthur Wint, delighting the crowd as usual with his most graceful running, chipped a fraction of a second off his own record time in the 440 yards, a very creditable performance on a track which, by the nature of its surface and its bends, was not conducive to record times. We would like to take this opportunity to congratulate him upon his performance at White City on Whit Monday when he further lowered the British 440 yards record.

J. I. Burn, running beautifully to win the mile, a result which never looked in doubt, was ably supported by his second string, A. H. Macdonald who, resisting a final challenge in the home straight, ran into second place. Bee, Khurshid and Porteous were the mainstay in the field events. The final event, the relay, was won by the Bart's team in a time equalling the previous record.

Scoring positions were gained by:—
 Pole Vault.—3rd, J. S. Nielsen.
 Javelin.—2nd, D. L. Bee; 6th, P. D. Matthews.
 Hammer.—4th, C. J. Porteous.
 Tug-o'-War.—2nd, Barts.
 Discus.—2nd, M. N. Khurshid; 6th, C. J. Porteous.
 Weight.—3rd, M. N. Khurshid; 4th, D. L. Bee.
 120 yds. Hurdles.—3rd, E. M. Rosser; 4th, P. D. Matthews.

APPOINTMENTS

Dr. John Lister, M.R.C.P., has been appointed Editor of the *Clinical Journal*.

Dr. G. D. Kersley, M.D., F.R.C.P., has been appointed Director of Research and Advisor in Chronic Rheumatic Diseases to the South West and Oxford Regions.

440 yds. Hurdles.—1st, E. M. Rosser, time 58.6 secs. 3th, P. D. Matthews.
100 yds.—3rd, D. C. Morgan.
220 yds.—4th, D. C. Morgan; 5th, B. D. Lascelles.
440 yds.—1st, A. S. Wint, time 48.9 secs. (record); 3rd, D. C. Morgan.
880 yds.—1st, A. E. Dormer, time 2 mins. 0.2 secs.; 2nd, A. S. Wint.
1 mile.—1st, J. I. Burn, time 4 mins. 29.8 secs.; 2nd, A. H. MacDonald.
3 miles.—1st, J. A. Menon, time 15 mins. 53.4 secs.; 2nd, J. I. Burn.
Relay.—1st, Bart's (Dormer, Morgan, Lascelles, Rosser), time 3 mins. 42.8 secs. (equals record).
RESULT: 1st, Bart's.—102 pts.; 2nd, Middlesex—60½ pts.; 3rd, London—50 pts.; 4th, Thomas's—48½ pts.; 5th—Guys—24 pts.; 6th, Mary's—23 pts.; 7th, Westminster—16 pts.; 8th, U.C.H.—9 pts.; 9th, George's—3 pts.; 10th, King's—1pt.



Winners of the United Hospitals Championship, 1949

SPORTS DAY, Saturday, July 2nd, Chislehurst

We could scarcely have had a better day, a warm, sunny afternoon with a light breeze occasionally blowing across the ground—an afternoon suiting both competitors and spectators, and undoubtedly everyone present had a most enjoyable time. Dr. E. F. Scowen, who was to have been the President of the Sports was at the last moment unable to come, and his place was most ably taken over by Mr. H. B. Stallard.

The general standard of performance was high, with four new records being set up—each record beating the previous best by quite a good margin. Rosser in the 120 yards Hurdles, the first event of the afternoon, returned 15.8 secs., a time equal to the one which recently gained for him the Welsh record for this event, and one which better

the previous time by 0.7 secs. This was followed by the 1 mile, an exciting battle for first place between A. E. Dormer and J. I. Burn, which resulted in the lowering of the previous record by 5.4 secs. Dormer set a fast first lap pace, passing the quarter mile mark in 58 secs. with Burn immediately on his heels, where he hung on closely until at the final bell he took the lead, and although in the duel fought out on the back straight he was unable to hold this lead. Burn's time was also well inside the previous record.

Records, however, are not the chief part of sport, and we would praise the excellent spirit of sportsmanship shown by all competitors which prevailed at the meeting—a spirit which caused the gallant Dr. Cates to go pounding down the track in the (so-called) "Houseman's Hundred" (where were all the housemen this year?), and so many ladies to go for the 80 yard dash—although we have yet to discover why so many of them were to be found sprawled on the ground

half way through the race.

Finally, thanks must be expressed, especially to Mrs. C. F. Harris who presented the prizes, to all who helped as officials, and to Mr. White for the excellent state into which he had got the courses.

SPORTS DAY RESULTS

Discus.—1st, M. N. Khurshid (101 ft. 2 ins.); 2nd, A. H. John; 3rd, D. L. Bee.
Long Jump.—1st, A. H. John (21 ft.); 2nd, B. D. Lascelles; 3rd, G. Mears.
High Jump.—1st, D. Matthews (5 ft. 3½ ins.); 2nd, E. M. Rosser; 3rd, A. H. John.
Weight.—1st, A. H. John (36 ft. 5½ ins.); 2nd, D. L. Bee; 3rd, M. N. Khurshid.
Pole Vault.—1st, V. R. Chuck (7 ft. 9 ins.); 2nd, J. S. Nielsen.

Javelin.—1st D. L. Bee (131 ft. 6 ins.); 2nd, V. R. Chuck; 3rd, M. N. Khurshid.
Relay (4 x 220 yds.)—1st, Pre-clinicals (Murphy, Stainton Ellis, Carter, Wint) (1 min. 36.2 secs., record); 2nd, Dark Blue.
120 yds. Hurdles.—1st, E. M. Rosser (15.8 secs., record); 2nd, P. D. Matthews.
100 yds.—1st, D. C. Morgan (10.5 secs.); 2nd, E. M. Rosser; 3rd, B. D. Lascelles.
220 yds.—1st, D. C. Morgan (24.6 secs.); 2nd, E. M. Rosser; 3rd, B. D. Lascelles.
440 yds.—1st, A. S. Wint (57.2 secs.); 2nd, J. C. Carter; 3rd, D. C. Morgan.
880 yds.—1st, A. S. Wint (1 min. 56.2 secs., record); 2nd, A. E. Dormer; 3rd, A. H. MacDonald.

1 mile.—1st, A. E. Dormer (4 mins. 25.4 secs., record); 2nd, J. I. Burn; 3rd, J. A. Menon.
3 miles.—1st, J. I. Burn (15 mins. 39.1 secs.); 2nd, J. A. Menon; 3rd, J. A. Stainton-Ellis.

Other Results

15th June—Inter-Hospitals Relay Match:
1st Middlesex and Mary's—36 points.
2nd Bart's and Guy's—28 points.
3rd London and Thomas's—25 points.
21st June—
1st Bart's—65 points
2nd Orion and Ranelagh—22 points.
3rd Barclays Bank—20 points.
University of London colours for 1949 have been awarded to the following Bart's men:—
Full purple—A. S. Wint, A. E. Dormer.
Half purple—E. M. Rosser.

EXAMINATION RESULTS ROYAL COLLEGE OF PHYSICIANS

The following Candidates, having satisfied the Censors' Board, are proposed for election as members:—

Boyle, A. C. Magnus, H. A. McKerrow, C. B. Tweedy, P. S. Cook, J. B.

ROYAL COLLEGE OF SURGEONS

Final F.R.C.S. Examination		June, 1949	
Bates, M.	Fredman, M.	Hershman, M.	Mirza, H. H.
Bell, R. C.	Gowland, H. W.	Jamison, H. M.	Ruddick, D. W. H.
Fisk, G. R.	Harland, D. H. C.	Jayes, P. H.	Waterston, D. J.
Fowler, N. A.	Hay, B. M.	McGuire, N. G.	Yassa, D.

UNIVERSITY OF CAMBRIDGE

Final M.B. Examination		June, 1949	
Part I. Surgery, Midwifery and Gynaecology			
Cooper, E. A.	Court, G. A.	McWhinney, I. R.	Tomlinson, J. D. W.
Cooper, M. B. S.	Garrod, D. C. H.	Milligan, J. L.	

CONJOINT BOARD

Final Examination		April, 1949	
Pathology			
Abraham, R. J. D.	Evans, T. L.	Kazantzis, G.	Struthers, R. A.
Andrews, J. D. B.	Garrod, D. C. H.	McCloy, J. W.	Tannen, G. P.
Brest, B. I.	Griffiths, J. D.	Menon, J. A.	Thomas, D. H. C.
Capstick, N. S.	Hardy, C. G. J.	Montfort, F. G.	Wainwright, A. J.
Davies, W. H. G.	Holland, W. G.	Raines, R. J. H.	Widdicombe, J. G.
Dickerson, R. P. G.	James, D. C.	Rees, J. H.	
Medicine			
Bratt, B. J.	Dawson, W. G.	Harris, J. W. S.	Maude, A. R. S.
Brandreth, T. K.	Evans, C. M. W.	Hawkes, P. H. R.	Mendel, Dennis
Burns, H. J.	Farrar, E. B.	Hobbs, J. J. B.	Reckless, M.
Chesover, I.	Freier, S.	Hooper, E. R. S.	Struthers, R. A.
Surgery			
Batt, B. I.	Johnston, M. E.	Shaerf, M. D.	Wilson, F.
Griffiths, A. W.	Lester, J. P.	Simpson, E. A. D.	Wiseman, D.
Harris, J. W. S.	Morris, V. C.	Timmins, W. L.	
Hooper, E. R. S.	Reiss, B. B.	Wallis, F. P.	
Midwifery			
Brest, B. I.	Giri, G. A. R.	Gosling, R. E. G.	Melotte, G. H. C.
Cox, J. S.	Goodrich, P. M.	Lester, J. P.	Morris, V. C.

The following students have completed the examination for the Diplomas M.R.C.S., L.R.C.P.:—
Freier, S. Johnston, M. E. Shaerf, M. D.
Goodrich, P. M. Maude, A. R. S.
Harris, J. W. S. Mendel, Dennis
Hooper, E. R. S. Reiss, B. B.

SCHOLARSHIPS

Junior Scholarship in Anatomy and Physiology	
J. S. Hopkins—1st scholarship	J. F. Pearce—2nd scholarship

BOOK REVIEWS

OBSTETRICS AND GYNAECOLOGY, by B. M. W. Dobbie, Lewis, 1948. Pp. xi + 358. Price 20s.

This book, a synoptic guide to treatment, has been written to bridge the gap between "classical teaching and pitiless reality." As the author admits, to do this it has been necessary to descend from scientific detachment, but this has been done without adopting that "popular" style which pervades so many books at the present time, and she is to be congratulated.

Some of the matter included is of doubtful benefit to the general practitioner, and it is difficult to see how statistical tables help in this essentially practical book.

In the main, however, it is acceptable and eminently readable, and the chapter on "Telling the patient" and "Common errors," should be read by all.

PSYCHIATRY IN GENERAL PRACTICE, by Melvin W. Thorne, W. B. Saunders Company, Philadelphia, 1948, pp. xi + 659. Price 40s.

General practitioners have the same background, receive the same basic training, and are presumably as intelligent as their colleagues who eventually decide to specialise. It is, therefore, regrettable when an author and a publisher think it necessary in a medical publication to talk down to the general practitioner. "Psychiatry in General Practice" is intended to be an American "psychiatry without tears" for M.D.'s (M.D. to be interpreted as one sees fit). For every page of text, written in basic American, there are two or three italicised pages of case histories, written in racy, sensational journalese. To select the beginning of a typical case history at random: "*Dorothy Humboldt was one of the most enviable of people, but she could never admit it to herself for fear of reprisals from the jealous gods of fortune. She was worrisome, and being in her eighteenth summer, pretty, and in love, could not dispel her apprehensiveness that something was surely going to go wrong.*" You either like this sort of thing, or you don't. Your reviewer doesn't. This book is likely to prove of greater interest to the social historian and anthropologist than to the general practitioner.

E.B.S.

CLINICAL ENDOCRINOLOGY AND CONSTITUTIONAL MEDICINE, by A. P. Cawadias, O.B.E., Frederick Muller, pp. iv + 362. Price 42s.

Endocrinology has made rapid strides during recent years, and most books on the subject are incomplete and out of date on publication. A satisfactory textbook for students is still awaited, despite the fact that several volumes have appeared during the past two years. This book is certainly not intended for students and, unlike most writings on the subject, it does not approach the subject from the physiological and pathological viewpoints. Dr. Cawadias describes endocrinology from the point of view of clinical science or nosology (in its historical sense) and as may be expected from Dr. Cawadias, the historical aspect of the subject is given adequate consideration. The book is divided into the following sections: Physiology and pathology of the neuro-endocrine system; Diseases of the thyroid, parathyroid and thymus group; Diseases of the gonadal adrenal

group; Diseases of the pituitary-pineal group; Diseases of the pancreas-liver group; and Confinia endocrinologica; followed by a representative, yet extensive, bibliography. The chapters deal with physiopathology, etiology, symptomatology, therapy, prognosis, etc., and typical cases are described rather than the usual case histories presented. Also purposely, Dr. Cawadias illustrates his book with composite pictures instead of photographs, and colotype reproductions of drawings (which tail off to rather crude woodcuts towards the end of the book), although of technical interest, might be deemed of little value in scientific literature.

J.L.T.

EARLY RECOGNITION OF DISEASE, edited by Sir Henrice Ogilvie, K.B.E., and W.A.R. Thomson, Eyre and Spottiswoode, 1949, pp. 134. Price 10s. 6d.

The *Practitioner Handbooks* have earned a very high reputation, which this book will help to maintain. It includes reviews of fourteen subjects by acknowledged authorities, which should go far to assist the general practitioner to earlier recognition and treatment by giving him the clear synthesis of a specialist's experience on each. To the articles which have already appeared in the *Practitioner* are added one on Diseases of Childhood, by Professor Moncrieff, and one on Diseases of the Eye, by Professor Sorshy.

PSYCHIATRY, Theory and Practice for Students and Nurses, by H. C. Beccle, Faber, 1948, 2nd Edition, pp. 254. Price 10s. 6d.

There is a plethora of books on the psychological

aspects of medicine, and their scope is not always clearly defined. This one started as a textbook for nurses and was well received in 1946; it has been altered only in title and in detail. A review of the anatomy, physiology, and organic disease of the nervous system, which occupies the first 80 pages, will prove superfluous to most clinical students; but the section on psychiatry gives a preliminary survey of the field of mental illness which may satisfy the final year student nurse and stimulate the medical student to further reading.

ANAESTHETICS AND THE PATIENT, by Gordon Ostlere, 1949, Sigma Books, pp. 166, 4 illustrations. Price 7s. 6d.

This is one of the Sigma Introduction to Science series, which presents Science to the Lally. Dr. Ostlere, aiming his story at an audience of pre-clinical medical students, has achieved an account of modern anaesthesia and its historical background which should satisfy the layman who has some grounding in science and the usual curiosity about Medicine.

SCHAFFER'S ESSENTIALS OF HISTOLOGY, edited by H. M. Carleton and E. H. Leach, Longmans, 1949, 15th edition. Pp. xii + 655. Price 25s.

The fifteenth edition of this valuable work remains fundamentally the same as its predecessor of three years ago. There has, however, been a revision in the text with increased reference to the correlation of histological appearance with

its physiological counterpart. This should be welcomed by students, particularly those preparing for the 2nd M.B. examination, as some works on histology tend to treat their subject in a somewhat insular way.

There are a number of new photographs which have been labelled directly, thus avoiding letter-references which can be so tiresome. An improvement this, and it is to be hoped that when the next edition appears this policy will have been carried out throughout.

The book is so complete that it could be used satisfactorily from the first year of study to qualification.

TEXTBOOK FOR NURSES, Edited by J. A. Nixon and Sir Cecil Wakeley, Oxford Medical Publications, Groves & Brickdale, 7th Edition, 1949. Price 30s.

This book is attractive to handle, being of a better quality than most textbooks for nurses. It is a well-known and workmanlike endeavour to provide a comprehensive textbook, and has been revised sufficiently to include heparin and streptomycin therapy. More revision is needed; there must be few patients who stay in bed for a fortnight after appendectomy, and few physicians who rely only on serum treatment for scarlet fever. The authors might well consider excluding such topics as glanders and Friedreich's ataxia, and expanding the section on nutrition.

W.H.

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ST. BARTHOLOMEW'S



HOSPITAL JOURNAL

Vol. LIII

SEPTEMBER, 1949

No. 9

SMOKE

*"Hell is a city much like London—
A populous and smoky city."*

—Shelley

To those brought up in the country, it is astonishing that life in an industrial city should be possible at all. The air itself, all-permeating, is thick, congested, heated, filthy, the exhalation and the inspiration of a crowded mechanical life. But the atmosphere is such a constant part of our environment that it is accepted and ignored; like everything familiar, it has become habitual.

About 500 tons of smoke a year fall on each square mile in London; the page of a book is coated with a visible layer of dust, soot and bedevilment in the time taken to read it. On the finest day the view from the summit of St. Paul's does not extend to the bounds of London, and the sunlight falls on a grey impervious carpet of smoke. In all the Home Counties, it is exceptionally rare to be able to fly with a clear horizon; summer haze and winter fog are but meteorological exacerbations of a persistent miasma of our own making. Only out of England does the reality of this pollution become obvious by contrast: the vigour and zest of unadulterated air must largely explain the attraction for invalids and politicians, for undergraduates and field-marshal, of a holiday in Switzerland or Scandinavia.

Why do millions flock to the West Country, turning the Duchy and the Principality into Trippers' kingdoms? Why is the West End synonymous with the Best End, and the Eastern railway system so much less efficient than the Southern? Surely it is because the wind blows generally from the west and

south, and collects in its passage the effluvium of a million chimneys. Every steeple in the City reveals the direction of the prevailing wind by its blackened leeward side and rain-washed windward face, as a tree will serve for compass in the country, its trunk only half moss-grown.

The damage done by atmospheric pollution is incalculable, but it is grave enough, and steadily increasing. As long ago as 1661. John Evelyn wrote: "This is that pernicious Smoake which sullyes all her Glory, super-inducing a sooty Crust or Fur upon all that it lights, spoyling the moveables, tarnishing the Plate, Gildings and Furniture, and corroding the very Iron-bars and hardest Stones with these piercing and acrimonious Spirits which accompany its Sulphure; and executing more in one year, than exposed to the pure *Aer* of the Country it could effect in some hundreds. It is this horrid Smoake which obscures our Churches, and makes our Palaces look old, which fouls our Clothes, and corrupts the Waters, so as the very Rain, and refreshing Dews which fall in the several Seasons, precipitate this impure vapour, which, with its black and tenacious quality, spots and contaminates whatever is exposed to it. It is this which scatters and srews about those black and smutty *Atomes* upon all things where it comes, insinuating itself into our very secret *Cabinets*, and most precious *Repositories*: Finally, it is this which diffuses and spreads a *Yellowness* upon our choicest Pictures and Hangings:

which does this mischief at home, is *Avernus* to *Fowl*, and kills our *Bees* and *Flowers* abroad, suffering nothing in our Gardens to bud, display themselves, or ripen . . ." In the seventeenth century apple trees grew in the Strand, though they bore well only when the supply of sea-coal was cut off by the siege of Newcastle. Today, plane trees alone breathe freely in London, perhaps because they shed their grime-stained bark; and it has proved impossible to maintain the conifer collection in the Botanical Gardens at Kew. More than one enterprise is flourishing on the demand for its services in cleaning London stone; and a monument to our three greatest poets has been removed because it was falling to pieces.

In preventive medicine, there is no single step that would eradicate more ill-health and inconvenience than would effective legislation against smoke. A London fog, carrying sulphur dioxide and carbon, tar and silica, in high concentration, can kill; fortunately we have not yet experienced those curious weather conditions that caused the Mense Valley fog in 1930, and the "smog" in the United States a year ago. But they might easily happen here. Meanwhile, the incidence of tuberculosis, lung cancer, and respiratory disorders of all sorts is considerably higher in our towns than in our

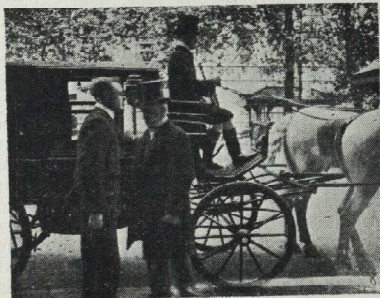
countryside. "Is there under Heaven such *Coughing* and *Snuffing* to be heard, as in *London Churches* and *Assemblies of People*, where the *Barking* and the *Spitting* is uncessant and most importunate?"

Evelyn's proposed remedy was the removal of the big smoke-producers, the commercial undertakings of his day, several miles down the river. Now, we need not banish the chimneys, but only insist that they produce no harmful waste; there are efficient methods of fuel consumption, which could become obligatory. The domestic hearth is responsible for more of the contamination today, perhaps a third of the total: the cheery fire is the least effective way of burning coal. That something can be done is proved by Pittsburgh, which now enjoys twice as much sunlight as before its smoke-prevention campaign. Perhaps smoke control, like some of the industrial techniques which make it so urgent, will be yet another advance originating here, and developed across the Atlantic before returning home. If so, let us give it the welcome of a Prodigal Son.

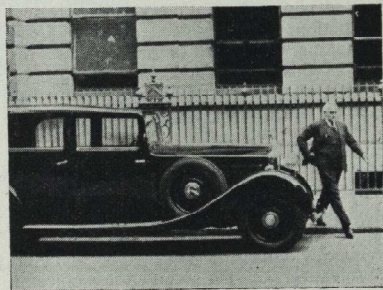
References:

- "Fumifugium: or the Smoake of London Dissipated," Evelyn, 1661.
 "Guilty Chimneys." The National Smoke Abatement Society, 1948.

FORTY YEARS ON



Dr. Samuel Gee greeted by his H.P.



Mr. Wilfrid Shaw

WHAT IS HOMOEPATHY?

by JOHN PATERSON, M.B., CH.B., D.P.H. (CAMB) F.F.HOM.
 An Address to The Abernethian Society, June 16th, 1949.

IN an official bulletin issued from Buckingham Palace after the birth of Prince Charles, there appeared among the qualifications of the doctors in attendance, the letters "F.F.Hom." The public Press gave some prominence to the fact that these letters indicated that Sir John Weir was a Fellow of the Faculty of Homœopathy. To most people lay and medical it was indeed news to learn that there was such a thing as a Faculty of Homœopathy and it gave Homœopathy a *respectability* because it was used in Royal Circles, and *acceptability* because these letters appeared among the degrees and qualifications of medical men of eminence.

The conclusion seemed to be that Homœopathy must have a place in General Medicine, but the question arose—what is this position?—in other words "What is Homœopathy?"—hence your request and my presence here today as a substitute speaker for Sir John Weir.

I need hardly remind you that the present Medical Curriculum is a very full one, but in so doing I wish to congratulate your Society for asking for information on a subject outside the ordinary course in Medicine.

What is Homœopathy? To begin with I would ask you to consider the literal interpretation of the word itself. It is derived from the Greek word "HOMOIOS" meaning "similar"—not to be confused with "HOMOS" which means "the same"—and "PATHOS" meaning "Disease."

We therefore start with two headings (1) *Homœo*—which is concerned with drugs, and (2) *pathy* which has reference to disease.

As students of Medicine, you will say that you are already studying *Materia Medica*, and *Pathology* but fail to understand where Homœopathy comes into this. I hope to show you that Homœopathy is based upon an *extension* of the knowledge you are now acquiring in this school of Medicine.

At this point I would like to say that we—the Members of the Faculty of Homœopathy—recognise all the methods of diagnosis and all the laboratory tests with which you are acquainted; also that we accept and are prepared to use any of the drugs in the British

Pharmacopœia and the Codex, even to the Sulpha drugs and Penicillin.

The diploma of the Faculty is available only to registered medical practitioners—after the completion of a course in "orthodox" or as we prefer to say "ordinary" Medicine. Candidates must satisfy examiners in a written paper and clinical work on subjects pertaining to Homœopathy. Membership entitles the holder to the letters M.F.Hom.; while F.F.Hom. (Fellowship) represents a higher standard of examination.

What is the source of this *extended* knowledge in Medicine? In answer I must say something about the work of Samuel Hahnemann, the founder of Homœopathy. Hahnemann studied medicine in the year 1775 at the University of Leipzig, then considered to be the centre of intellectual activity in the whole of Europe, and later he was appointed to the hospital at Vienna, the finest hospital on the Continent at that time. It should be noted then, that he was a fully trained doctor, but not only was he qualified as a physician, he was also a fully qualified chemist and distinguished as a linguist. He was held in high esteem by his colleagues of that period.

What was it that led him to his founding of Homœopathy with its extended knowledge of drugs and disease? It was while he was translating a book of Cullen's on *Materia Medica*—and incidentally Cullen is said by Guthrie in his recently published "History of Medicine," to be the Founder of the West of Scotland School of Medicine; whether there is any connection between this fact and the number of Homœopathic Doctors who hold their medical degrees from Glasgow University, I do not presume to know—but Hahnemann was interested in the article on *Cinchona* and found himself questioning Cullen's explanation of its action. He therefore started experimenting on himself by taking 4 drachms of the extract twice daily, and was astonished to find that he developed symptoms similar to ague or malaria.

When he stopped taking the *Cinchona* the symptoms disappeared; when he repeated the doses, they returned. The therapeutic action of *Cinchona* in Malaria was well known, and

it was while he was contemplating these observations that he had occasion to see a similar sort of effect with the drug Belladonna. He was attending a household where there was Scarlet Fever; and only one member of the family escaped, and the only reason Hahnemann could put this down to was that this person had been taking a mixture of Cascara in which there was Tincture of Belladonna. Was this a new law of therapeutics? That was the question in Hahnemann's mind as he set out to make a study of drugs, "*Drug Proving*."

There is considerable discussion as to whether experiments on animals are of value or not, but as Homœopaths we are *not* concerned with this controversy. What we do declare is the fact that experiments on human beings are of prime value in the subsequent treatment of human beings.

In our "drug provings" we take a number of selected and volunteer students or physicians, who are free from apparent disease, and give them doses of a drug; each volunteer keeps a daily record of his feelings and sensations or of any symptoms which develop. This record is compared with that of other volunteers who are (unknown to themselves) taking placebo—they are the "controls."

If you carry out these experiments, you will find, as Hahnemann found, that the action of any drug can be classified under two headings.

Symptoms may be graded from (1) *Functional* to (2) *Pathological*.

Functional: The first sign of *dis-ease* may be disordered function or sensation—something which is experienced by the patient and expressed in his own language.

Pathological: As a later sign of action of a drug, definite pathological symptoms may develop and be diagnosed by the physician.

You are familiar with the pathological, but are you aware of the functional symptoms of your drugs?

I would like to illustrate this point by making a comparison between a *Materia Medica* of your school of medicine and a *Materia Medica* of the homœopathic school.

You are probably familiar with *Materia Medica* (Dilling) which is now in its 18th edition (January, 1948)—a text-book used by the student of Medicine.

Homœo-therapeutics (Neatby & Stonham—1931) is a text-book used by the student of homœopathy and I suggest that we take the

drug sulphur and make comparison from these two text-books.

Dilling: There you will find 12 lines of print to describe the action of sulphur. The main reference is to its laxative action.

Neatby & Stonham: These authors quote the 12 lines as found in Dilling, but thereafter they require 24 pages of type to describe the therapeutic action of sulphur, and they finish with a summary giving 26 leading symptoms of the action of this drug. If you study this list you will note that the symptoms can be graded from the functional or disturbances of normal sensations to crude pathological; from the burning sensations of any or all parts of the body, sinking sensation and feeling of hunger at 11 a.m.; disturbed function, the laxative effect of sulphur which drives the patient out of bed in the morning or as soon as he rises, to evacuate the bowel, and so on to the definite pathological action of itching skin eruption, boils, congestion of liver and jaundice. You do not find these functional symptoms in your Dilling's *Materia Medica*.

Take another group of similar drugs, Belladonna, Stramonium, and Hyoscyamus, which are botanically related and described as "peripheral parasympathetic depressants." They are each capable of producing delirium.

Could you, in a case of poisoning, from your knowledge of your *Materia Medica*, determine which of these three drugs was causing the delirium?

"*Drug Pictures*" by Dr. Margaret Tyler points out that in Belladonna and Stramonium, the face is flushed, while with Hyoscyamus, it is pale. How, then, can one distinguish between Belladonna and Stramonium? By the effect of light; patients suffering from Belladonna are susceptible to bright light, while those under the effect of Stramonium cannot bear the dark.

That is an example of the "finer symptoms" of drug action being of clinical value. It also illustrates the point I am trying to make, that the homœopathic *materia medica* offers the student an extension of the action of drugs to that found in the ordinary *materia medica*. The distinguishing feature of the homœopathic *materia medica* is that it accepts not only the pathological, but also the functional symptoms of drug action. The *materia medica* of the ordinary school is built up mainly on pathology; upon the results of animal experimentation and pathological evidence; or upon the results of

therapeutic action in disease of the human when pathological symptoms are present. There is no reference to any action upon the healthy human.

If you wish, then, to study Homœopathy you require to *extend* your knowledge of the action of drugs and there are volumes of experimental evidence on the provings of many remedies available.

A study of these volumes on *Materia Medica* would answer the question which is often put "What has Homœopathy done to advance Medicine?"

Now I would pass to consideration of my second heading—"Pathos"—the study of disease, and again I suggest that, as in drug proving, you can extend your knowledge of disease by clinical observations, and you will find that it is possible to grade symptoms into Functional and Pathological. Again, I offer you an example and will take an acute disease—*Acute Lobar Pneumonia*. We, of the homœopathic school accept every means of diagnosis, clinical and laboratory, but we go one step further. We wish to know the "higher grade symptoms" of the disease in the individual. "Well, you may say, 'but are not all cases of acute lobar pneumonia the same? Can you, by clinical observation, distinguish different types of pneumonia?'" The answer is, "*We can.*" In what ways do pneumonias differ? Here are some of the points which would assist.

Rate of onset: the condition may come on very suddenly or develop after a period with prodromal symptoms.

Facies: Face may be pale or flushed, with expression of fear or of complete resignation.

Temperament: Patient may be restless or prefer to lie absolutely still; he may be irritable or calm; have a sense of heat or cold.

Fever: Temperature chart is characteristic with its variations in the time of maximum rise in the 24 hours.

Thirst: Desire for cold drinks during fever is to be expected, but you will find patients with "fever, with absence of thirst."

These variations must be taken as symptoms of the patient's disease and the question is, "Can you distinguish types of pneumonia from these symptoms?" To the ordinary physician, even if he observes these symptoms, they mean nothing relative to his treatment of the case.

To the homœopathic physician they mean everything for it is on the totality of the

symptoms that he bases his diagnosis and treatment.

Here are six examples of pneumonia types, in three stages of the disease: onset, well established and nearing the crisis.

Onset

(1) **SUDDEN ONSET**, immediate rise of temperature, patient feels ill, and shows this by a marked expression of fear and restlessness. If he attempts to sit up he turns pale, feels faint and may collapse.

(2) **GRADUAL ONSET** after an indefinite prodromal illness, which now develops typical pneumonic symptoms. Patient's face looks suffused, he is delirious, does not make any attempt to move in bed, but makes a curious "chewing the cud" movement with his lower jaw all the time; he desires large drinks of cold water at frequent intervals.

Pneumonia, well established

(3) With florid anxious facies, flapping of the alae nasi, which is not synchronous with respiration; temperature shows a daily maximum rise between 4 and 8 p.m.; nurse or attendant reports that patient actively resents all attention; cross and irritable.

(4) With hectic malar flush; anxious, expression of fear, which is very marked if patient is left alone for even a few seconds. Patient *demand*s close attention at his bedside all the time. He is thirsty for cold drinks, which are vomited as soon as taken. *Pneumonia*, nearing the crisis

(5) Prostration and evidence of an approaching crisis; obvious fear *but* of death, but despite this he is *ensorious* and *hyper particular* about the arrangement of the bed-clothes; will call attention if the nurse's cap is not on straight; will refuse to drink from a cup which has any defect or spot of dirt. The temperature chart will show that his maximum rise was about 1 a.m.

(6) Prostration, patient in extremis, pale pinched face, with high fever *but absence* of thirst. Further, he cannot tolerate milk and if this is given it will be vomited immediately. There you have six types of pneumonia, each with its own group of symptoms, and to the Homœopathic physician, the diagnosis would be as follows:—

No. 1 Aconite; No. 2 Bryonia; No. 3 Lycopodium; No. 4 Phosphorus; No. 5 Arsenic; No. 6 Antimony Tart. (pneumonia)—the similar drug being used to describe the type.

What conclusion can one draw from these clinical observations? It is that the *same pathological state* in different individuals presents a series of *different clinical pictures* of the disease called "Pneumonia."

In a small booklet "*Pneumonia*," published by Borland of the London Homœopathic Hospital you will find 22 clinical pictures of pneumonia types with 22 indicated homœopathic remedies.

Is there anything equivalent to this in ordinary medicine? Lederle Laboratories (New York) state "that the greatest advance in present-day knowledge of pneumonia is the understanding of the bacteriology of the disease. Pneumococci are responsible for 95 per cent. of the cases; *pneumococci have been classified into 32 serological types*; there must therefore be 32 etiological forms of pneumonia."

The clinical observations of the homœopathically trained physician and the bacteriological evidence of the laboratory seem to agree that there are different types of Pneumonia.

It is thus possible for the graduate from the ordinary school of medicine to extend and advance his clinical knowledge of disease.

I have now dealt with two headings (1) Drugs and (2) Disease and indicated the possibilities of extending your knowledge.

The facilities for clinical study are within your reach and you can verify the clinical pictures of pneumonia I have given you in your clinical work in the wards of this, St. Bartholomew's Hospital, and whether you eventually wish to apply the homœopathic principles in treatment or not, you will be the better physicians for having observed the finer symptoms of disease, according to the method of the homœopath.

There is a growing tendency today—and I say this as a research and laboratory worker—to trust too much to the laboratory and too little to the clinical acuity of the physician.

If you wish to study "drug provings" I have already named useful text-books for this purpose, but if anyone desires fuller information I would refer him to the Librarian of the Faculty of Homœopathy at the Royal London Homœopathic Hospital, who would be glad to assist any enquiries in the choice of books.

Now comes the rub—if you have acquainted yourself with the advanced knowledge of drugs and disease—and *not till*

then—you are qualified to try out the principles of homœopathic therapeutics. The homœopathic practitioner applies his knowledge according to a definite therapeutic law—the law of similars. He gives the drug which, when given to a healthy individual, produces symptoms *similar* to (not exactly the same as) those shown by the sick patient.

He takes into consideration the "totality of the symptoms," functional and pathological, and having got this picture, he applies the appropriate remedy from his knowledge of the *Materia Medica*.

THAT, AND NOTHING ELSE IS HOMŒOPATHY.

Now I have answered your question, "What is Homœopathy," I should conclude this address, but I know that before I am seated, someone will immediately get up and say, "But, I thought Homœopathy was the doctrine of the infinitesimal dose?" My answer is, "*It is not.*" The size or method of preparation of the dose does not govern the law of similars, but if you are prepared to accept this as a therapeutic principle it is logical to give consideration to the dose. If a drug in large or repeated dose is capable of ultimate pathological action, it would be wiser to give a smaller dose to act on the functional or physiological level when given as a therapeutic agent in disease.

In Allergy the same principle applies in treatment, to give the smallest dose which would fall short of causing an aggravation of the symptoms—the *optimum* dose. The method of preparation and the size of the dose is a matter of much discussion even in homœopathic circles but it is never disputed that the LAW OF SIMILARS is a therapeutic law.

It is possible for the physician of the ordinary school of medicine to apply the law of similars with his ordinary drugs and doses. Every time a dose of Quinine is given to a case of Malaria, the law of similars is being applied, probably unawares to the physician.

Summary and Conclusion

To understand Homœopathy, one must go back to the literal interpretation of the word; HOMOIOS, meaning SIMILAR, which is applicable to the DRUG, and PATHOS to the DISEASE. It is the doctrine of the similar drug for the similar disease, and requires the student already qualified in the ordinary medical school to extend and advance his knowledge of drugs and disease.

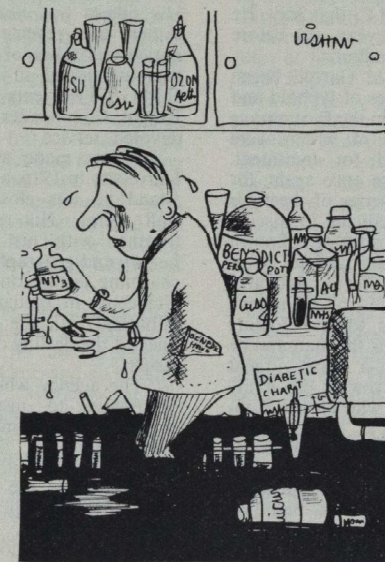
It is only after he has acquired this knowledge that he is in a position to apply a specialised form of Homœo-therapeutics.

The Faculty of Homœopathy was established to maintain a standard of *post-graduate* education in Homœopathy, and its diplomas of Membership (M.F.Hom.) and Fellowship (F.F.Hom.) are available only to qualified medical graduates, registered by the General Medical Council of this country.

Its object is, not to replace, but to advance the standard medical curriculum. Homœopathy has a place in the Art and Science of General Medicine.

On behalf of the Faculty, I invite any final year students or graduates in Medicine, who are interested, to attend the scientific sessions which are held on the first Thursday, at 5 p.m., of each month from October to June, at the Royal London Homœopathic Hospital, Great Ormond Street, London, W.C.1.

THE DUTY CLERK



"A summer's day will seem an hour but short,
Being wasted in such time-beguiling sport."
(Venus and Adonis)

THE LIFE AND WORKS OF SIR ARCHIBALD GARROD

Part II

By C. J. R. HART

WAR AND POST-WAR

War found him with an established reputation and a grown-up family. He was gazetted to the 1st London General Hospital (T.F.) at Camberwell, and so spent the first part of the conflict in England. Of his three sons, the eldest, Alfred Noël, had just qualified at Bart.'s and became a houseman there. Basil, the youngest, entered Sandhurst on leaving Marlborough. The second son, Thomas, was commissioned in the 6th Batt. London Regt. Dr. Garrod's daughter was then still at school. So for the time being, all but one were safe.

They were not granted many months immunity. The first blow fell on May 10th, 1915, when 2/Lieut. T. A. Garrod was killed in action in France. To the family's deep bereavement was added anxiety for the remaining members. Dr. Alfred Garrod was commissioned in the R.A.M.C. that July. He went to France later in the year, just before his brother passed out at Sandhurst.

Meanwhile, Dr. Archibald Garrod began to concern himself with cases of typhoid and paratyphoid, then rampant in the East among un inoculated troops, some of whom were brought back to England for treatment. Osler comes into the picture once again, for he arranged an important series of meetings at the Royal Society of Medicine to discuss all aspects of 'P.U.O.'—pyrexia of unknown origin, then so readily diagnosed to cover such diseases as trench fever, infective hepatitis, and paratyphoid fever. He notes: "21st Oct. I saw Garrod today. Failing Dawson I will open but D. is the man and he should be asked. It is a most urgent problem. I will ask tomorrow at the Army Med. College for any man who knows Paratyphoid."

Garrod's activity in this field resulted in his promotion to Acting Colonel, A.M.S., and appointment as a consulting physician to the Mediterranean Forces. He was based on Malta, where he saw patients evacuated from Gallipoli and later from Salonika. "This," said Dr. Graham, "called forth all his great powers, for he had to treat patients suffering from tropical diseases which he had never seen previously, but his powers of observation and research enabled him to cope successfully with these problems, and to give valuable service."

He formed a close friendship with the archaeologist Professor Zammit, who was then curator of the Valetta Museum, and who was excavating the Neolithic temples of the island. Whenever he could spare the time he accompanied Zammit on these expeditions, and became very knowledgeable on Maltese pre-history.

Some such occupation was very necessary for him, to take his mind off the tragedy which war had brought to his family. In January, 1916, his eldest son, the only one to follow his father into the profession, was killed in action at Givenchy, near Bethune, when a shell exploded while he was working with an ambulance. He had been in France only two months.

At this period of adversity Garrod concentrated on his clinical work as never before. His object was not to seek recognition—rather the reverse: nevertheless official notice was taken of his efforts. In 1916 he was mentioned in despatches and created C.M.G. Two years later he was appointed a Knight Commander of this Order, for his devoted service.

He was made an hon. M.D. of Malta University in 1916, and during his stay on the island he was closely associated with the staff there. His researches with Zammit, together with his unusual knowledge of history and geography, were drawn upon in a charming lecture on *Islands* delivered at the University in January, 1919, and afterwards published. In the fine peroration he prophesied the destiny of Malta with remarkable insight:—

"The agency which promises to be most destructive to insular seclusion is only emerging from its infancy. Malta has been a halting-place for flocks of migrant birds, northward and southward bound; so we may expect that in the future it will become a place of call for squadrons of aircraft making the same traverse. But even when the sea-girt fortress shall no longer afford protection, nor insular retreat seclusion, there will remain the fascination of the far-spread sea, the island's beauty and the island's charm."

A month afterwards, fate dealt its final blow. His last remaining son, who had survived three years of war, was carried off in the great influenza pandemic which scoured

Europe in its first few months of peace. Garrod was heartbroken. His daughter travelled out from England to be with him, but the shock left permanent effects. All who knew him, speak of the way in which the rest of his life was overshadowed by his triple bereavement.

Later that year, Sir Archibald arrived back at Bart.'s to resume his duties as physician. He was a very different man from five years previously: even more reticent, and very aged—not so much by time, as by events. A fellow-physician called him "the shadow of his former self."

Nevertheless his concern for medical science remained, and he sought to use his increasing influence in fresh fields of endeavour. An important reconstruction committee was sitting at the time, which was drawing up the post war plan for the hospital and the medical school. They had before them the recommendations made by Garrod and his colleagues to the Haldane Commission. Sir Archibald pressed strongly for the formation of self-contained Professorial Units, with bedside teaching in the British tradition, but having also their own laboratories attached, on the pre-war German model. There were certain research problems, he maintained, which only the clinician could appreciate to the full, and he should have all the necessary facilities for working out his own ideas in his own way. Sir Archibald's views were summarised in a chapter entitled "The Laboratory and the Ward," which he wrote for the two-volume symposium produced that year in honour of Osler's 70th birthday.

When the committee decided that October to go ahead with the scheme, Sir Archibald was the obvious choice for the whole-time Director of the Medical Unit, and so became the first Professor of Medicine at St. Bartholomew's. Although he did not enjoy present-day facilities—the wards built by Gibb in the 1750s were then little changed—nevertheless he was given a free hand to incorporate many of his ideas into the organisation of the unit. The concept of a special set of laboratories proved so successful in practice, that when the units were freshly housed in 1935, the Dunn laboratories were made an integral part of their design.

Meanwhile the end of the decade at Oxford had brought with it the death of Osler. A man of great learning, a unique capacity for work and a most generous and affectionate

nature, he had long held an undoubted position as leader of medical thought on both sides of the Atlantic. The problem of finding a successor to the Regius Chair of Medicine at Oxford was of unusual difficulty. Whoever was chosen would have an unenviable task in following so remarkable a man. In London, the Oxford graduates pressed for Sir Wilmot Heringham, but their solicitations were of no avail. The appointment was in the hands of the Prime Minister, and Mr. Lloyd George chose Sir Archibald Garrod.

So great an honour was not to be refused. In his brief year as Professor at Bart.'s, Sir Archibald had laid excellent foundations, and he was content to leave to younger men the task of building up the new tradition. Bart.'s will not forget his work; a ward on the unit bears his name.

OXFORD AND CAMBRIDGE

Sir Archibald and Lady Garrod moved accordingly to Oxford, where he was elected to a senior studentship at his old college, Christ Church. In his obituary on Osler, Sir Archibald described some of the responsibilities of his new office, of which he was the 22nd holder: "... a Chair dating from the reign of Henry VIII... a position of high prestige, which has been enhanced by the tenure of Acland and Saunderson, with great opportunities of influence but little clinical teaching. The duties of the Regius Professor are varied, and others are added to them."

Some of these duties may be detailed. He was *ex officio* a Curator of the Bodleian, and Master of the Almshouses at Ewelme. This latter dignity had been bestowed upon the Chair by James I in 1617, to augment its income. Ewelme is a beautiful little village on the foot of the Chilterns, fourteen miles out from Oxford. The almshouses, which have their own church, are five centuries old, and house thirteen aged pensioners. There are rooms for the Master, which Sir Archibald was fond of occupying for short visits, being as one would expect most interested in his duties in this connection.

He had also his own stall in the Cathedral, with the privilege of reading the lessons, if he so desired. His predecessor had treated this concession very lightly—"These old fools have put me in a surplice and I had to go to chapel, but I wished I had been in the pulpit instead of the Regius Prof. of Divinity—who is a dry old stick"—but Sir Archibald had a very different approach. "He was," says

Dr. Heaton, who knew him there, "always kindly, courteous and gentle, a regular attender at morning service at the Cathedral on Sunday mornings, where he was very fond of reading the Lessons (quite inaudibly), and very proud of his membership of Christ Church."

As Regius Professor he was responsible for the examinations for medical degrees of the University. Another of his appointments was that of Consulting Physician at the Radcliffe Infirmary, where he was allowed five teaching beds. He was also elected a delegate to the Clarendon Press, but probably his most important office was his membership of the Hebdomadal Council, the 21 members of which formed the governing body of the University and met to pursue their deliberations every Monday afternoon.

He found that the administration of the medical faculty gave him opportunities for advancing his plans for "better medicine," in which the scientific approach could be encouraged. The best exposition of his views is contained in the Linaere Lecture which he gave at St. John's, Cambridge, in 1923, entitled "Glimpses of the Higher Medicine."

His interest in metabolic errors was stimulated once more by a case discovered by Dr. Mackey, in which the very first urine passed by a child was red in colour, suggesting that his porphyrinuria, detected on analysis, was congenital in origin. The disease of Hæmatoporphyrin Congenita, in which the clinical picture is the remarkable one of skin eruptions, red urine and pink milk teeth, was added therefore to the list of hereditary anomalies, and included in the 2nd Edition of his *Inborn Errors of Metabolism* which appeared the following year in 1923.

Various other tasks devolved upon Sir Archibald as the years went by. He was made a member of the Statutory Commission set up for the University, where the task of representing the claims of the Science Faculties was one which called for much patient investigation and tact. Two years later he found himself on the Advisory Commission formed by the Home Secretary to report upon the Administration of the Cruelty to Animals Act.

In this year, 1934, he was invited to deliver the Harveian Oration before the Royal College of Physicians. He chose for his subject "The Debt of Science to Medicine." A year later he became the first recipient of the Osler Bronze Medal, given quinquennially

to "the Oxford medical graduate who shall have made the most valuable contribution in the science, art or literature of medicine."

That year he wrote a biography of Alexander Gaspard Marchet for the Guy's Hospital Journal. Marchet was a French emigré who became a physician at Guy's, and in 1822 published *An Account of a Singular Variety of Urine, which turns Black soon after being Discharged*. Until this biography was written, Bædeker had been credited with the discovery of Alkaptonuria, in 1858. Thus did a member of one great hospital remind another of its forgotten achievements.

In 1927, upon reaching the age of 70, Sir Archibald retired from the Chair at Oxford. He had been very happy there, and was loth to give up his appointment. In the first years of his retirement he lived with his wife at Wilford Lodge, Melton, in Suffolk, a house which they had long possessed, inherited from his Ipswich ancestors. They found, however, that the isolation from his friends and many of his interests was not very satisfactory. At Cambridge their daughter, whose interest in archaeology had first been stimulated by her father during her visit to Malta, now held a Research Fellowship in the subject, and invited them to stay with her.

When they moved there in 1929 they were received with open arms by many friends, and through the good offices of Sir Gowland Hopkins, who held the Chair of Biochemistry, Sir Archibald was elected to dining rights at Trinity College.

"Soon after his move," relates his daughter, "his eyesight began to fail, a deprivation which he felt very keenly, but which was lightened by his wife's devotion. He had always been fond of travel, and during these years went with his wife and daughter on several cruises, a very easy form of travel which he enjoyed very much as he grew older.

"He was always interested in puzzles, such as acrostics, and was therefore predestined to be a solver of cross-words. In his last years the solution of the 'Times' cross-word was a daily family event, and Sir Archibald, who could no longer read, became extremely skilful at solving anagrams in his head."

But Sir Archibald's period of usefulness had not yet come to an end. In 1928 he delivered an Oration to the Royal Society of Medicine, on "The Lessons of the Rare Maladies." In 1930 he published his last

book, *The Inborn Factors in Disease*, based on the Huxley lecture on "Diathesis" which he had given three years previously. In this small volume he made his final *tour de force*, summarising the memories of a lifetime of observation. A convincing exponent of Mendelism since his Great Ormond Street days, he developed to near-perfection his theories on constitutional predisposition to disease.

Honours showered upon him. In 1931 he was elected an hon. F.R.C.P.E.. He was already a Fellow of the Royal Faculty at Glasgow, and hon. L.L.D. of Glasgow University, and an hon. M.D. of Dublin and Padua. Abroad he was made an honorary member of the American Association of Physicians, and of the Artzlicher Verein, München. Finally in 1935, at the age of 78, he was awarded the Gold Medal of the Royal Society of Medicine.

He was then considerably invalidated with cardiac asthma, but his mind was as alert as ever. In November, 1935, he submitted a postscript to the Quarterly Journal of Medicine, on the subject of Congenital Porphyrinuria. He asked for the paper back for revision, and he was engaged on this task when on March 28th, 1936, he died, very suddenly, of coronary thrombosis, without acute illness. His last paper was published posthumously.

EPILOGUE

When Abernethy pleaded before the Governors of this Hospital for more provisions for the students, he mentioned that their attendance formed "a strong incentive to the medical officers to perform their duties diligently and with skill and conscience, since their conduct is open to the public expression of praise and censure by these vigilant observers." The praise and the censure is still expressed, but it is doubtful if the medical and surgical staff remain as dependent for their practice upon the good offices of their students, as they have been in the past.

There is, however, another tradition arising by which the students are able to give voice effectively to their opinions of their masters. In 1842 the Reverend Samuel Wix gave £200 to found an annual prize for a composition on "the connection between physical science and revealed religion, or on the connection between the studies of ancient and modern literature, and the studies of

medical science." Such a subject was capable of wide interpretation, and generations of students have laboured upon abstruse and learned discourses on various aspects of this theme.

In recent years the founder's wishes have been construed to fit the need for short biographies of the more illustrious alumni of St. Bartholomew's, many of whom would have remained otherwise unhonoured and unsung. So it has come about that the last word upon many of the staff has rested with the students, who "draw their frailties from their dread abode."

Upon Sir Archibald's death, the usual obituaries appeared in the usual journals, and they were followed by a period of silence which might have lasted much longer, had this new tradition not arisen. He might well have become one of that great majority of whom Sir Thomas Browne wrote the immortal epitaph: "But the iniquity of oblivion blindly scattereth her poppy, and deals with the memory of men without distinction to merit of perpetuity... Who knows whether the best of men be known, or whether there be not more remarkable persons forgot than any that stand remembered in the known account of time?"

He was born in the year of the Indian Mutiny and the visit to England of Napoleon III; the year of his demise witnessed the beginning of the Civil War in Spain and Hitler's remilitarisation of the Rhineland. In 1857 many still believed in the spontaneous generation of germs, and anti-septic surgery was unheard of. In 1936 the sulphonamides were well established, and penicillin was on the way. He saw the first cars, the first aeroplanes, and the First World War. In spite of his scientific background, like many of his generation he found it hard to adapt himself to this bewildering world of change.

Viewed from the present day, his lifetime spanned that twilight period for which neither historical record nor personal reminiscence can yet afford an objective description. It has not been easy to reconstruct his life and works year by year, nor has it proved possible to enliven the narrative with those more intimate accounts of thought and environment which the biographical essay demands. He is an extraordinary example of an era in which family life formed that sacred and almost secret existence which was the affair of the family and nobody else.

No truly contemporary description of the man, not a diary, not a single letter even, has been found. One is thrown back upon the obituaries, the printed works, and such odd and obscure relics of his existence as have by chance survived.

He came from a most distinguished line, whose diversity of talent cannot be better demonstrated than by listing the peculiar collection of Garrodia which reposes in the British Museum. Excluding the works of Keene, Townshend and other collaterals, one finds there: a catalogue of an estate sale by his grandfather, his father's medical textbooks, literary essays by one brother and the scientific papers of the other, works on astronomy, geography, history and chemistry by Sir Archibald himself, and accounts of the archaeological discoveries of his daughter.

He was born to a tradition of success early in life, and his own delay in mounting the ladder nearly resulted in drastic action by his father, which would have wrecked his whole career. When eventually he did start climbing, his father's guiding hand was well in evidence.

But it was upon his own abilities that Sir Archibald depended as he built up his contribution to human knowledge. Although the inborn metabolic errors are rare, and practical applications of their knowledge restricted, nevertheless Garrod's researches were on fundamental problems, and did much to point the way to modern concepts of body chemistry. The scholarly little books in which he summarised his discoveries are the best possible demonstration of his modesty and restraint. Many elaborate and expensive monographs since published contain work of lesser quality.

He felt the waiting period for his appointment to the staff at Bart.'s most keenly, and it is recorded that during a visit to the great Virchow, he gave utterance to the complaint that "opportunities are not what they were

in the good old days, when nuggets lay thick on the surface for anyone who kept his eyes open to pick them up, whereas now the gold is only to be reached by skilful mining."

His public and professional life was blameless, to such an extent that one feels that a few of the human frailties would not have come amiss. Though always kind and thoughtful for others, he was not over-popular with the students, and the reason is not far to seek: he had no sense of humour. At Oxford his work for the improvement of medical teaching was as valuable as it was unspectacular. At Bart.'s he will always be remembered with pride as the first Professor of Medicine. Sir Francis Fraser, his successor to this office, has written:

"He was a scholar in all he said and gentle in all he did, and those who had the privilege of knowing him lived better and worked better because of him."

Who could desire a finer epitaph?

ACKNOWLEDGMENTS

I wish to thank Professor Dorothy Garrod for her kindness in providing many details of her father's life not to be found elsewhere. Mr. John Thornton, A.L.A., has given valuable advice on sources, and Mr. J. G. O'Leary, F.L.A., has also offered many valuable suggestions. In addition, the librarians of the following institutions have all gone to great pains to provide what information they could:—The Bodleian Library, The Royal Geographical Society, Marlborough College, The Royal Society of Medicine, the Royal College of Physicians and the Wellcome Library and Museum. The following friends and colleagues of Sir Archibald have helped with details of their recollections:—Professor K. J. Franklin, Sir Francis Fraser, Dr. Robert Frew, Dr. George Graham, Dr. T. B. Heaton, Sir Robert Hutchison and K. H. Rutherford, Esq.

BIBLIOGRAPHY AND WORKS

A detailed list of the works of Sir Archibald Garrod, including ten books and over one hundred papers, is appended to his obituary in the St. Bart.'s Hospital Reports, written by Dr. George Graham. A few additional papers are listed in the Wix Essay, which has been deposited in the College Library, and readers are referred to this for a bibliography.

ABERNETHIAN SOCIETY

The Annual General Meeting of the 1948-49 session was held on June 15th, when officers were elected for 1949-50. The committee elected was:

Presidents: N. A. Green, S. F. Hazelton.

Vice-Presidents: Miss J. Wheelwright, G. Davies.

Secretaries: K. E. J. Bowers, J. P. Waterhouse.

Pre-Clinical Representatives: Miss R. Hurst, J. Batterham.

The first two meetings of the 1949-50 session have been arranged:—

October 20th Professor Sir James Paterson Ross on "Your Patient and You."

October 27th—Dr. Charles Hill on "Current Events."

OBITUARY

MR. BRIAN RAIT-SMITH

THE death of Mr. Rait-Smith at Hill End on July 14th, at the early age of 45 was a great shock to his many friends, and a shattering blow to the Department of Anaesthesia.

He qualified at Bart.'s in 1929, and after holding the posts of junior and senior resident anaesthetist he was elected to the senior staff in 1937, having taken his D.A. two years earlier. He also became Anaesthetist to the Brompton Chest Hospital, Papworth Settlement, and the British Post-graduate Medical School, while the L.C.C. retained his services as consulting anaesthetist.

At the outbreak of war, Rait-Smith was transferred to Hill End Hospital, St. Albans, where he worked in a full-time capacity until his death. Here ample scope was given to his activities, as the hospital was unique in housing under one roof Orthopaedic, Thoracic, Neurosurgical and Plastic Units, at the same time dealing with E.N.T. and general surgery.

As regards professional ability, those who are in a position to judge placed him in the very front rank of British anaesthetists, and the surgeons will readily agree that very many difficult and tedious cranial and thoracic operations were successfully completed only through the most brilliant piloting at the top end of the table. Owing to his modesty and detestation of self-advertisement, Rait-Smith did not write much in the literature, but he was prevailed upon to publish some original work on the problems presented by cardiovascular surgery, and has contributed to a recent text-book on Anaesthesia. He also took his share in the various papers emanating from the Department of Anaesthesia during the war, notably those on the properties of trichlorethylene (worked out at Hill End) and of curare. Public recognition of his eminence in the specialty was afforded by his election in 1949 to the Fellowship of the Faculty of Anaesthetists, the highest academic distinction in this country.

Rait-Smith could not bear bombast or humbug, as students showing these characteristics found to their cost. On the other hand, he would take any amount of trouble in teaching those who really wished to learn, and he was always helping the residents with unobtrusive advice. It is quite typical of the man that the only photograph of him that

could be discovered was a small passport one taken eleven years ago.

Since 1942, ill-health was Rait-Smith's constant companion. While he lived at Hill End, he had three serious illnesses involving two major operations, and even during intervals of comparative ease he suffered from trigeminal neuralgia and continual headaches. He never let his disabilities interfere with his work or his mental outlook, but continued as a hard worker and a gay companion. This was the more remarkable as he knew that a second subarachnoid haemorrhage was practically certain. Here was courage of a rare order. The end was mercifully sudden, as he was working in the theatre on the morning of his death.

The esteem and affection in which Rait-Smith was held were shown at the funeral service held at Hill End Hospital Chapel. Every member of the Staff who could possibly get there was present, and the piles of beautiful floral tributes were most impressive. At the Memorial Service held a week later at St. Bartholomew-the-Less, Dr. Spence gave an excellent address epitomizing the life and character of "Rait." His memory should be a source of pride to Bart.'s.

C. L. H.

THE sudden death of Brian Rait-Smith on the evening of July 14th brought sorrow to many, and especially to the wide circle of his friends at St. Bartholomew's—both in the City and at St. Albans. For in the twenty-five years since he came here from Jesus College, Cambridge, he had been constantly associated with the Hospital and in the minds of many he had become a part of the place. For them his memory will remain so and there will often recur a picture of his lean, tanned face, so quick to smile, his brisk walk, his slight figure immaculately dressed with a cornflower in his button-hole. His quiet voice, his humour and his laughter will be likewise remembered and missed in the years to come.

There could not be a better anaesthetist. His experience and conscientiousness brought him a high reputation at an early age and there soon developed an artistry in his work

that gave the impression that all he did was simplicity itself. During long difficult operations on sometimes extremely ill patients his character enabled him willingly to accept heavy responsibility and the surgeon knew immediately that an operation must be terminated if Rait-Smith said so. Except for such occasions his work was done so unobtrusively that it would pass unnoticed by many, which—since he hated showmanship—was what he desired. The kindness which he possessed in such measure was given full scope in his work and his quiet reassurance and gentleness gave comfort to thousands of his patients. His residents became devoted to him, and he had a happy way of taking control of a case which was causing one of them anxiety without suggesting to anyone that he was more than an interested spectator. There must also be many house-surgeons and chief assistants who recall with gratitude words of encouragement from him which were of value in times of difficulty. In the period of almost ten years during which part of the Hospital has been situated at St. Albans, Rait-Smith's work was of outstanding value. He spent his days in the operating theatre; the majority of the patients he dealt with were the more difficult anaesthetic problems; he was always available to deal with emergencies or help his juniors; his advice was frequently of value to the Sisters in both wards and operating theatres; he gave the vast majority of the anaesthetics for the thoracic and neurological surgeons and his work was of inestimable value in the development of these new departments.

Of the many qualities which combined to produce Rait's charm of manner, outstanding was his unflinching courtesy. This was seen in all his contacts with medical colleagues and the nursing staff, as well as those with orderlies, porters and other members of the lay staff of the Hospital. It was based upon kindness, generosity and an understanding of human nature and these qualities coupled with his sense of humour go far to explain

his popularity and the number of his friends. However, when it was necessary he could be an outspoken critic of meanness, hypocrisy or discourtesy and the reaction of others to his character was clearly indicated in the respect with which his opinion was received and his easy control of his colleagues during the years when he was the senior resident.

He loved life and was keenly interested in all forms of sport. At rugby football he had played regularly in the centre or at fly-half in a strong hospital fifteen and, a graceful batsman and fine field, he had been a member of one of the cup-winning hospital cricket elevens. He remained keenly interested in both games and was a frequent visitor at Twickenham. Indeed, he was a natural games player and during recent years at the first available moment each day he would turn to the sports page of the *Times*. Good food and wine, travel, and books he enjoyed. At one time no gathering of his contemporaries was complete without him, but of recent years he had lived quietly and it sometimes seemed that he would appear at some party for the pleasure of others rather than for personal enjoyment.

He will be remembered for his skill and charm, but courage was perhaps his outstanding characteristic. This was a quiet continuous courage over the years, during which he had a succession of serious and different illnesses each one of which might recur. There was never a word of complaint, never a suggestion of self-pity, never any diminution of his love of life. He continued to work without sparing himself. Many have been saddened and impoverished by his passing and will extend their sympathy to his wife at her loss so early in their married life. Rait-Smith loved Bart's and, though he has passed from us in the prime of life, it can be said that Bart's had for him a deep affection which will secure his memory there for us in the years to come.

J.E.A.O.C.

D. C. MORGAN

THE news of David Morgan's death at the early age of 21, on Friday, July 22nd, after a short illness, came as a great shock to his many friends and colleagues.

"Dave" Morgan entered Bart's. in October, 1944, and after spending his pre-clinical days partly in Cambridge and partly

in Charterhouse Square, commenced his clinical work in the Hospital in April, 1947.

He was an all-round athlete, and took a keen and active interest in many Hospital activities. His especial love was track athletics, and his death came at the time when he was approaching the zenith of a brilliant athletic career. He had recently

been elected Captain of the United Hospitals' Athletic Club, an honour richly deserved.

Always of a happy disposition, David Morgan will be grievously missed; and proof of his popularity was the large congregation present at the Memorial Service held in his honour, in the Church of St. Bartholomew-the-Less.

We, his friends, are deeply conscious of a sense of loss and sorrow, and extend our sincere sympathy to his relatives and his fiancée in their bereavement.

J. I. B.

David Morgan's spirit was that epitomised in the motto over the Medical School door: "Whatsoever thy hand findeth to do, do it with all thy might." His courage and tenacity on the athletic field were always admirable. In winning he was both gallant and

modest, and in adversity he never gave up against opponents with more generous physical endowments than his own. It is this spirit which rises above everything else which makes a man, who, whether he wins or loses, we salute and remember as a sportsman.

We will also remember David Morgan for his ability to work hard at his profession, for his enthusiasm and interest, and above all we will miss him as a good friend whose loyalty, tolerance and good manners made him so acceptable to all of us who were privileged to know him.

It is tragic that he has left us when just in sight of qualification and on the threshold of his career as a doctor. His family and his fiancée have our sincerest sympathy in their great loss.

H. B. S.

CORRESPONDENCE

VIEW DAY

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

Sir,
How very delightful it is to see that a valiant "member of the Bart's family" (to quote Mr. Ullmann's own words) is sitting up and taking such an interest in the affairs of this Hospital.

I am sure we are all most touched by his attention: some of us may even feel distressed over his misfortune at missing this year's View Day: not so myself.

If our patriotic friend would avail himself of a small booklet which was openly on sale in the library at Charterhouse Square, his knowledge may still further be increased. I refer to "A Short Story of St. Bartholomew's Hospital," the price of which is hardly exorbitant at one shilling.

He will find in this booklet a very concise account of View Day and he would do well to observe that this day has been a traditional occasion for, it is said, 600 years. He will also note that it always occurs on the second Wednesday in May. If he cares to check this information, I think he will find that this has been the case for the last 200 years.

If Mr. Ullmann takes any interest in football pools, it should not be too difficult to work out which day View Day was, or, for his future benefit, will be. Quite a straightforward permutation, you know.

I am still further distressed to hear that your unfortunate correspondent has discovered "the existence of a very deep gap between Charterhouse Square and the Hospital." "Nothing," he tells us, "is done in order to bridge this gap—on the contrary, its existence seems to be welcomed."

I suggest that the gentleman concerned could himself play a noble part in the closing of this self-discovered gap. I put it to him that if he would take some part in the organised games which this

Hospital plays, he would meet very many clinical students: and if he likes a pint of beer after his games, he would meet many more.

Since he came to Bart's, has he played a single game of rugby or Association football, or of cricket? Did he, I wonder, attend Sports Day? It is only by taking part in functions such as I have mentioned and by taking an active interest in the Hospital itself that Mr. Ullmann and others like him can possibly hope to bridge this gap which he has found so insurmountable. Let him not think that clinical students, their professors and lecturers are going to lay down their tools, form up in a neat squad and double-march over to Charterhouse Square exclusively to discover the whereabouts of one Ullmann.

With regard to the non-advertisement of View Day, I think perhaps a small notice in the appropriate place would have been desirable for those few people who, like your correspondent, have been at Bart's a year or more and are only now developing a small interest in the Hospital's history and activities.

It seems peculiar that very many pre-clinical students (of whom I am one) do not appear to have noticed or complained of Mr. Ullmann's gap: further, that many of us knew the date of View Day, and quite a number attended that function. Many of us have a large number of "clinical" acquaintances.

However, I think it most chivalrous of your correspondent not to have ventured into the ladies' cloakroom to read the notice therein—a gesture which I am sure all the ladies much appreciated.

Yours faithfully,

BRIAN S. HICK.

*Charterhouse Square,
London, E.C.1.*

July 16th, 1949.

EPITHELIOMA OF THE ANGLE OF THE MOUTH

by A. J. WALKER, M.B., F.R.C.S.

Mr. A. D., aged 54, was well until December, 1948, when he noticed a lump at the right angle of the mouth. Treatment with penicillin tablets produced a sensitization rash; he was then referred to Dr. R. M. B. MacKenna. A past history of syphilis suggested that the tumour might be a gumma, but it continued to grow despite a two weeks course of iodides. A biopsy was therefore taken and showed the lesion to be a keratinizing epithelioma.

He was admitted to Percival Pott Ward on February 3rd, 1949. On examination, his dental hygiene was appalling, and he showed leucoplakia on the tongue and buccal surface of the cheek. The lesion had grown appreciably, and was an obvious malignant ulcer, $1\frac{1}{4}$ in. x 1 in. in size, with elevated edges and a dirty sloughing base, and was very tender. It had eroded the angle of the mouth and had extended on to the lower lip, which was oedematous, while inside the mouth the ulcer spread down to the alveolar sulcus. It had extended into the substance of the cheek and a hard purplish lump $\frac{1}{4}$ in. diameter was visible just below the angle of the mouth. The submandibular and upper deep cervical glands were enlarged and tender.

After total dental extraction and control of sepsis by procaine penicillin he was treated by Mr. I. G. Williams in the Sassoon Department. Unfortunately, relief of pain and growth regression were short lived. Dr. Aldren Turner attempted injection of the Gasserian ganglion to ease the pain but was unsuccessful. The patient was re-admitted

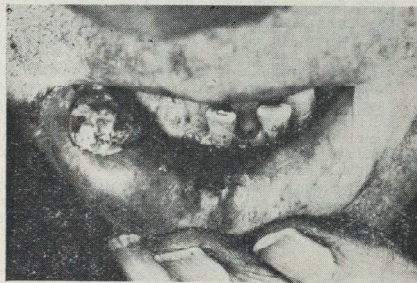


Fig. 1. Appearance of the lesion, January 4th, 1949.

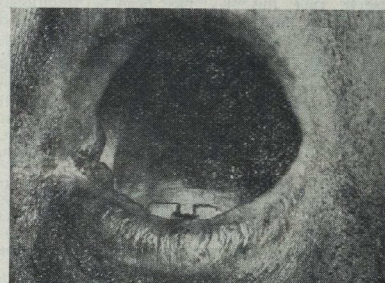


Fig. 2. Appearance of the lesion, January 27th, 1949.

under the care of the Surgical Professorial Unit and by this time the growth had extended to the mandible. Excision of the growth including part of the mandible offered the only hope of cure.

Operation. On May 19th, 1949, after preliminary transfusion and under a "penicillin umbrella," with nasal endotracheal anaesthesia, the external carotid artery was ligated just above the superior thyroid artery. The incision was continued forwards and up to divide the lower lip clear of the growth. A second incision encircling the growth and avoiding it by the same margin, ended on the upper lip. The skin flap in the neck was elevated and the suprahyoid structures dissected up off the mylohyoid and hyoglossus muscles until the mandible was reached. The bone was divided 1 in. to the right of the midline and through the ascending ramus. When the muscles had been cleared from the loosened segment, the undersurface of the buccal mucosa was exposed and divided close to the tongue. It was then possible to turn over the whole specimen, consisting of the growth, mandible and suprahyoid structures, so that the buccal aspect of the lesion was outwards. The cheek structures were then divided clear of the growth under vision and the whole mass removed.

It was only possible to close the buccal defect by suturing the epithelium of the side of the tongue to near the upper alveolar sulcus, though this seriously limited tongue movement. The angle of the lip was reconstructed by suturing the cut edges of the lip.

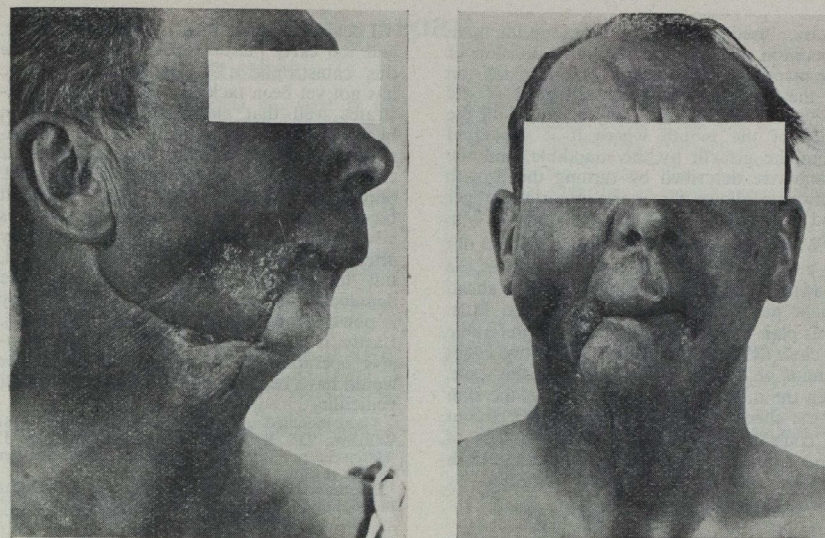


Fig. 3. Post-operative appearance, showing method of closure.

The gap in the cheek was closed by bringing up the skin flap from the neck, mobilised earlier in the operation. Skin closure was obtained except for one small area by bringing up another flap from lower in the neck (Fig. 3).

Discussion. This case demonstrated some points in diagnosis. When first seen (Fig. 1) the lesion was small. The edges were not raised and it was not typical of an epithelioma, while the syphilitic background raised the possibility of a gumma. Previous investigation by Dr. Aldren Turner had suggested asymptomatic neuro-syphilis, and it is well known that gummata and neuro-syphilis do not often co-exist. Nevertheless, a therapeutic test was instituted. This should never be pursued for longer than a month, and in this case the diagnosis was evident in only two weeks. The biopsy would have been more valuable if taken earlier. The rapid growth illustrated the well known greater malignancy of this site compared with other parts of the lip. It is of interest also that, except for not smoking a clay-pipe he demonstrated all the classic aetiological factors of intra-buccal cancer—dental sepsis, syphilis and leukoplakia. Syphilis is only important in

so far as it often co-exists with leukoplakia, which need not be confined to the tongue. It is seen on the palate, or as in this case, on the cheek. Leukoplakia, wherever found, is always precancerous and demands urgent attention. The present-day treatment of intra-buccal cancer is primarily a radiotherapeutic problem. The recurrence rates are the same as with surgery, but there is less disfigurement after treatment. The objection to applying radium to this lesion was the nearness of the mandible and the risk of its necrosis, and, therefore, Mr. Williams preferred to use the 1,000 Kv. plant; but, as has been shown, this treatment was not successful. Radiotherapy in this case did help by reducing the activity of the tumour, as in preoperative radiotherapy elsewhere.

It is worth remembering the attempt made to relieve pain by injecting the Gasserian ganglion. The situation of the growth ruled out the usual anterior route, and the lateral route over the mandibular notch was chosen. This only effectively anaesthetises the mandibular nerve, and this would have sufficed, but the mouth could not be opened sufficiently. Surgery has so far proved successful. The only special points in the operation were the incorporation of the

incision used to ligate the carotid in the main operation incision and the early division of the mandible. It is essential that the division of the mucosa should be well clear of the growth. This can be safely achieved on the floor of the mouth where it is separated from the growth by the mandible, and the manœuvre described by turning the growth outwards allows the more important upper and inner parts to be resected under vision.

Whenever possible, the closure should not be attempted by the surgeon who excises the growth, as the thought of what lies ahead might make him tend to remove too little. This plan was adopted here. It is preferable to close the buccal mucosa. If the two edges cannot be united, as was done in this case, then the mucosa must be sutured to the skin of the cheek. The latter subjects the patient to constant drooling of saliva and loss of food from the hole into the mouth. Both sepulchra can be subsequently remedied by plastic surgery.

Local recurrence must still be looked for, and too early plastic repair may precipitate this catastrophic. The lymphatic drainage has not yet been tackled. This case demonstrates well that glandular enlargement in buccal cancers is as likely to be inflammatory as neoplastic, the original glandular enlargement now having disappeared. Should the glands enlarge again, a difficult block dissection will be necessary. In less advanced cases, this is usually done routinely after the primary growth has been controlled, but the peculiar difficulties of this case demand an expectant policy. Radiotherapy is powerless to control lymphatic metastases. Lastly, it is well to remember that an extensive operation on the mouth of this order would have been far more hazardous without penicillin.

I am indebted to Mr. F. F. Rundle, Mr. I. G. Williams, Dr. R. M. B. MacKeuna and Dr. J. Aldren Turner for their interest in the production of this record.

Photographs by the Department of Medical Photography, St. Bartholomew's Hospital.

ANNOUNCEMENTS

DEATH

DAVIES, John Philip Henry, M.A., M.B., B.Ch. (Cantab.), D.P.H., of Elgin, Llanishen, Cardiff, on July 19th, 1949, suddenly, at the age of 66.

CHANGE OF ADDRESS

Dr. I. de Burgh Daly to the Institute of Animal Physiology, Babraham Hall, Babraham, Cambs. Tel.: Sawston 48.

Dr. I. P. Edwards to 16, Beechley Road, Wrexham. Tel.: Wrexham 2382.

BRITISH RHEUMATIC ASSOCIATION

There will be an exhibition of aids, appliances and services for sufferers from rheumatism at the Town Hall, Chelsea, from September 27th to 30th.

THE JOURNAL

Contributions must reach the Editor before the first Tuesday of the month for inclusion in the following number.

SPORT

GOLFING SOCIETY

The 15th Summer Meeting was held at the Denham Golf Club on Wednesday, June 8th, 1949, and was attended by 22 members. Mr. R. C. Corbett presided at the Supper in the Clubhouse after the meeting. The results were:—

Singles (under handicap, against bogey)

Gordon-Watson Cup: Dr. C. A. Francis—all square.

Runners-up: Dr. R. A. Shooter—2 down.

Dr. R. Moore Patterson—2 down.

Last 9 holes: Dr. W. J. Hanbury—all square.

Sealed holes: Dr. J. Wilson—all square.

Foursomes (9 holes under handicap, against bogey)

Winners: Dr. N. C. Oswald and Mr. G. T. Hankey—all square.

Runners-up: Dr. R. A. Shooter and Dr. J. M. S.

Knott—1 down.

Dr. W. J. Hanbury and Dr. H. D.

White—1 down.

Gillies Trophy (Singles, against bogey, without handicap)

Dr. J. Wilson—5 down.

The Autumn Meeting of the Society is being held at the Royal Wimbledon Club on the afternoon of Wednesday, September 14th.

All qualified Bart's men are eligible for membership and also any person from another school holding a medical appointment at the Hospital. The present Secretaries are Dr. H. F. Brewer and Dr. M. B. Mellroy, St. Bartholomew's Hospital.

CRICKET CLUB

Friday, June 10th v. Guy's Hospital. Second Round Inter-Hospital Cup.

RESULT: Match drawn.

On winning the toss Moyes decided to bat first on a plumb wicket. As usual in our Cup matches, disasters were soon upon us. Hawkes was bowled, Tomlinson stumped, and Braimbridge caught at slip, with only a handful of runs on the board. Worse was to follow Cairns, who was batting confidently, was well caught at short-leg off an attempted hook shot, just before the luncheon interval—the score then being 75—4. On returning to the wicket the Bart's batsmen never looked safe against the Guy's bowling and wickets fell steadily until, with the score at 114—8, Haigh joined Aubin, and together after playing through a period of very bad light, took the score slowly to 141. Here Aubin had the bad luck to pull a loose ball on to his wicket, a pity, as he had shown us some grand carefree swings. Then came Moyes, and the end seemed near. But no! The innings lasted until tea and then for another half an hour in a last-wicket stand of 46, making a total of 187, many more than could have been hoped for at one time.

Although the Bart's batting was at times painfully slow (187 in just under five hours) the batsmen were not entirely to blame as the Guy's bowling, though very good at times, had as its line of direction a point two or three feet outside the off stump, tactics requiring the active co-operation of the batsman for the fall of his wicket,

and they had only themselves to blame for not finishing the innings off sooner.

However, Guy's were left to score 188 in two hours 15 minutes (a rate of 84 runs an hour)—a not too difficult task even for them. They started well enough by taking 20 runs off the first two overs, but Vazifdar soon had two quick wickets, and from then on, against some excellent bowling by Foy and Clappen, were fighting to play out time. They gave us a useful lesson in this art which we thought we had perfected and the game ended with their score at 109—7.

Scores:

Bart's 187 (P. G. Haigh 36 not out, J. D. Cairns 34).

Guy's 109—7 (B. N. Foy 3 for 20).

Saturday, July 9th v. Hampstead, Away.

RESULT: Won by 7 wickets.

Hampstead elected to bat first on a hard, but fairly lively wicket.

They lost two quick wickets for only 28 runs, but then two left-handers were brought together and playing dour cricket slowly pushed the score upwards.

At this stage of the game Bart's were strengthened by the arrival of their captain, Tomlinson, who for this occasion had risen before lunch.

After lunch Clapper bowled well and very steadily; and when Aubin was brought back for his second spell, the last seven Hampstead wickets fell for a mere 40 runs.

Left to get 162 runs, Biddell batted confidently, making a useful 20; but a second wicket partnership between Tomlinson and Braimbridge really took command of the bowling and the runs were soon hit off for the loss of three wickets—Tomlinson being 95 not out at the close.

Scores:

Hampstead 162 (Aubin 4 for 25).

St. Bart's 166 for 3 (Tomlinson 95 not out).

Sunday, July 10th v. Rabbits.

RESULT: Lost by 5 runs.

On a perfect wicket at Chislehurst the Rabbits opened the batting confidently. Runs flowed steadily and it was difficult to see how a wicket could fall. However, before lunch May was given the ball and with a varied flight took a wicket.

After lunch wickets fell at the rate of one an hour. Eight bowlers were tried altogether. Tomlinson was the most persistent, cleverly varying his pace, flight and aim!

Left to get 253, Bart's went out to get the runs from the start. With a 66 from Whitting and 60 from Ross, the prospects looked bright, but three foolish run-outs set us back. Finally, with four balls to go before stumps were drawn, our last man was howled attempting a mighty hit which might well have won us the game.

Scores:

Rabbits 253 for 4 dec.

Bart's 248 (Whitting 66, Ross 60).

July 11th v. Guy's Hospital. Cup Match replay.

RESULT: Lost by 7 wickets.

The Hospital were defeated by Guy's in the second round of the Hospitals' Cricket Competition, thus relinquishing their hold on the Cup they won last year, against the same rivals.

Moyes won the toss, and took Ross in to open with him. The bowling of Russell and Gray was reasonably accurate but never hostile, and the wicket gave them no assistance whatever. We lost our first wicket at 20, when Ross played a break-back on to his stumps. Even so early in the day the heat was intense and the bowlers and batsmen alike had already shed more than the generally accepted amount of "invisible" perspiration.

Tomlinson, having got his eye in, took three fours in one over from Gray, but was then unfortunately run out by a good return from Williams at cover. At this stage the scoreboard read 49 : 2 : 24—a mere pittance considering the state of the wicket. Guy's now reverted to their slow bowlers and very soon Moyes was out playing back to Woodford. Cairns and Braimbridge soon settled down, however, and never seemed to be in any trouble, although a series of full tosses from Graham received more courtesy than is proper, even in a Cup match. After lunch the partnership bloomed, and Cairns employed the square drive to good effect, whilst Braimbridge favoured the more vigorous off-drive between mid-off and extra cover. The stand was eventually broken, after it had put on over a hundred, when Cairns failed to get over a ball from Tweed and was caught on the off side. Braimbridge, however, went from strength to strength and was most unfortunate to miss his century by five runs, being out to an atrocious ball from Graham. With the exception of May (36) the rest of the Bart's batsmen seemed strangely unable to choose either the right ball to hit, or the right place to hit it, and the innings closed for 262 at 4.30 p.m.

Woodford and Blake opened for Guy's and put on a hundred runs before Clappen caught and bowled the former for 36. Blake batted magnificently throughout his innings. He is a "south-paw"—a member of a tribe who, as O'Reilly said, "should be strangled as soon after birth as their abnormality shows itself." His innings laid the foundations of victory for his side and was fittingly ended by a great one-handed catch by Clappen in the slips off Aubin. Shortly afterwards Aubin bowled Lipington, and May missed Russell's off-stump by a whisker. The latter then set about the Bart's bowling, ably abetted by Williams, both producing shots the envy of the writer. Russell worthily made the winning hit, which had it been a four and not a one, would have given him his century as well as victory for Guy's.

So the Cup now remains in the Bart's library only on sufferance. Our congratulations go to Guys on a most excellent performance—an object lesson in fielding and enterprising batsmanship. Scores :

Bart's 262 (Braimbridge 95, Cairns 44).

Guy's 263 for 3 (Blake 91, Russell 98 not out).

July 17th. Bart's Past v. Bart's Present.

RESULT : Bart's Present won.

The quiet start to this match gave little indication of the excitement to follow. The Past batted first on a wicket which enabled the bowlers to impart spin, but the ball turned too slowly to trouble the batsmen very much. In fact the batsmen were able to take the score, albeit sedately, to 235 for 7 wickets when Mr. O'Connell declared the innings closed. Ralph Heyland, with 67, was top scorer.

The Present, with two and a quarter hours to score the runs, began as though they had plenty of time to spare. Tomlinson, however, played himself in and proceeded to demonstrate the art of scoring quickly, despite a well-placed defensive field. He was unbeaten with a magnificent 148 when the necessary runs had been scored to win within a few minutes of time.

The many spectators thus enjoyed the best Past v. Present match for many years.

We are extremely grateful to Mr. O'Connell for his generosity in providing lunch and tea for all. Scores :

Past 235 for 7 dec. (R. Heyland 67).

Present 236 for 6 (Tomlinson 148 not out; Finch 5 for 94).

RESULTS

Saturday, June 4th v. Balliol College, Oxford.

Lost by 3 wickets.

Bart's 147 (J. D. W. Tomlinson 44).

Balliol College 148—7 (J. D. W. Tomlinson 4 for 15).

Wednesday, June 8th v. Gerrards Cross C.C.

Lost by 7 wickets.

Bart's 106.

Gerrards Cross 108—3.

Saturday, June 18th v. Horlicks C.C.

Lost by 48 runs.

Horlicks 188 (P. G. Haigh 5 for 79, J. A. Clappen 4 for 59).

Bart's 140 (J. A. Clappen 47, J. P. Waterhouse 34 not out).

Sunday, June 19th v. Barking C.C.

Match drawn.

Barking 219—7 dec. (P. G. Haigh 4 for 87).

Bart's 160—6 (J. A. Clappen 70 not out).

Saturday, June 25th v. Nomads C.C.

Match drawn.

Bart's 143—8 dec. (P. D. Moyes 33).

Nomads 128—4 (P. G. Haigh 4 for 53).

Sunday, June 26th v. H.Q. Eastern Command.

Won by 97 runs.

Bart's 231—8 dec. (A. G. May 118, P. D. Moyes 55).

Eastern Command 134 (P. G. Haigh 5 for 55, A. J. Clappen 4 for 78).

Saturday, July 16th v. Finchley.

Match drawn.

St. Bart's 146 for 6 dec. (Ross 80).

Finchley C.C. 146 for 5 (Vaughan 90 not out).

Saturday, July 23rd v. Hornsey.

Lost by 198 runs.

Hornsey 345 for 5 dec.

St. Bart's 154 (Ross 58).

TABLE TENNIS CLUB

It is some time since the activities of Bart's Table Tennis Club were recorded in the Journal and now that the season is nearly over I felt that it would be of interest to readers to hear of the progress and achievements of the club.

University League Matches

Bart's 1st team, playing in the University 2nd League, had a successful season, winning seven out of their 10 matches. The team was drawn from Messrs. Cohen, Connell, Cracknell and Husaince.

Bart's 2nd team, playing in the University 3rd League, got away to a fine start, winning four out of their first five matches. After that, the opposition became stronger and the final figures were four out of eight matches won. The team

was drawn from Messrs. Glasset, Greenhalgh, Hellings-Evans, Lacey, Marky, Parrish, Pearsons, Rushton, Smith and Waddy.

Full results of matches are appended.

London University Championships

These were held at the Union Assembly Hall, Malet Street, and Bart's entered nine representatives out of a total entry of 150. Of the nine, two, namely Messrs. Cohen and Connell, reached the last 40 before being knocked out. This championship was very enjoyable and provided valuable match experience.

General Remarks

The last General Meeting was held in October, 1948, and only 13 people turned up. The future of the Club looked uncertain, to say the least of it. It was decided at that meeting that a subscription of 5s. per year would have to be collected from each member to cover the cost of balls and bats.

By Christmas the number of members had risen to 30 and now the figure stands at 45, seven of whom are women.

The Club has no table at the Hospital owing to lack of space, but we have one fairly good table and two poor tables in the Gym at Charterhouse Square and one has only to go there between the hours of 12 a.m. to 3 p.m. in the cooler months to see how the Club thrives.

The Future

It is hoped to run open and handicap tournaments during the next season and to play friendly matches with other hospitals as well as playing in the University League.

It is also hoped to run a 3rd team in the University League.

The possibility of obtaining the services of a coach will also be fully explored.

The Annual General Meeting will be held on October 5th. Time and place to be announced later.

P. H. C.

RESULTS

UNIVERSITY LEAGUE II

(Bart's 1st Team)

December 15th (home) v. Imperial College III—WON 7—2.

January 12th (away) v. Westminster College I—WON 6—3.

January 19th (away) v. London School of Economics III—WON 7—2.

January 27th (home) v. Battersea Polytechnic II—LOST 3—6.

February 2nd (home) v. King's College III—WON 7—2.

February 10th (home) v. Queen Mary College I—LOST 2—7.

February 15th (away) v. Royal Dental Hospital II—LOST 4—5.

March 7th (home) v. School of Oriental and Asiatic Science I—WON 5—4.

March 9th (home) v. University College III—WON 7—2.

March 17th (away) v. West Ham College II—WON 6—3.

UNIVERSITY LEAGUE III

(Bart's 2nd Team)

December 8th (home) v. Westminster College II—WON 6—3.

December 13th (home) v. Northampton Engineering College II—WON 5—4.

January 13th (away) v. Northampton Engineering College I—WON 5—4.

February 8th (home) v. Northampton Polytechnic II—LOST 2—7.

February 22nd (home) v. Goldsmiths College I—WON 7—2.

March 3rd (away) v. Royal Veterinary College I—LOST 2—7.

March 11th (away) v. Queen Mary College—LOST 1—8.

March 17th (away) v. University College IV—LOST 3—6.

ATHLETIC CLUB

At the conclusion of the 1949 season Colours were awarded as follows :—

Honours : B. D. Lascelles.

Honours Re-awarded : J. I. Burn, J. A. Menon, D. C. Morgan, P. D. Matthews.

Team Colours : D. L. Bee, J. K. Murphy, J. A. MacDonald, J. A. Stainton-Ellis, J. C. Carter.

RUGGER CLUB 1948-49

The following have been awarded Honours :—

P. D. Moyes, A. H. John.

The following have been awarded Colours :—

P. D. Moyes, J. L. M. Corbet, A. M. Baker,

D. G. Dick, A. H. John, A. F. Wynne-Jones,

A. J. Third, M. B. S. Cooper, W. G. Holland,

J. K. Murphy, K. A. Clare, J. D. Griffiths.

PLYMOUTH SPECIAL HOSPITAL MANAGEMENT COMMITTEE

The Isolation Hospital, Beacon Park Road, Plymouth.

Resident Assistant Medical Officer (B.1) (Male, unmarried)

Applications are invited for the above whole-time appointment. The duties are chiefly in connection with fevers, venereal diseases and early tuberculosis, and applicants should be able to drive a car.

Salary £500 per annum, together with full residential emoluments. Previous general hospital house appointments essential.

The appointment will be for a period of six months in the first instance, mutually renewable for a further six months, subject to any alterations of salary and conditions which may be in force at that time. Appointment is terminable by one month's notice on either side.

Applications from practitioners holding B1 appointments cannot be considered unless ineligible for H.M. Forces.

Applications should be sent to the Medical Superintendent, at the above address, as soon as possible, enclosing copies of two recent testimonials.

B.M.A. PRIZES

Application forms for entry may be obtained from the Secretary of the British Medical Association, Tavistock Square, W.C.1.

EXAMINATION RESULTS

ROYAL COLLEGE OF PHYSICIANS

The following Candidates, having satisfied the Censors' Board, are proposed for election as Members:—

Cotes, J. E.	Ellis, R. H.	Grunbaum, L. N.	Joeles, A. M.
King, R. C.	Whitfield, D.		

ROYAL COLLEGE OF SURGEONS

At the Primary Examination held in July, 1949, the following candidates were successful:—

Archer, R. M.	Jones, R. F. M.	Robinson, J. O.	Frampton, H. G.
Nicholson, R. D.	Routledge, R. T.	Harrison, R.	Robins, R. H. C.

ROYAL COLLEGES OF PHYSICIANS AND SURGEONS

Pratt, T. L. C.	Diploma in Medical Radio-Diagnosis	April, 1949
	Stone, P. H. D.	
Cohen, L.	Diploma in Medical Radiotherapy	April, 1949
	Goolden, A. W. G.	
Middleton, H. G.	Diploma in Anæsthetics	May, 1949
	Samrah, M. E.	

UNIVERSITY OF CAMBRIDGE

Final M.B. Examination Easter Term, 1949

Part II—Principles and Practice of Physic, Pathoduete Diploma in Bacteriology—1949			
Bates, A.	Cooper, E. A.	Court, G. A.	Dawson, W. G.
Freeman, P. A.	Harris, J. R.	Kehoe, M. J.	McWhinney, I. R.
Morrison, W. P. L.	Odlum, H. R.	Roberts, J. M.	Struthers, R. A.
Wilkinson, M.			

CONJOINT BOARD

First Examination

Anatomy	Hill, A. N.	Watmough, G. C.	June, 1949
Allan, R.			
Physiology	Newberry, R. G.		
Allan, R.			
Pharmacology	Moyes, P. D.	Sacks, R. H. B.	Marsh, G. W.
Beattie, A. O. C.	Turner, W. J. A.		
Nielsen, J. S.			

Final Examination

Pathology	Cardwell, J. S.	Carter, F. G. T.	Cox, J. S.
Brown, H. S.	Liu, S.	Mehta, J. S.	Pedersen, J. L.
Jones, N.	Singh, B.	Turner, W. J. A.	Vercoe, M. G. S.
Rowson, K. E. K.			
Vince, A. A. P.			
Medicine	Bhandari, N. P.	Brown, H. S.	Crook, R. A.
Andrews, J. D. B.	Ffooks, O. O. F.	Hardy, C. G. J.	Latham, J. W.
Evans, T. L.	Singh, B.	Timmins, W. L.	
Mehta, J. S.			
Surgery	Capstick, N. S.	Chesover, I.	Dibb, F. R. F.
Burns, H. J.	Facer, J. L.	Ffooks, O. O. F.	Garrod, D. C. H.
Evans, T. L.	Hawkes, P. H. R.	Jackson, P. G.	Jowett, J. H. G.
Griffiths, J. D.	Latham, J. W.	Mason-Walshaw, K. R.	Mehta, J. S.
Kazantzis, G.	Morley, D. F.	Rees, J. H.	Richards, R. B. O.
Montfort, F. G.	Singh, B.	Thomas, D. H. C.	Wainwright, A. J.
Rohan, R. F.			
Midwifery	Blakeway, I.	Burn, J. I.	Chandler, G. C. H.
Andrews, J. D. B.	Green, N. A.	Hale, B. C.	Hibbard, B. M.
Chorley, G. E.	Hovenden, B. J.	James, D. C.	Jenkins, G. C.
Holland, W. G.	Kinsman, F. M.	Lewis, H. E.	Liu, S.
Kaye, M.	Mehta, J. S.	Montgomery, B. K.	Moore, G. J. M.
Marsh, G. W.	Nielsen, J. S.	Richards, R. B. O.	Rowson, K. E. K.
Morgan, D. C.	Stebbins, N. E.	Tannen, G. P.	Warlow, P. F. M.
Simmons, P. H.			

The following students have completed the examination for the Diplomas M.R.C.S., L.R.C.P.:

Burns, H. J.	Ffooks, O. O. F.	Hawkes, P. H. R.	Latham, J. W.
Mehta, J. S.	Singh, B.	Timmins, W. L.	

ST. BARTHOLOMEW'S



HOSPITAL JOURNAL

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HEALING ART

MEDICINE is an Art, and its practitioners should be artists. Before the technical growth of science, every doctor had to be himself a man of skill and learning in the wisdom of the mind and emotions; he cured by imagination rather than apparatus, by the magic impact of his personality on his patients, not by mechanical analysis and repair. The increasing knowledge of the body's mechanism in the last century has tended to conceal the importance of this quality, while the complexity of rational civilization has increased the need for it.

Eleven years ago Mr. Adrian Hill went into a sanatorium with pulmonary tuberculosis. While he was there he found that his painting was the key to return to activity of life and mind, the perfect antidote to the mental poison of prolonged illness. Later he realised that others would benefit too, and by continuous exertion and the persuasion of results has now brought many patients and a few doctors to agree with him. The British Red Cross Society and the National Association for the Prevention of Tuberculosis have organized the provision of Art Therapy in over a hundred sanatoria in Great Britain, and similar work is being started in other countries. A committee of the South-West Metropolitan Regional Hospital Board is trying to assess the value and the cost of the method, and many mental hospitals already wear the aspect of studios.

For the well a means of relaxation and mental refreshment, enthusiastically supported by Winston Churchill and others, painting can be for the sick a life-line. First, it is easily managed by the most bedridden; and those who say they "could never draw at all" prove as capable as the overtly artistic.

Second, an occupation of any sort is of great value to the nearly-stagnant sufferer: art is in this respect a tool of Occupational Therapy. Third, and perhaps most vital, it is a means of expression, conscious or unconscious, which liberates the personality from morbid introspection and the tedium of daily routine, and may be of diagnostic use in psychiatry. Lastly, a number of latent talents have been discovered, and a path opened to self-maintenance in convalescence and recovery.

Although a clever novelist can bring profit and amusement out of a year in a sanatorium, and a journalist has reported his illness as he would any other "story," for most victims of protracted illness there is a grave likelihood of mental degeneration implicit in confinement to bed. Anything which will help to counteract this decline is valuable, and is a weapon of healing appropriate to a physician. The material requirements are small. Paint-boxes, pencils and canvas are not going to compete with the synthesis of cortisone for the funds of the State, any more than their use implies a neglect of conventional therapy. Nor is general assent to this argument sufficient to produce results; the individual must still be treated alone, and given that personal attention that is so difficult to reconcile with bureaucracy. William Blake declared that:—

He who would do good to another must do it in Minute Particulars. General Good is the plea of the scoundrel, hypocrite, and flatterer: For Art and Science cannot exist but in minutely organised Particulars.

Medicine, we have said, is an art. Art can also be a medicine.

LIVER BIOPSY

By RICHARD TERRY

THE characteristic histology of the liver in many disorders makes biopsy of the liver an obvious and valuable procedure, provided there is no undue risk and the indications and contraindications are recognised and observed.

There are three methods of obtaining the biopsy. Wedge biopsy taken after laparotomy provides excellent material and allows inspection of the liver: however, when liver biopsy is indicated, an abdominal operation is often inadvisable and Womacks (1947, 1949) is one of the few supporters. Peritoneoscopy permits inspection of the liver as well as biopsy and is often valuable in malignant disease of the liver, but the specimen is small and superficial, and often inadequate in other conditions. Thirdly, a core of liver may be obtained by passing a needle through the chest or abdominal wall: this method is here called needle biopsy of the liver and has been used in this hospital since December 6, 1947, on one hundred occasions.

Indications

The indications have been regarded as:—

1. Jaundice, when the cause is uncertain. N.B. During the first ten days and after two months, parenchymatous and obstructive jaundice have similar histology.
2. Hepatic enlargement of unknown origin.
3. Malignant disease, when liver involvement is suspected and especially if surgery is planned.
4. Hepatic disease, in which precise diagnosis is otherwise difficult: fatty infiltration, acute, subacute and chronic hepatitis.
5. Obscure systemic disease, when other diagnostic methods have failed: amyloidosis, polyarteritis nodosa, haemochromatosis, sarcoidosis, Gaucher's disease, abdominal reticulosis, aleukæmic lymphatic leukaemia, myelosclerosis, undulant fever, glandular fever, miliary tuberculosis, kala-azar, and schistosomiasis.
6. The investigation of portal hypertension, splenomegaly, and hypersplenism. Sherlock (1949) states that splenectomy is not carried out at the Postgraduate Hospital. Hammersmith, without preliminary liver biopsy.

7. The investigation of the state of the liver in constrictive pericarditis.

8. The evaluation of treatment in fatty infiltration of the liver, homologous serum jaundice and infective hepatitis.

Contraindications

The following contraindications have been observed:—

1. Haemorrhagic states, not responding to treatment. These include abnormal bleeding and clotting times, thrombocytopenia, and a prothrombin level below 65%.
2. Marked anaemia.
3. Absence of superficial liver dullness.
4. Senility.
5. Inability of the patient to co-operate, because of age, marked dyspnoea, agitation or mental deficiency.
6. The suspicion of liver abscess, hydatid disease or active cholangitis.
7. Infection in the right lower chest. Ascites and congestive heart failure (even with tricuspid regurgitation and pulsation of the liver) have not been regarded as contraindications.

Method

The instrument and technique described by Gillman and Gillman (1945) appeared safe and efficient, and after modification was adopted. The instrument consists of a special 20 cc. syringe carrying a needle 15 cm. long and 1.8 mm. in bore, with a stylet attached to the plunger. The stylet has a flattened side, allowing the pressure within the barrel to be transmitted along the needle. A spring-catch mounted on the syringe-cap engages notches on the plunger rod and maintains the plunger in position against negative pressure.

After preliminary sedation and local anaesthesia, the needle is introduced transpleurally, usually through the seventh intercostal space in the anterior axillary line. After telling the patient to stop breathing, the needle is advanced into the liver about 0.5 cm., and then with the left hand holding the syringe handle stationary, the right hand thrusts the barrel forwards and so drives the needle into the liver, punching out a core as it advances. (In other words, the movements are opposite of those used in aspirating a

fluid, when the left hand holds the barrel stationary and the right hand withdraws the syringe handle.) The needle is removed after 1.5 to 3.5 seconds within the liver and the core of liver gently extruded into 10% formal saline.

Comment on Method

This combination of needle, stylet and syringe in one instrument allows the biopsy to be carried out in one brief movement. In the widely used method of Iversen and Roholm (1939), a trocar and cannula are introduced into the liver, the trocar removed, the cannula advanced to make the biopsy, a syringe attached to the cannula, the core sucked into the barrel by withdrawing the plunger and finally the instrument is removed. The patient holds his breath throughout and the method seems an ordeal for both patient and operator. The Vim-Silverman needle is popular in the U.S.A., but Brick (1948) states that the method requires 2 to 5 minutes after local anaesthesia is induced, and Davis (1947) states that the material is "usually macerated and cellular detail is distorted."

Some advise the subcostal route, but it has been responsible for all the reported perforations of hollow viscera. It must be remembered that growths of the colon, kidney and suprarenal may sometimes infiltrate the liver and imitate hepatomegaly, a danger referred to by Schiff (1949) and encountered twice in recent months in this hospital.

Many articles do not mention failures. Early failure rates of 40% were experienced by Watson (Greene, 1944) and Schiff (1949), and of 22.5% by Iversen and Roholm (1939). Schiff now reduces his percentage of failures by repeating the puncture two or even three times! Gillman reported failures in only 5% and a similar figure has been achieved in the present series.

Complications

Complications reported in the literature include haemorrhage from the wound in the liver, haemothorax, pneumothorax, perforation of a hydatid cyst, shock, perihepatitis and perforation of gall bladder and colon. No complication occurred in the present series.

Mortality

Without the present knowledge of specific contraindications and in ignorance of hypoprothrombinæmia and other hæmorrhagic states, early attempts at liver biopsy caused an alarming number of complications and deaths, and the procedure rightly fell into disrepute. Mortality figures of 2.0% were widely quoted and discouraged many interested in the problem. However, Iversen and Roholm (1939) in Scandinavia, and Sherlock (Dible *et al.*, 1943) in this country demonstrated the safety of liver biopsy and since 1939 the following results have been reported:—

hagic states, early attempts at liver biopsy caused an alarming number of complications and deaths, and the procedure rightly fell into disrepute. Mortality figures of 2.0% were widely quoted and discouraged many interested in the problem. However, Iversen and Roholm (1939) in Scandinavia, and Sherlock (Dible *et al.*, 1943) in this country demonstrated the safety of liver biopsy and since 1939 the following results have been reported:—

Author	Biopsies	Deaths
Gillman (1948)	1,000	1
Sherlock (1949)	450	2
Cogswell <i>et al.</i> (1949)	403	0
Roholm <i>et al.</i> (1942)	297	2
Volwiler <i>et al.</i> (1947)	278	1
Beek <i>et al.</i> (1943)	200	0
Topp <i>et al.</i> (1948)	150	0
Awwad (1949)	130	0
Davis (1947)	128	0
Koch <i>et al.</i> (1948)	100	0
Parekh (1949)	100	0
Terry (1949)	100	0
Herrera <i>et al.</i> (1947)	72	0
Hoffbauer (1945)	65	0
McHardy <i>et al.</i> (1948)	50	0
Baron (1939)	48	1
King (1948)	48	0
Beierwalters <i>et al.</i> (1946)	30	0

3,649 7

Total mortality = 0.19%

Even at this low mortality, the death of a single person whose prognosis was good would undermine confidence in liver biopsy. It is therefore reassuring to discover that these seven deaths occurred in patients who were suffering from the following incurable conditions:—

1. "A huge tuberculous liver." (Gillman)
2. Acute necrosis of the liver. Autopsy showed a lethal degree of liver damage. (Sherlock)
3. Acute necrosis of the liver, general paralysis of the insane, and carcinoma of the rectum. (Sherlock)
4. Carcinoma of the head of the pancreas. (Roholm)
5. Malignant glands in the portal fissure. (Roholm)
6. Hepatic amyloidosis. Bleeding spread in the friable liver and led to gross disruption. (Volwiler)

7 Diffuse hepatic metastases. (Baron)

Death followed hæmorrhage in all seven instances; in cases 4, 5, and 7 no Vitamin K was given.

Summary

The indications and contraindications for liver biopsy are outlined.

A satisfactory method of needle biopsy of the liver is described: this method has been employed in this hospital in 100 biopsies without complication.

The result of a recent survey of the literature is given, showing a mortality rate of 0.19%.

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MR. REGINALD M. VICK, O.B.E., M. CHIR.

THE retirement of Mr. Vick from active work at Bart.'s, though not from practice, merits notice in these pages.

It is over 40 years since Mr. Vick entered Bart.'s from Jesus College, Cambridge, and Bart.'s and Cambridge have remained his greatest interests. The flourishing "Club" for Cambridge graduates at Bart.'s owed its success to his indefatigable work as secretary. It is not appropriate here to list the stepping stones by which he reached the staff, nor should we journey with him to France and Salonica in World War I. In 1919 he moved into the Warden's House of the old Residential College, to which he was soon to bring his bride. He was elected an Assistant Surgeon in 1920, and became one of the most able and popular teachers. I can remember 30 or 40 men following him into the East Block at 1.30 p.m. on Wednesdays, especially when the F.R.C.S. exams were near. He believed in teaching by the bedside or in the practical surgery room rather than by formal lectures, though you have all heard for yourselves how well he can deliver the latter. He

loved practical illustrations and cautionary tales of what not to do, and conducted his teaching mainly by question and answer, with a knack of getting answers even from the dullest. His own responses sparkled with wit but were never unkind.

It was natural that he should prove an ideal examiner, and for 29 years his services have been sought by the Court of Examiners and the boards of five Universities.

World War II took him from Bart.'s to a hospital less worthy of his talents, but even there the welfare of the patients and the students was his constant aim. It was largely due to his efforts that the hospital became imbued with the Bart.'s spirit, and that those who worked or studied there had happier memories than seemed likely at the beginning.

Mr. Vick is to give his final clinical lecture at Bart.'s on Wednesday, October 5th, and will address the Abernethian Society on Thursday, December 1st. All his colleagues and old students wish him long life and happiness.

SURGEON.

DRINK, DRUGS AND DOCTORS*

By W. R. BETT

LUCKILY a title is like a spider's web—it entangles the weak, but it is broken by the strong. This afternoon, I shall talk not about, but round about, the title of my subject which, in all its alliterative allure, has, I confess, been thrust upon me.

Some of you may recall a popular song which included these lines:—

"Ashes to ashes and dust to dust,
If the women don't get you, the
co-caine must."

Let me begin with that great, but elusive surgeon William Stewart Halsted (1852-1922), who, to the casual observer at least, spent most of his time trying to escape from patients and students alike and in the intervals as it were founded in the United States of America a school of surgery to be compared in stature only with that of Billroth in Vienna. A strange personality, shy and remote, possessed of a caustic wit and of a couple of exacting dachshunds, Halsted loved to search the pages of the dictionary for long and unusual words, which he might inflict upon his company. As a young surgeon in New York he exuded physical and intellectual vigour. After 1885, however, people began to notice a change in him. In the course of his pioneer experiments on conduction and infiltration anaesthesia by cocaine he became an addict to that drug. His three associates died miserably. He himself was taken in hand by William Henry ("Popsy") Welch, who accompanied him on a trip to Europe and eventually succeeded in breaking him of the cocaine habit, but it is doubtful if Halsted was ever the same again. The evil drug had left too deep a mark upon him.

In the annals of medical history Halsted is reverently spoken of as the man who introduced rubber gloves into surgery. For the sake of historical accuracy it must be recorded that the intention behind this revolutionary venture was not to eliminate the surgeon as a source of sepsis, but merely to protect the delicate hands of his theatre nurse—the future Mrs. Halsted—from the strong mercuric chloride solutions extensively used in those days.

Let us turn to three Bart.'s men; quite a mixed lot, I am afraid, but that makes them all the more fascinating. My first two

* An address given to the Devon & Exeter Medicico-Chirurgical Society on March 17th, 1949.

characters are on the shady side. A native of Portugal, Roderigo Lopez is remembered in the history of the Hospital as having been its first resident house-physician, being rewarded with a house, a garden, coal, and the munificent sum of forty shillings a year. Those trained at other hospitals will more likely remember Lopez as the man who plotted against the life of the Virgin Queen. Having wormed his way into the Court, in 1586 Lopez was appointed physician to Queen Elizabeth, who apparently thought very highly of him, but whom he was afterwards accused of attempting to poison (the nature of the poison is not disclosed). For this crime he was hanged on purely circumstantial evidence.

Another Bart.'s man who died on the gallows was William Palmer who qualified in 1846. In the Library of the Royal College of Surgeons of England is preserved a students' entry-book kept between the years 1843 and 1858 by James Paget, Warden of the Residential College. His description of young Palmer is worth reproducing: "Idle, dissolute, extravagant, vulgar, and stupid." What an epitaph to strive for! Both Paget and Palmer have attained the distinction of being included in the *Dictionary of National Biography*. Palmer's father was a wealthy man who died worth £70,000. The son was apprenticed to a firm of wholesale druggists in Liverpool and promptly ran away with their money. As a doctor in Rugeley, Staffordshire, Palmer was more interested in horse racing than in his patients, and sooner or later turned over his practice to his assistant. Several mysterious and highly suspicious deaths occurred in his home. An illegitimate child which he had by a Rugeley woman died after it had visited him. His mother-in-law, persuaded to live under his roof, died within two weeks, Palmer, of course, inheriting her money. A racing man, Bladon by name, stayed with Palmer who owed him a large sum of money, and promptly said goodbye to this life. The next on the list were Palmer's wife and his brother Walter, whose lives had been insured for £13,000 each. Of the five children by his wife four died rather suddenly in infancy. The eldest lived to see his father hanged.

Palmer was a practised poisoner whose technique was first to reduce his victim to a condition of weakness and prostration by

repeated doses of antimony. The old scoundrel always preached the advisability of drinking one's liquor (in which the poison was administered) at one draught, in order to obtain the full flavour and beneficial effects of the spirit—and the poison. This Palmer technique paid full dividends till the final tragedy of John Parsons Cook, his betting associate, who was systematically dosed with antimony and ultimately poisoned with strychnine. Though Palmer was convicted of, and hanged for, the crime, the evidence was entirely circumstantial, the medical testimony given by thirty-seven doctors being particularly conflicting. Some of the most eminent medical men of the time expressed expert opinion; Sir Benjamin Brodie, Alfred Taylor, Robert Cristison, George Owen Rees, Thomas Blizard Curling. Contemporary accounts describe William Palmer as courteous, sympathetic, and bland; his face was honest, calm, passionless, and truthful, and his voice low, unctuous, almost tender, the very smoothness of the man suggesting a stealthily creeping reptile!

Another man who played truant from medicine and shared Palmer's fate was H. H. Crippen. An insignificant little fellow with a sandy moustache and gold-rimmed spectacles, he came to London from America in 1900 as manager of Munyon's advertising business in patent medicines. It was here that an equally insignificant typist, Ethel Le Neve, dulled his affection for his wife, excitable, extravagant music-hall artiste "Belle Elmore." To this day the tale of how Crippen poisoned his wife to make room for his mistress remains shrouded in mystery. The chief features of medico-legal interest in this case are the identification of the body six months after death by an abdominal operation scar, and the detection of hyoscine in the viscera by Sir William Willcox. Incidentally, Sir Bernard Spilsbury made his first appearance in Court as an expert pathologist. Sir Edward Marshall-Hall advanced a most ingenious theory, suggesting a charge of manslaughter rather than of murder: Crippen was described as a weak little chap whose sexual energies were completely exhausted by the double demands made on them by his mistress and by his wife who apparently suffered from acute nymphomania. In order to depress his wife's appetite Crippen gave her five grains of hyoscine in a cup of coffee. That he, a fully qualified man, should have been ignorant of

the correct dose is a little difficult to explain. When Mrs. Crippen died suddenly, Crippen became panicky, cut up his victim, and buried the fragments under the floor of the coal-cellar. The head he took on a trip to Dieppe and dropped it overboard in a hand-bag. With his mistress disguised as a boy, the murderer fled across the seas. For the first time in the history of crime detection, wireless, then in its commercial infancy, was used to bring about the criminal's arrest.

A second ingenious theory may here be mentioned, put forward by Ingleby Oddie: Crippen decided to get rid of his wife by poisoning her with hyoscine and then attribute her death to fatty degeneration of the heart. His plans miscarried in that he gave her an overdose and she became hysterical. To stifle her cries he shot her with a revolver. In support of his theory is the evidence that shrieks were heard by the neighbours on that fatal night and a loud noise like the banging of a door.

If you agree with Rudyard Kipling that words are the most powerful drugs used by mankind, then you will welcome the intrusion into this portrait gallery of mine of another Bart's man—a great surgeon, a great pathologist, and one of the greatest orators not only of his profession, but indeed of his generation. Sir James Paget's public speeches were always studiously prepared and carefully learnt by heart, but when they were delivered they gave the impression of spontaneous eloquence—an impression deepened by slight but suitable pauses which, as it were, naturally interrupted the flow of his words. On the whole Paget was fond of the simple grandeur of monosyllabic Anglo-Saxon words. He did not care for words of undue length or of exaggerated importance. Of his style one characteristic example must here suffice. He is talking of John Hunter:—

"He was growing old; he had lately been very ill, and he knew that he was in instant peril of that sudden death in which, at last, he fell... Yet he would stand for hours, motionless as a statue; patient and watchful as a prophet, as if he were sure that the truth would come, whether in the gradual unveiling of new forms, or in the clearing of some mental cloud, or as in a sudden flash, with which, as in an inspiration, the intellectual darkness becomes light."

The relationship between drug addiction

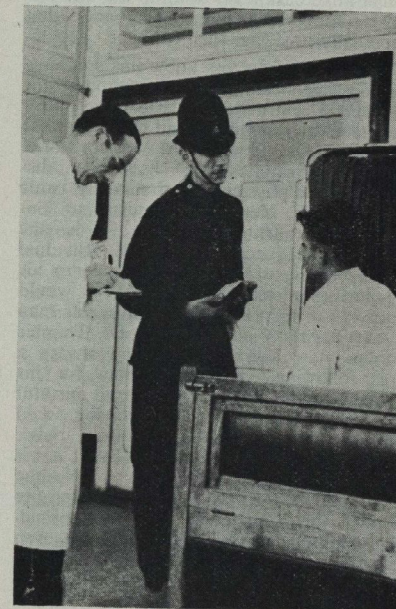
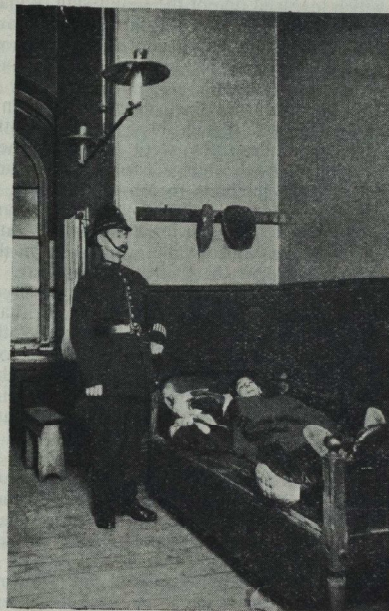
and literary—especially poetic—genius is as intriguing as it is obscure. To do justice to the subject would demand a whole course of lectures. It has been claimed, rightly or wrongly, that the following wrote with true genius because their partiality to drink or drugs paralysed their mundane inhibitions: Charles Lamb, Walt Whitman, Torquato Tasso, Swinburne, Byron, Verlaine, Baudelaire, Samuel Butler, Poe, Oscar Wilde, Coleridge, DeQuincey, Cervantes, Crabbe, Goldsmith, Addison Swift, Steele, Pope, Gay, Herrick, Balzac, Dickens, Francis Thompson, and many, many more.

Few of his contemporaries suspected that highly respectable, genial clergyman George Crabbe—a truant from medicine, by the way—of being an opium addict. It is a fact, however, that that strangely beautiful, weird poem of his, *Sir Eustace Grey*, was dashed off in one night as the vivid recollection of an

opium dream. How many of you, I wonder, are familiar with its theme—a madman's narrative of his fiendish persecution for the slaying of his young wife's lover? You will enjoy reading it, remembering that it was penned by an opium eater.

Paul Verlaine provides a remarkable example of a poet who produced delicate, sincere lyric poetry at a time when he was suffering from a mania for alcohol. After his imprisonment following an unsuccessful attempt to shoot his friend Rimbaud, he gave up his dissipated mode of living and became a devout Catholic. It is a little startling to find that his later work, though possessing great beauty, falls short of the poetic stature of his earlier years. This certainly makes one think! On this note of bewilderment I shall call a halt to this rambling anecdotal story.

FORTY YEARS ON



A DOCTOR REMEMBERS

By LLEWELLYN PRIDHAM

MEDICAL students are less exuberant than they were in my time, and this change, I think, is the reflection of an increased sobriety in the outlook of the nation, which is more temperate after two wars of horror and the threatened possibility of complete annihilation ahead. But let us travel back just thirty odd years and take a look at how life went in those distant days.

I came up to St. Bartholomew's in 1912, whither my brother had already preceded me. My mother insisted on her sons going to Bart.'s, where her husband had learnt his job... that fact clinching the matter so far as she was concerned.

At that time the hospital could not have altered much since his day; the blocks of buildings must have seemed just as imposing to him in their Georgian splendour as they did to me. The mansion-like tiers of wards surrounded the great square with its central fountain and luxuriant plane trees. The latter thriving in spite of fogs, fumes and comparative darkness, owing to the fact that they continually shed their bark, thus perpetually renewing their youth.

Thousands of doctors know this spot, and the begrimed stones that compose the ornamental centre-piece must conjure up for them memories as sincere and reverent as the *Ka'aba* of Mecca does for the Moslem world. A million cigarettes must have been discarded as the physicians and surgeons came in through the Henry VIII gateway to conduct their students round the wards—the length of the queue behind each individual "chief" being exactly proportionate to his popularity and teaching capacity. It would be invidious to pick out any particular man in such a galaxy of talent, but Dr. Thomas Horder—now Lord Horder—had always a large following. He was famous for his sarcasms, and I remember he waxed mirthful over one unfortunate youth. Having asked this nervous individual to examine a pulse, he told him—to save time—to count it for half a minute only, and then double the figure obtained so as to achieve a proper number for comparison with the normal. The confused man came out with an uneven figure, and there followed many good-humoured quips as to his powers as a mathematician.

Having already passed my first medical exam, I went straight into "the rooms." It is a bit of an ordeal for the young student when he first makes acquaintance with the "specimens." However, all thought that the body once encased a human soul is soon forgotten as the earnest student concentrates on the unbelievably intricate structure.

Having one day penetrated out of curiosity into the vaults beneath "the rooms" I heard the thud of a door being banged accompanied by the grate of a key. It occurred to me with an unpleasant shock that I was shut up in these vaults for at least an hour while the attendant was away at his dinner.

Down there was spent the longest of hours in the gloom and shadows, surrounded by all the emblems of death, only made the more sinister by the glimmer of a flickering gas-jet. Though not a particularly superstitious young man I was delighted to see the familiar features of "Old Hallet" reappear.

About this time there leaked out a tale which involved one of the senior staff, a man whose name is now world-famous. The yarn had a wide circulation and illustrates most forcibly the power of a strong mind over one of inferior calibre.

It occurred when the "Votes for Women" campaign was raging through the country and the suffragettes were pursuing their militant methods; hunger-striking and using all possible methods to attract attention to their claims; padlocking themselves to park railings and then throwing away the key; and one was even killed while bringing down the King's horse in the Derby of that year.

I remember witnessing a scene in Hyde Park, near the Marble Arch, in which a hay-wagon crowded with partisans of "the cause" was attacked by a mob of folk out for a little fun on an otherwise dull Sunday afternoon; the unfortunate occupants being chased all the way down Park Lane and compelled to take refuge in the mansions of that select neighbourhood.

This particular physician, whom the story concerns, brought down on his head all their wrath by making an injudicious speech condemning their methods. Doctors usually keep out of politics, that is if they wish to retain half their patients; and this "butting-in" was greatly resented by the suffragettes.

They had their male supporters, and one of these vowed he would "get" the offending consultant and give him the thrashing of his life.

Shortly after this statement, he gained admission to the doctor's consulting-room. As the door closed behind him, he, significantly enough, produced a riding-quirt from beneath his coat.

The doctor, no doubt, noticed the size and strength of his visitor, but he pretended to pay no attention to his ugly weapon, though the big man's face was familiar to him through the columns of the illustrated press.

The physician rose from his chair and placed both his hands on the make-believe patient's shoulders, pressing him into a comfortable seat. The gentle touch was almost a caress, and the doctor's face had assumed an expression of deep concern.

The man allowed himself to be thus cajoled; it would be rather amusing to put off the castigation and dally awhile with his frail victim.

But the fellow did not realise what he was up against; and held by the semi-hypnotic gaze of the physician's eyes he found himself divested of his shirt and his chest being tapped, and examined by a poised stethoscope. In a matter of minutes he was completely at the mercy of the alarming doctor; and was soon convinced that he was suffering from, indeed, a fatal disease.

While the shivering man donned his clothes, the doctor excused himself on the pretext that he had to ring up the Harley-street chemist about some drug suitable for his patient's condition. But instead of the druggist the police were communicated with.

Of course, the medico realised his awkward position from the start and his nimble mind dealt with the situation in the manner described.

To diverge a little, another instance of the effects of mind over matter happened a few years later when I was serving with the Grand Fleet at Scapa Flow. The incident occurred on one of the P. & O. hospital ships.

A lascar seaman had the misfortune to upset a pot of paint over the immaculate planking of the promenade deck. He was severely reprimanded, and as a result the native took to his bunk, announcing his intention of dying. The brains of the whole medical staff were brought into play in order to combat this declared intention. He was examined but nothing was found organically wrong with him. Excellent food was

supplied and he was watched while he partook of it. In spite, however, of all that science could do for the oriental, he slowly faded out of existence. A post-mortem was performed, but no material reason could be found to account for his death, and the whole affair remained inexplicable to western notions.

To diverge again from medical matters for a time, let us pass under the colonnade of the British Museum. In the Egyptian Hall are exhibited the mummies of that ancient race. It is an open question, whether or no, these relics of a bygone civilisation should be exhibited to every inquisitive, if not ribald, Tom, Dick and Harry.

There was one painted mummy-case on which was depicted the figure of a priestess of Amen-Ra; this apparently harmless object gradually became surrounded with an aura of malignancy. People who observed her features too closely or mocked at the image suffered grievous misfortune. The Press, always ready to make a "stunt" about anything bizarre or out-of-the-way, made great play with the facts.

With that love of the macabre, which so many of us possess, queues of British citizens lined up to take a look at the baleful lady.

Accompanied by my young brother I went to the museum to gaze at the treasures. Coming into the "Mummy Room" he attracted my attention to one particular case. "This is the old girl whom all the fuss is about... see, there's her description!"

I remember it was a dark, foggy day—the lights had not been switched on yet—and we two were alone in the gloomy gallery. In spite of the oppressive atmosphere, the young devil beside me began to make game of the painted lady. There was not a vestige of superstition in his make up, but I became a victim of acute depression... a sense of evil seemed to surround me.

Two years later the 1914 war was raging and my brother, Trevor Pridham, volunteered as a gunner in the R.F.A. He was sent to India and served at Ferosepore. Invalided home from there, the youngster was on a trooper coming through the Red Sea, when he was attacked by a malignant form of "flu." The already frail body could not withstand this culminating blow, and he died, being buried at Suez, in Egypt.

Just a coincidence?

The fountain in the central square at Bart.'s is a nicely proportioned bit of stonework, surrounded by a basin which is always kept filled to the brim. It is a legendary tale that anyone who offends against the unwritten customs and codes of the hospital shall be ducked. This punishment is a severe one, as not only is the water chilly, but it must be difficult to obtain a change of clothing; besides which all the nurses and patients looking through the ward-windows are there to watch the ignominious figure crawl out of the basin.

This "execution" only took place once to my knowledge while I was at the hospital. The tale spread around that a first-year student had written to the *Times* contradicting a statement made in that paper by one of the senior staff. Now the student is jealous of these hospital big wigs, their honour is his honour, and on being asked to form one of the party of "throwers-in" I reluctantly accepted, not troubling to make sure of the truth, which was probably garbled.

Anyway, we seized the unfortunate youth, who was in entire ignorance of what the commotion was all about, carried his protesting body into the square, swung it three times and then heaved it into the slimy water.

We walked away feeling rather shamefaced, and I personally have regretted it ever since. At the least, we ought to have made allowances for the fact that he was not yet aware of our peculiar shibboleths.

Cup-ties usually produced a "rag" on the field of play. University College, when they were engaged in such a contest, escorted "Phineas" to the field of battle, and flaunted him before their opponents in much the same manner as the Irishman is supposed to trail the tails of his coat. This object was the figure of a Scotsman, about six feet high, brightly painted, carved out of solid wood and in the act of taking snuff. He was the trade-mark, I think, of a Tottenham Court Road tobacconist or furniture dealer; the students giving him an annual outing.

Before play commenced a battle was joined over the mascot, our side striving to capture the figure as a trophy. This ended in a deadlock as the Scotsman was too heavy to be moved except by a squad of men working together. I remember the forcible tearing off of an arm, which was subsequently returned.

Guy's had their famous "milk-can" as a rallying point, and I really believe a student of that famous hospital would suffer bodily harm in defence of his treasured jug.

Talking of "rags" my elder brother, after coming up to Bart.'s, took part in one that concerned the notorious statuette to the "little brown dog" of Battersea. The inscription underneath was the cause of the trouble, which cast a slur on the humanity of the medical profession.

Anyway, a procession was formed to protest, and it marched through the West End. Trouble soon started, probably some policemen's helmets were seized—always coveted trophies. Battle was joined and there took place a rare skirmish. Several students were arrested, among them being my unfortunate brother, who was taken to Vine Street.

He spent the night in the cells, and was up before the "Beak" in the morning who let the prisoners go free on the paying of small fines. Imagine my mother's horror on reading the proceedings the next morning. There staring at her was the hitherto unblemished name of "Pridham." But she soon viewed the whole affair in its right proportions and dismissed the "crime" from her mind.

A year later there was another "rag," this time of a much more serious nature. That famous man, Ben Tillett, who has done so much for the "working" classes, intended addressing a meeting at the Albert Hall. For some obscure reason all the students of London were up in arms against him. They held a combined council of war and it was decided that while one party stormed the hall, another should attack the power-station, immediately behind the great building, which supplied it with light.

I was a member of the first contingent; we battered down the door and soon were inside the outer passage that runs round the central space. Then the stewards came at us! We had entered in a light-hearted spirit and were completely unprepared for the desperate body of men that attacked us with their cudgels. Lean, hard fellows they were with set jaws and glinting eyes; while we were simply engaged in a bit of fun.

The issue was never in doubt! The students were bundled out of the building in double-quick time.

Meanwhile the engineering men had broken down the two doors of the power-

plant and secured the staff. They then proceeded to dismantle one of the dynamos, fortunately not the one that lit the hall. If they had succeeded in plunging the vast building into darkness, the crush of people might have panicked and, no doubt, there would have been a disaster.

Several young fellows were arrested and heavy fines were inflicted, which were paid by a general subscription throughout the hospitals and university. So ended a very inglorious page in student-life.

When I was a third-year student that most spectacular operation—Caesarian Section—was due to be performed. In connection with this same happening I committed what would, no doubt, have been considered by those in authority a most heinous crime.

I had a pal working in the City and he led a dull, desk-cramped life. The two of us were lunching together and, to cheer him up, I, there and then, entirely without thinking, invited him to come and view the operation. He, being an enterprising youth, accepted this unique offer of entertainment gladly enough.

We crossed the city street to the hospital, and entered the hot, steamy atmosphere of the theatre reeking with fumes of ether and antiseptics. Nurses assisted us into sterile robes, and he—unquestioned—took his place at the steel table.

To my dismay the young man's face, seen between the shoulders of my fellow students, momentarily became paler, beaded with sweat, while his eyes alternately closed and opened; and his obvious torment was apparently unrelieved by the audible sighs when the tension was broken by the wail of an infant so reluctant to be born.

As for me, I had endured one of the worst half-hours of my life wondering if this tyro would collapse and give the whole show

away, thus causing my expulsion from the medical school.

However, the fellow just managed to survive, but I don't believe he ever forgave me for treating him to such an experience for which, unlike myself, he had received no gradual initiation.

A party of us attended the "Derby" of 1914. A bus was hired for the outing and its most important cargo was a large barrel of beer . . . X.X.X. strength!

I remember sundry dealings with a down-at-heel bookie, who subsequently vanished into thin air before I could collect my winnings. Again there is a distinct recollection of myself fighting my way to the white fence bordering on the course; then there was a thunder of hoofs, a snap-shot view of straining, white-flecked horse-flesh, the momentary glimpse of vivid colour as the jockeys hurtled by, their silken shirts bellying, and the race of the year was over!

Whether or no the barrel had anything to do with it, I am not in a position to say, but that is all that recurs to me of Durbar II's Derby. Beer was beer in those happy years!

There followed the drive back to the hospital and through the hustling pre-war London streets; each pub had its group of costers dancing, care-free and happy, to the jangling lilt of a hurdy-gurdy. Outside all the little houses were lined up rows of chairs, where sat "Pa and Ma" surrounded by their relatives, out to see the gentry riding home; reserving a special cheer for a coach-and-four as it rumbled by: hoofs hammering, pretty ladies smiling, whip-lash a-flicker, and post-horn sounding.

This is the last picture of London life I can call to mind before 1914, which changed everything. The gear was about to crash into the cogs of Great Britain's juggernaut car for the long and tragic up-hill climb.

ABERNETHIAN SOCIETY

Meetings to be held in 1949:

October 20 Professor Sir James Paterson Ross on "Your Patient and You."

October 27 Dr. Charles Hill on "Current Events."

November 10 Medical Films.

November 17 Professor J. W. S. Blacklock.

December 1 Mr. Reginald M. Vick.

The subjects of the addresses for the last two meetings will be announced later. Meetings will be held at 5.30 p.m. on October 20th and November 10th in the Anatomy Lecture Theatre, Charterhouse Square, and on October 27th, November 17th, and December 1st in the Clinical Lecture Theatre at the Hospital.

WILLIAM HARVEY, MAN-MIDWIFE

By C. P. WENDELL-SMITH

THE importance of Harvey's work in the field of obstetrics is not generally realised, nor is it given due recognition. Particularly is this so with respect to this hospital, there being no mention of his activities as an accoucheur in Sir Norman Moore's "History of St. Bartholomew's Hospital"; in fact, John Freke, born 31 years after Harvey's death, is cited as our first "improver of midwifery." Yet Aveling referred to Harvey as "The Father of British Midwifery," and Spencer's subject for the 1921 Harveian Oration was "William Harvey, Obstetric Physician and Gynaecologist."

William Harvey was "admytted to the office of the Phisycon of this Hospital" in 1609. He had studied medicine under Fabricius ab Acquapendente at Padua, then the most distinguished university in Europe, in the tradition of Vesalius, Fallopius and Realdus Columbus ("a practical obstetrician"). Four years before he commenced his studies, Scipione Mercurio, a Paduan obstetrician, published the first Italian book on Midwifery, "La Comare o Ricoglitrice," which aroused much interest, and must certainly have been read by Harvey. With this background it is not surprising that his interests should include obstetrics and gynaecology.

What is surprising, however, is that he was allowed to practise unopposed, for until comparatively recent times obstetrics has been entirely in the hands of women, who resented the intrusion of the man-midwife; furthermore, fashion decreed that to be delivered by a man was immodest. So much was this so that a Dr. Viles of Hamburg was publicly branded—some say burned at the stake—for attending a woman in labour, himself disguised as a woman. Even more interesting, from the standpoint of the obstetrician's status, is the fact that most of the early men-midwives were not physicians but barber-surgeons, being frequently summonsed by the College of Physicians for prescribing and practising medicine (the Chamberlens, of forceps fame, are notable examples). Yet William Harvey, physician and pride of the Royal College, chose to practise midwifery and did much for its advancement.

His life was full, and after his discovery of the circulation of the blood (1616), and the publication of "De Mortu cordis" (1628), he was "busily engaged in practice and in attendance upon the King, whom he served loyally in peace and war." The House of Commons Journals in 1644 record his withdrawal from the hospital as follows: "...Dr. Harvey, who has withdrawn himself from his charge, and is retired to the party in arms against the Parliament." After the surrender of Oxford (1646), he retired from the King's service and lived in the country.

Four years later he was visited by George Ent who "sought to rid [his] spirit of the cloud that oppressed it, by a visit to that great man, the chief honour and ornament of our College [of Physicians], Dr. William Harvey." Harvey showed Ent the manuscript of "De Generatione Animalium," which Ent carried off to the press "like another Jason with the golden fleece," and published early in 1651. This great work is divided into sections headed: On Animal Generation, On Parturition, On the Uterine Membranes and Humours, and On Conception.

The chapter on labour ("de partu") was the first original British work in Midwifery and justifies his title of "The Father of British Midwifery."

It consists in criticism of previous views (notably those of Fabricius) on the anatomy and physiology of parturition, with statements of his own opinions, substantiated by observations from what must have been a vast experience ("Haud inexpertus loquor").

The guiding principle, which Harvey adopted, "Nature must be our adviser, the path she chalks must be our walk," was watchful patience in ordinary cases and podalic version in cases, "where there is necessity for handiwork in the business." The rationale of this was Harvey's belief that, prior to labour, the fetus, which throughout the pregnancy lies head uppermost and back to the front, dives down head first, and "attacks the portals of the womb." He does not, however, deny the uterus an expulsive function, but believes this to assume prime importance only in preternatural cases



EXERCITATIONES DE Generatione Animalium.

*Quibus accedunt quaedam
De Partu: de Membris ac Humoribus Uteri:
& de Conceptione.*

AUTORE
GUILLIELMO HARVEO
*Anglo, in Collegio Medicorum Londi-
nensium Anatomæ & Chirurgiæ Professoris.*



LONDINI,
Typis Du-GARDIANIS; impensis Oltevarianis
Pulley in Coemeterio Paulino.
M. DC. LI.

where the foetus cannot fight its way out. Thus he cites a case of stillbirth labour observed in a procident uterus, and elsewhere states that a mother may fail in her "expulsive office" (uterine inertia). "Hence when we chiefly depend upon the foetus, as being lively and active, to accomplish delivery, we must do our best that the head escape first; but if the business is to be done by the uterus, it is advisable that the feet come foremost," "they act as a wedge on the narrow uterine passages." The cause of labour Harvey finds to be, "that the juices within the amnion, hitherto admirably adapted for nutriment, at that particular period, either fail or become contaminated by excrementitious matter."

The signs of approaching delivery are excellently described and the duration of pregnancy is discussed at length. He quotes cases from the literature of five month and sixteen month pregnancies successfully terminated, but recognises the phenomenon of superfetation, again citing examples. He concludes that, "Prudent matrons—as long as they note the day of the month in which the catamenia usually appear, are rarely out of their reckoning; but after ten lunar months have elapsed, fall in labour and reap the fruit of their womb the very

day on which the catamenia would have appeared had impregnation not taken place." Cases of spurious pregnancy are recorded followed by the statement: "No arguments of mine could divest her of this belief. Hence the symptoms depend on flatulence and fat."

Throughout this section illustrations are drawn from a wealth of clinical material and there can be little doubt that his experience was very wide—such remarks as "which I have often seen" abound. Much of his practical work was set down in his "Medicinal Observations," to which he frequently refers, but this, unfortunately, has been lost. We can, however, judge his repute and the esteem in which he was held by the words of his contemporary, Percy Willughby, who quotes Harvey no less than sixteen times in his "Observations in Midwifery," and attributes all his knowledge to him. "I know none but Dr. Harvey's directions and method, the which I wish all midwives to observe and follow, and oft to read over and over again; and in so doing they will better observe and remember the sayings and doings of that most worthy, good, and learned Doctor whose memory ought to be had for ever in great esteem with midwives and child-bearing women."

Thus William Harvey, Father of British

Midwifery, may be said to be the first "improver of midwifery" in the history of this hospital. In conclusion Spencer's 1927 Fitz-Patrick lectures are quoted:—

"England, though last of the great countries to produce a writer on obstetrics, was fortunate in having as a father Harvey, who introduced into that branch of medicine, the wide view, the scientific spirit, and the conservative practice which have been its characteristics, and made a great and lasting

impression on his followers, who were not confined to this country."

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CORRESPONDENCE

BRIAN RAIT-SMITH

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

One of the writers of your most fitting contributions about Brian Rait-Smith mentions the impossibility of discovering a recent photograph of him. I therefore venture to send you a snapshot taken at Hill End in the summer of 1941, before the onset of his sad ill-health.

Yours faithfully,

E. C. O. J.

4th September, 1949.



REMINISCENCE

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

I am sending you a copy of a certificate that was handed to the patient's mother by Mr. Watkins, the Steward of St. Bartholomew's Hospital, on April 10th, 1892.

The "patient" is now 63, and a very vigorous artisan.

He states that the case made a stir at the time, as it was said to be the first case of drastic operation for rickets [osteoclasia of both tibiae and fibulae for genu valgum].

Before the operation, he could get about quite nimbly—according to his Mother's accounts—by sitting flat on the floor and propelling himself along by his hands.

He thought he was in *John Ward*; and he remembers being taken across the Square to the operating theatre.

I entered Bart.'s as a Probationer in May, 1893, and I was first in Rahere Ward—then served by Mr. Howard Marsh, if I remember rightly. *John Ward* was *medical*—under Sir Dyce Duckworth.

It so happened that at that time my brother, A. A. Kanthack, was Pathologist to the Hospital, and I owe my admission to the Hospital as a Probationer to his influence. I later became Sister of Charity Ward, under Mr. John Langton, Mr. Bruce Clarke, Sir Henry Butlin and Mr. Lockwood.

My brother died in Cambridge in 1899, and Ernest Shaw was working in his laboratory there at the time. I was greatly interested in Ernest Shaw's reminiscences in a recent number of the JOURNAL.

Mr. Frederick Goodman has an undiminished devotion to St. Bartholomew's, and was glad to meet someone closely associated with it. He told me that when he was discharged "cured," the surgeon said to him: "Don't ever break your leg, for we can never set it for you!" He is a short, sturdy man, very quick in movement, and has enjoyed remarkably good health all his life since his operation at Bart.'s. He lives now in Wood Green.

My letter is lengthy, but I would like to add this: When I entered Bart.'s, three important features were unknown—there was no electric light; there were no telephones; and there was no central heating. We had gas-light, and strong lamps with reflectors; we had enormous open fireplaces in the ward—dusty and cheerful; and when a surgeon was required for an emergency operation, Tutton, one of the porters, took a hansom and bowled along to Harley Street and brought back one of the big Harley Street men (generally in evening dress).

We managed without a Psychiatrist in those dim times.

Yours faithfully,

E. V. de VOSS.

22, The Upper Mall,
 Hammersmith, W.6.

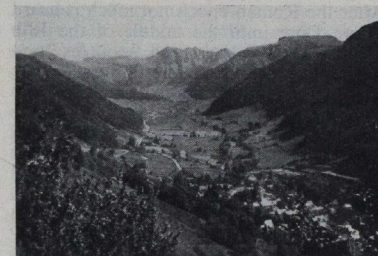
TAKING THE WATERS

By F. WINSTON

Illustrated by J. S. BUNTING

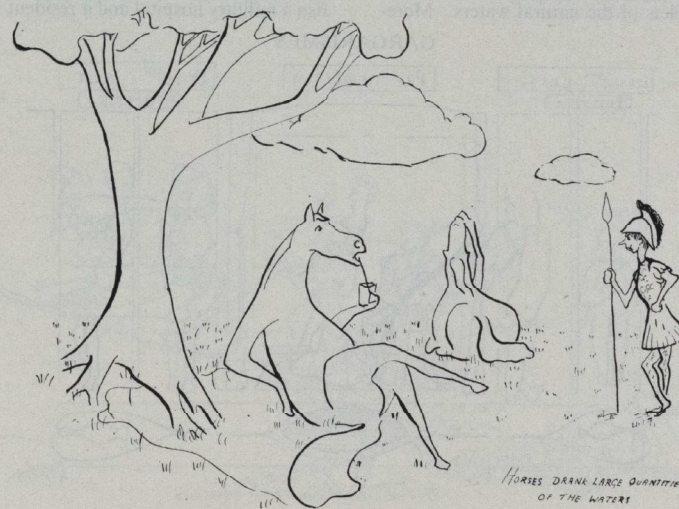
ONE does not take treatment at a French spa; one takes what is optimistically called "la cure." Among the more serious of these "cures" is that provided at Le Mont Dore, situated at an altitude of 3,000 feet on the banks of the Dordogne in the heart of the "Massif Central," Auvergne. Perhaps at no other spa is so much emphasis placed on the treatment and so little on social life and the fashionable round; though it must be admitted that while the doctors and the Thermal Establishment will endeavour to rid you of your complaint, the villagers are no less untiring in their efforts to rid you of your money. However, one cannot be too hard on them, for the season lasts only four months of the year—from June to September.

The population of Mont Dore is somewhere in the region of 500, but every summer is swollen by nearly 5,000 patients, tourists and hoteliers. From all over the world come the hopeful—the asthmatic, the emphysematous, the hay fever sufferers and the Great War gas casualties—bringing with them their coughs and their sneezes, their wheezes and their "sinuses"; all hoping for the relief they have not found elsewhere. Year after year they return; some finding complete relief after only one or two seasons, others



after ten or fifteen years still hopefully taking the "cure"; but practically all securing some amelioration of their condition.

The origins of Mont Dore are, to quote a cliché, lost in antiquity. It is believed that even before the Roman conquest of Gaul the local inhabitants knew of the properties of the natural spring waters found in this wild but picturesque valley. Certainly the Romans did. The remains of the Roman baths on the site of the present day Thermal Establishment are there for all to see; and the bust of a Roman in the typical aspect of an asthmatic in an acute attack is displayed in the entrance hall. The story is told that



HORSES DRANK LARGE QUANTITIES
 OF THE WATERS

the Romans grazed asthmatic horses in the valley. The horses drank large quantities of the waters and were cured of their asthma. It's a good tale anyway.

After the Roman epoch not much is heard of Mont Dore until the middle of the 18th century, when the baths and "sources" are again mentioned in the literature and in the letters of one or two distinguished visitors. It was all very primitive, and for those hardy enough to brave the long journey over the stony track from Clermont Ferrand there were one or two hostellers which "charged thirty-six francs for supper and lodging, five in three beds, for one night in a room shared with the wind the rain and the fleas." Apparently enormous quantities of the waters were drunk and the conditions of residence and treatment were enough to ensure that if there was nothing wrong with your chest the first year you would have plenty of reason to seek a second "cure."

In 1805 Michel Bertrand, a young doctor from the nearby village of St. Sauves, who was practising in Clermont, was made *Medecin Inspecteur des Eaux de Mont Dore*. In 1810 he published a book on the physical, chemical and medicinal properties of the waters and set about supervising the building of a new Thermal Establishment. He revolutionised the treatment and instituted the "aspirations," which consist of making the patient inhale a cloud of microscopic droplets of the natural waters. More-

over he imposed a strict regiment of treatment. One evening he went into a hotel and found ice cream (which he had forbidden) being served to patients. He got hold of the corner of the tablecloth and scattered everything, including all the ices, on the floor. Ice cream was not served in the hotels of Mont Dore for another forty years.

The present day Thermal Establishment is a fine building constructed above the "sources," of which six are regularly used for drinking. There are numerous vapour and aerosol rooms for the "aspirations," and baths of all types. Most disorders of the upper and lower respiratory tracts are treated, provided there is no evidence of tuberculosis.

The prospective patient on arrival at Mont Dore will find over 200 hotels and "pensions de famille" to choose from. If he has not already been recommended a doctor the concierge or landlord will waste no time directing him to one. He will visit the doctor on the first day and then every four days during the 21 days period of treatment. The "cure" is normally taken for three successive years.

Some of the doctors see an average of six patients an hour, eight hours a day, at an average of £1 per visit, during the high season! Treatment can also be obtained through the "Credit Social," the French equivalent of "National Health." There is also a military hospital and a resident military

physician. For children whose parents cannot accompany them there are two "maisons des infants." Here it might be mentioned that the possibility of a complete cure is statistically in inverse proportion to the age of the patient. The *Compagnie Thermale* claim a hundred per cent. success in the case of children. The prognosis for adults is less favourable. No doubt many of the children treated would have grown out of their condition anyway, but nevertheless some remarkable results have been obtained. The average course of treatment is as follows:

In the morning, on an empty stomach, at seven or eight o'clock 100—150 gm. of thermal water to drink, then a liquid or vapour douche for some minutes followed by half to three-quarters of an hour in the "salles d'aspiration" at a temperature of 30—32 degrees centigrade. On return to the hotel a prolonged rest in a well warmed bed, and breakfast. Before lunch a further drink of thermal water. Towards the middle of the afternoon another glass of water followed by a foot bath of five or ten minutes and inhalation through the nose of thermal gases for a similar time. From time to time a bath to the waist in the mineral water at its natural temperature. Other varieties of hydro and inhalation therapy are available for individual requirements as prescribed by the physician. A special costume

consisting of woollen jacket with cowl and "pantalons de cure" is worn to avoid catching a chill on coming out of the inhalation rooms.

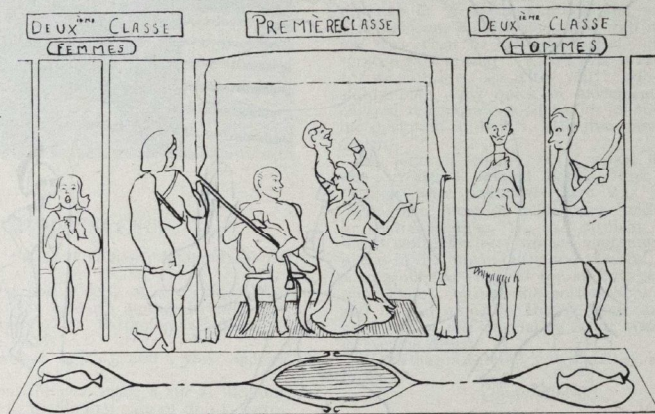
Among the principal evidence of the action of the cure on the asthmatic state is the constant fall in the eosinophil count, the lowered pH of the blood and the reduced alkaline reserve on completion of the treatment. The anti-spasmodic action of the mineral waters has been demonstrated by perfusion of the isolated bronchus.

The average course of treatment costs £5—£8 in addition to the doctor's fees, which seem to vary according to the hotel at which you are staying.

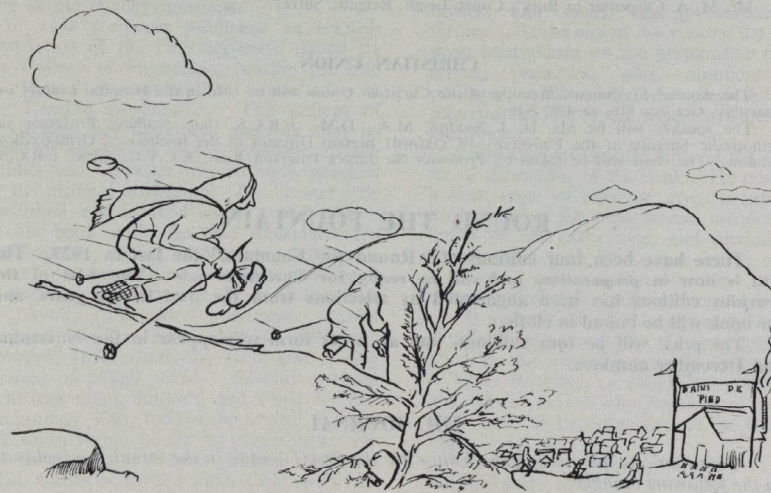
Each patient has his own numbered glass at the "source" and within a day or so the attendant knows each patient's number by heart. As there are sometimes nearly 4,000 patients, drinking mainly from three "sources," you can imagine this is quite a considerable feat of memory.

The treatment is provided in first, second and third class. For example the first class foot bath is taken in a private cabin and the attendant dries your feet with two towels. In the second class you have only one towel and you dry your own feet. In the third class you use a communal foot bath in the basement, though I do not think you have to dry your feet with a handkerchief. In the second class "gargles" men and women are

GARGARISMES



.... BUT THE SECOND CLASS ARE STRICTLY SEGREGATED



strictly segregated. If you desire mixed gargling you must take first class. For a large fee you can have your "demi bain" in the "bain de luxe" of inlaid marble, which is the showpiece of the establishment. Respiratory re-education in quite a violent manner is provided for those who require it.

An "after-cure" of two to three weeks in the alps is recommended for those who can afford it.

Doctors, of course, are treated free—medical students half price.

The lighter side of life is also provided for in the form of a Casino and public park complete with Rumba Band and "Bar du Soleil" for your aperitif. Two or three "boites de nuit" function rather haphazardly; the patients are generally too exhausted to make very merry, though gala nights at the casino are well attended. By custom the doctors of the spa have always been admitted free to the Casino. At one time, however, the management decided that they must in future pay for admission. The doctors retaliated by forbidding their patients to go out dancing or gambling in the evening as it

would interfere with their treatment. After the casino had been empty every evening for a while the management rescinded their decision. The doctors then obliged by advising their patients not to take the cure too seriously but to relax now and again, suggesting that a visit to the Casino occasionally would do them no harm.

For those who like walking there is plenty of scope, and one or two surrounding farms provide cream cheese and cream and pancakes and honey that are really worth walking to. There is also a nine hole golf course, a roller skating rink, a funicular railway, a "teleferique," numerous coach tours and all the other "advantages" of a modern mountain resort.

Of recent years efforts have been made to establish Mont Dore as a winter sports centre and it is advertised as "les champs de neige le plus pres de Paris." There is even talk of opening the Thermal Establishment in the winter. Then I suppose we shall enjoy the novel sight of seeing a succession of asthmatics ski-ing back not for their aperitif, but to their afternoon foot bath.

ANNOUNCEMENTS

CHANGE OF ADDRESS

Mr. M. A. Carpenter to Bury's Court, Leigh, Reigate, Surrey.

CHRISTIAN UNION

The Annual Freshmen's Meeting of the Christian Union will be held in the Hospital Library on Thursday, October 6th, at 4.30 p.m.

The speaker will be Mr. H. J. Seddon, M.A., D.M., F.R.C.S. (late Nuffield Professor of Orthopaedic Surgery at the University of Oxford), present Director of the Institute of Orthopaedics, London. The chair will be taken by Professor Sir James Paterson Ross, K.C.V.O., M.S., F.R.C.S.

ROUND THE FOUNTAIN

There have been four editions of "Round the Fountain," the last in 1927. The fifth is now in preparation, and will be ready for Christmas sale. The best of the previous editions has been augmented by selections from the past twenty years, and the book will be bound in cloth.

The price will be four shillings, and an order form will appear in the November and December numbers.

THE JOURNAL

Contributions must reach the Editor by the first Tuesday in the month for inclusion in the following number.

IN OUR LIBRARY XIV

NICHOLAS CULPEPER'S "THE ENGLISH PHYSICIAN" 1773

by JOHN L. THORNTON

THE name of Culpeper is still a household word, despite the fact that the bearer with whom we are concerned died almost three hundred years ago. His name is intimately connected with herbals, a fascinating subject that remains widely popular in this country, particularly in rural areas. He is also renowned as arch-quack, astrologer, and opponent of the College of Physicians, the members of which were jealous of Culpeper's popularity. His methods of treatment differed little from those of the recognised medical profession, and a glance at the 1618 edition of the *Pharmacopœia* of the College confirms that Culpeper's ingredients, fantastic as they may appear to modern ideas, were mostly officially recognised therapeutic agents.

Nicholas Culpeper was born in London on October 18th, 1616, the son of a clergyman, and spent a short period at Cambridge where he acquired a good knowledge of Greek and Latin. He studied the old writers on medicine, and became apprenticed to an apothecary of St. Helen's, Bishopsgate, before setting up as an astrologer and physician in Red Lion Street, Spitalfields, about the year 1640. During the Civil War he was seriously wounded in the chest while fighting on the side of the Parliamentarians.

In 1649 Culpeper published an English translation of the *Pharmacopœia* issued by the College of Physicians, bearing the title *A physical dispensatory, or a translation of the London dispensatory*. The College of Physicians was extremely annoyed that its formulæ should be made available to the public, and Culpeper was strongly attacked by the medical profession. But he was little perturbed, and in 1654 issued a new edition of his book with the title *Pharmacopœia Londinensis*, [etc.]. Among Culpeper's numerous other writings should be mentioned *A directory for midwives*, 1651; *Galen's Art of physic*, 1652; *Idea universalis medica practica*, 1652; *The English physician enlarged*, 1653; *Anatomy*, 1654, and *A new method of physic*, 1654. Several of these went into many editions, and when he died on January 10th, 1653/4, he is said to have left seventy-nine books in manuscript. He left also a wife and seven children, and Mrs. Alice Culpeper invited Peter Cole, who had

printed most of Culpeper's books, to issue the posthumous manuscripts. However, Nathaniel Brooks, a rival bookseller, published several works bearing Culpeper's name, some of which are probably authentic. When Peter Cole published *Two books of physick*, [etc.] in 1656, Mrs. Culpeper denounced *Culpeper's Last legacy* (the subject of an interesting note by G. C. H. Chandler in the August issue of this Journal) as in part a forgery, and partly "an undigested Gallimawfrey." Many of Culpeper's works were published posthumously, and owing to the success of his writings, many forgeries were issued bearing his name. This was not unusual at a period before copyright was adequately recognised.

Our Library contains a copy of the 1683 edition of *Pharmacopœia Londinensis*, and *The English physician enlarged with three hundred and sixty-nine medicines, made of English herbs, that were not in any impression until this . . .* By Nich. Culpepper, Gent. *Student in Physick and Astrology*, London 1733. This latter contains an alphabetical table of herbs and plants, with the planets governing them. It records the various names known to the author of each herb; a description; where found; times of leaves, flowers and seeds; and government and virtues. At the end of the volume the author gives instructions on the preparation of conserves, preserves, pills, ointments and poultices, while the index lists ailments, referring readers to the pages on which these are treated.

A few extracts reveal a little of the character of the author of the book. He possessed a keen sense of humour, gives personal information on his experiences, mentions the limits of his experience, and obviously at times writes with his tongue in his cheek: "*Amara dulcis*. It is excellent good to remove witchcraft both in men and beasts . . . It purgeth the body very gently, and not churlishly, as some hold: And when you find good by this, remember me." (p.2)

"*The Bramble, or Black-Berry-Bush*. If any ask the reason why *Venus* is so prickly? Tell them, 'tis because she is in the House of *Mars*." (p. 48.)

"*Cowslips, or Peagles*. If the flowers be not well dried and kept in a warm place, they

will soon putrify and look green: Have a special eye over them. If you let them see the *Sun* once a month, it will do neither the *Sun* nor them harm." (p. 101.)

He could not resist having an occasional dig at the College of Physicians:

"Bees are industrious, and go abroad to gather honey from each plant and flower; but drones lie at home, and eat up what the bees have taken pains for: just so do the College of Physicians lie at home, and domineer, and suck out the sweetness of other men's labours and studies, themselves being as ignorant in the knowledge of herbs as a child of four years old." (p. 144.)

A cure for baldness is suggested:

"*The Peach-Tree*. If the kernals be bruised and boiled in vinegar until they become thick, and applied to the head, it marvellously procures the hair to grow again

WHY READ THE JOURNAL?

"WHY should I read the JOURNAL?" asks an angry student, thoughtfully tearing his yellow-covered shillingsworth into tiny shreds and dropping them on the Abernethian Room floor. "Why, indeed," we murmured, thoughtlessly echoing his sentiments. Then we wondered.

Were we misguided to read the JOURNAL so patiently? Or would we also be wiser to add our copy to the stock of assorted litter on that self-same floor?

Carefully we questioned our destructive friend. He spoke volubly. "There is so much good literature in the world, so much that I would discover, that I cannot bear to waste valuable reading-time perusing a student-controlled magazine. Why, I might even become magazine-minded. This habit of flitting through magazines is one to be eschewed. It is a bar to serious reading, a damper on the intellect, a dam to the well-spring of Higher Thought...."

He said more. He warmed to his theme and waxed eloquent. I felt humble. This, then, was why I was not a Great Force in the world to-day. This contemptible rag—I felt my copy go limp in my hands—was the reason why I was illiterate. I remembered bitterly that my only claim to erudition lay in having had "Eric or Little by Little" read to me at my nursemaid's knee. Tears of rage mingled with those of gratitude for my nursemaid. But perhaps all was not lost. I, too, would destroy my copy: I, too, would

upon bald places, or where it is too thin." (p. 244.)

And a final example emphasizes the vein of humour that runs through the volume: "*Plums*. All plums are under *Venus*, and are like women some better some worse." (p. 259.)

Nicholas Culpeper was undoubtedly a quack, but was no worse than were the majority of medical men living in the seventeenth century, despite the efforts of enlightened teachers such as William Harvey. Culpeper was popular with the poorer classes, and was generous to those in need. He took advantage of the prevailing ignorance of the period, but was "as free of his purs as of his pen." Nich. Culpeper certainly entertained his readers, though he failed to cure their ailments, and his writings can still be perused with this object in view.

sneer at the labours of those who compiled this worthless magazine. Friends and teachers they might be, but I would read their works no more.

Eagerly I interrupted my instructor. He concluded a splendidly constructed sentence, then inclined a gracious ear.

"I am resolved," I said, "to read this rag no more. I will read Great Books instead. I will start today—or rather (bitterly I realised that I had read my copy) next month."

Then a thought struck me.

"How long," I asked him, "does it take to read this JOURNAL?"

He thought long enough for me to notice that he was shredding a page labelled "Sport and Examination Results."

"About twenty minutes," he imagined.

I felt suddenly sick at heart. Twenty minutes meant just four hours a year! A glorious vision faded abruptly. I had seen myself, at the end of this year, I supposed, expounding with easy familiarity the lesser Russian novelists.

"About twenty minutes?"

Sadly I watched him start on the back cover and admired his little heap of confetti. Then a fierce gust of wrath shook me. My only excuse for what happened is that I was blinded with disappointment. Recklessly I kicked and scattered his little paper pile. Too late I realised that I had destroyed the work of twenty minutes.

J.McO.

SPORT RIFLE CLUB

This brings the Club to the end of its first year of activity since 1938 and so it is useful to record briefly some of the events of the past year. Having got the range at the Cripplegate Institute and the necessary equipment available, the main difficulty at the onset was to find a consistent team. With no previous scores by which to judge this took some time and may possibly be the reason why we lost so many of our .22 matches in the London University League during the first three months. It was encouraging, however, to notice that when, about halfway through the .22 season, we had aperture instead of blade foresights fitted to the rifles, our scores rose immediately to figures which more nearly approximated to those of our opponents.

London University League match results:—
v. University College (lost) 525—581
v. Imperial College "B" (lost) 542—568
v. London Hospital "A" (lost) 567—573
v. King's College "B" (lost) 531—583
v. Queen Mary College (lost) 564—573
v. King's College "A" (lost) 565—582
v. London Hosp. "B" (drawn) 560—560
v. St. Mary's Hospital (lost) 567—577
v. Imperial College "A" (lost) 567—568

Despite the results we enjoyed the League matches very much and are looking forward to giving some of the teams a better run for their money next season. The discovery of several promising shots makes this the more likely.

Also on the miniature range the match started in 1908 of Staff versus Students was restarted. This proved to be an exciting event resulting in the Students retaining the cup, though by a very small margin, and saw some brilliant shooting on the part of the Staff. Dr. Potter making top score of 98/100.

Staff 562, Students 566.

The Individual Club Competitions were shot off in March and R. E. G. Gosling had an easy win in the Lady Ludlow Cup with a score of 97. B. D. Lascelles and J. S. Bunting were second, equal with 94. J. S. Bunting was unlucky in the Waring Handicap Cup when he was again second—M. C. Hall winning by a fraction of a point.

The following people with five or more shoots to count obtained averages of over 90 per cent.

	No. of shoots	Average
1st B. D. Lascelles	27	97.6%
1st G. C. R. Morris	5	97.6%
3rd J. S. Bunting	11	96.7%
4th M. C. Hall	12	94.2%
5th R. E. G. Gosling	10	94.0%
6th H. G. Scott	11	92.1%
7th C. M. Vickery	6	91.3%
8th D. N. Stathers	14	91.2%
9th R. G. Newill	6	91.0%

(H.P.S. = 100)

B. D. Lascelles made three "possibles" during the season but unfortunately none were scored during matches.

.303 Season—Bisley

During the months of May and June we made several journeys to Bisley on Saturdays to practice for the Inter-Hospitals Cup. For anyone fortunate enough to run a car—and for his friends who obtained a lift in it—the journey down was very

pleasant. We were fortunate, too, in that the weather was fine on every occasion on which we shot. The scores rose steadily with the practice and even those firing .303's for the first time were agreeably surprised by the small number of misses recorded.

On the first shoot B. D. Lascelles won the London and Middlesex Club daily handicap prize with 88 out of 100. On the next shoot G. C. R. Morris shot very well to win the Lady Waring Cup with a score of 92 out of 100, and the following time he won the Club N.R.A. Medal with 98 out of 105.

July 8th—Inter-Hospitals Cup day. It was with light hearts that the Bart.'s team travelled to Bisley, and it was this, coupled with the beautiful weather, that made the time so enjoyable. The reason for the light-heartedness was that at the first attempt since 1938 we had no serious hopes of victory and so were not worried as one usually is before a match of this kind. However, we did start to worry as soon as the firing commenced at 200 yards for one of the rifles, having fired the first sighter, ceased to function. Then on completing the 200 yards firing we found we were second, being three points behind Guy's Hospital. Despite these shocks we managed to complete the next shoot at 500 yards, the only mishap being the failure of a further rifle, and found ourselves still second, but now only one point behind the leaders. Then came the final shoot at 600 yards. By now the wind had become very tricky and we soon found that we lacked experience at this range. The other teams also had troubles here but our main rival, Guy's, kept remarkably clear of "magnies" and "outers," while our own scores showed several of these inexplicable shots. Bart.'s scores:

	200 yards	500 yards	600 yards	Total
B. D. Lascelles	34	32	32	98
G. C. R. Morris	31	33	30	94
J. S. Bunting	29	31	28	88
M. C. Hall	31	29	27	87
C. M. Vickery	33	28	20	81
		Total	...	448

Final result:

1st Guy's	461
2nd St. Bart's	448
3rd St. Mary's	430

The Benetfink Cup for the highest score in the team was awarded to B. D. Lascelles whose score of 98 out of 105 was the highest score of the day. G. C. R. Morris, with 94, shared the second highest with two from the London Hospital and one Guy's man.

In August we had the very good news that work was to go ahead on the repair of the Hospital's 25-yard range. This means that the notice outside the refectory giving information about the range may at last become applicable again. It is hoped that the repairs will be completed in time to use the range in October and that this will enable far more people to drop in and have a shoot, thus increasing our chances of finding new talent for the teams.

We are going to arrange several handicap competitions in the near future so that people of all standards will have an interest—we hope there will be a good number of entries.

The Annual General Meeting is to be held on Monday, October 17th.

READ ALL ABOUT IT

The professors of Yale University have selected the Kinsey Report as one of the outstanding books of the year.

Evening Standard, June 3rd, 1949

The sex life of the human male,
A subject once beyond the pale,
By approbation quiet ecstatic
Now becomes a new Yale classic.
The private life of half a nation,
Classified by occupation;
With interesting notes and news
From thirteen thousand interviews.
The vagaries of Cupid's darts,
Are all turned into graphs and charts,
With aberrations masochistic
Printed in a style statistic.
The orgies of Parisiana
Are put to shame by Indiana,
Oh! When will Congress start to purge
The un-American sexual urge!

F. W.

CHRISTIAN UNION

During the past year meetings were held at which the relevance of Christian belief and practice for to-day was shown.

At the Annual Freshmen's Meeting, held in the Library, Dr. Frederick W. Price, M.D., C.M., F.R.C.P., took the chair, while Mr. D. Bentley Taylor was the speaker.

The Vicar, Canon E. F. Donne, conducted a monthly service for students. The meetings during the lunch hour on Fridays were held in St. Bartholomew's-the-less. Speakers dealt with a wide range of subjects. Among those who dealt with various problems facing students, Dr. O. R. Barclay gave a Christian view of Evolution; while a psychiatrist, Dr. Whitteridge, discussed questions presented to him by students.

The essential Christian message of Christ as "the Way, the Truth and the Life," was presented in one series of meetings, while another was concerned with objections to the Christian faith. Christian doctrines were treated by a number of speakers who also showed their application to daily living.

Missionary interest was both stimulated and informed by missionary speakers: it was a pleasure to welcome some old Bart's men back from mission fields.

In addition, meetings for prayer were held in the chapel at the same time daily, except on Tuesdays, when the time was devoted to Bible study. St. John's Gospel was read with much profit.

One meeting was held at Charterhouse Square. The Union's association with the Inter-Varsity Fellowship enabled members to attend two Clinical Medical Students' Conferences, where advice and help was received from members of the medical profession.

PLYMOUTH SPECIAL HOSPITAL MANAGEMENT COMMITTEE

The Isolation Hospital, Beacon Park Road,
Plymouth.

Resident Assistant Medical Officer (B.1)
(Male, unmarried)

Applications are invited for the above whole-time appointment. The duties are chiefly in connection with fevers, venereal diseases and early tuberculosis, and applicants should be able to drive a car.

Salary £500 per annum, together with full residential emoluments. Previous general hospital house appointments essential.

The appointment will be for a period of six months in the first instance, mutually renewable for a further six months, subject to any alterations of salary and conditions which may be in force at that time. Appointment is terminable by one month's notice on either side.

Applications from practitioners holding B1 appointments cannot be considered unless ineligible for H.M. Forces.

Applications should be sent to the Medical Superintendent, at the above address, as soon as possible, enclosing copies of two recent testimonials.

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BOOK REVIEWS

AN INTRODUCTION TO CARDIOLOGY, by
Geoffrey Bourne. Edward Arnold & Co.,
London, 1949. Pp. 294. Price 18s.

This book is based on the lectures on cardiology given by the author at St. Bartholomew's Hospital and is intended to give the student help in understanding those cardiovascular diseases which are commonly encountered in the wards and in practice. The emphasis throughout is on disordered function of the heart. Heart failure is discussed in the early part of the book, and is followed by sections on the various factors which may produce heart failure. The clinical descriptions are excellent and the student will find these more helpful than the formal descriptions in the standard textbooks. There is little mention of the applied physiology of heart failure and a fuller discussion would make the book more valuable to the clinical students. Electrocardiographic changes are described in terms of changes in the three standard limb leads, a full description of the multiple precordial leads which are now coming into general use being wisely omitted in a book of this scope. There are numerous illustrations of the radiological changes in heart disease.

There are certain parts of the book which might be modified in a subsequent edition. The place of thiourea derivatives in the treatment of thyrotoxic heart disease is not clear; thiouracil itself is rarely used now and it is doubtful if blood counts every two days are necessary during treatment. The importance of thromboembolism in patients with coronary thrombosis is insufficiently stressed and the student may be required to know something of the controversial subject of anticoagulants. The chapter on bacterial endocarditis follows traditional lines, but it would be helpful if there was a further discussion on the change in the disease caused by the introduction of penicillin treatment.

As the title implies, the book is not intended to be a complete text-book of cardiology. It can safely be recommended to students as an introduction to the study of diseases of the cardiovascular system and it will certainly stimulate their interest in these diseases. G.W.H.

TEXTBOOK OF MEDICINE, by Sir John
Conybeare, E. & S. Livingstone Ltd., 9th
Edition, pp. xvi + 875. Price 30s.

Another edition of this popular book will be welcome in the eyes of the student. As before, it again offers an admirably concise exposition of the fundamentals of medicine and for a basis on which to build a sound knowledge of medicine it cannot be bettered. The printers must be congratulated on the reconstruction in shape and size which appears for the first time in this edition and which has given the book an altogether more attractive appearance. It is to be regretted that the classification of nephritis still follows the old pattern and not that of Professor Ellis but tradition dies hard and the matter is still one of considerable controversy.

AIDS TO MATERIA MEDICA FOR NURSES,
by Miss Squibbs. Bailliere, Tindall & Cox,
3rd Edition, pp. xvi + 216. Price 5s.

A great deal of useful information is given in a compact form but the anti-histamine drugs are not included, and the statement on p. 108 that an enema rash is an example of serum sickness seems somewhat unguarded. W.H.

THE NATIONAL HEALTH SERVICE, by
Charles Hill and John Woodcock. Christopher
Johnson, 1949. Pp. 283 + cl. Price 16s.

This is a very complete account of the complicated workings of the National Health Act, written by two authors who are in a peculiarly well-informed position.

Those seeking information on the structure and functions of the Health Act will find here an unbiased and factual account of the subject, and this book will be an invaluable reference work for all those who find themselves either happy or unwilling cogs in the machine of State medicine, be they patients, doctors or administrators.

A detailed study of this book serves to emphasize how great is the need for drastic amendment of certain features of the National Health Act, but in making these remarks the reviewer does not seek to detract from the value of this book.

PRACTICAL ORHOPTICS IN THE TREATMENT OF SQUINT, by T. Keith Lyle and
Sylvia Jackson. H. K. Lewis, 1949. 3rd
edition. Pp. xii + 251, 151 illus. Price 35s.

There is a detailed account of the instruments in common use in an orthoptic department, which is followed by chapters describing the diagnosis and treatment of the various types of squint and muscle imbalance.

The clinical applications are stressed throughout, and excellent illustrations and diagrams enliven a lucid text.

The book is primarily intended for orthoptists and ophthalmologists, other practitioners seeking enlightenment in the mysteries of squint work may find it a little bewildering. J.H.D.

THE THEORY AND PRACTICE OF MESSAGE AND MEDICAL GYMNASTICS, by
Beatrice M. G. Copestake. H. K. Lewis,
1949. 7th edition. Pp. x + 488, 24 plates.
212 illus. Price 21s.

This book suffers from the same disadvantage as all books that attempt to give a comprehensive outline of all physiotherapy treatments—the field is too large and the detail is therefore inadequate.

The chapters on lung diseases and peripheral nerve injuries are clear and up-to-date.

Unfortunately several chapters—notably the early ones dealing with the effects and uses of massage and exercises—have not been brought into line with modern physiological knowledge, and some of the claims made, such as "Massage aids the distribution of subcutaneous fat," or abdominal massage "strengthens the abdominal wall and the muscles of the intestines," can only be called quackery, and will rightly call forth derision from any member of the Medical Profession who might read them.

The illustrations are excellent—but this cannot be called a text-book of Modern Physiotherapy, apart from the chapter on lung diseases and peripheral nerve injuries and the brief mention of suspension therapy. T.W.

A SHORT HISTORY OF OPHTHALMOLOGY,
by Arnold Sorsby. Staples Press, 1948. 2nd.
edition. Price 8s. 6d.

This little book is divided into some 10 short chapters, each dealing with some particular aspect of ophthalmology, such as anatomy, cataract and spectacles.

Most of the more recent work of the last half century has evidently been deliberately omitted, but there is a scholarly and very readable survey of the knowledge of the ancient civilisations and of the developments of the 17th and 18th centuries, when the science of ophthalmology emerged from the charlatanism of the Middle Ages.

J. H. D.

CUNNINGHAMS MANUAL OF PRACTICAL ANATOMY, revised and edited by J. C. Brash, M.C. Vols. II and III. Oxford University Press, 1949. 11th edition. Price 21s.

Whilst the review of Vol. I, printed in the May, 1949, edition of this Journal, fairly covers the further two volumes, additional comment must be made about Vol. III.

In this new edition, the order for dissection of the brain has been reversed, so that it now proceeds from the hind-brain upwards. Although agreeing with the editor that this is the more logical method, it is obvious that, in laboratories where the older system is in operation, the student dissector, who finds the brain difficult to understand as it is, will find this alteration somewhat inconvenient.

RECENT PAPERS BY BARTS MEN

- ALCOCK, R. J. (and FLETCHER-JONES, H. C.). Abdominal injury from lightning. *Lancet*, May 14, 1949, pp. 823-5.
- ARCHER, H. E. Tests of renal function. *Practitioner*, 163, July, 1949, pp. 43-8.
- *ATKIN, M. (and others). The mortality from cancer of the skin and lip in certain occupations. *Brit. J. Cancer*, 3, March, 1949, pp. 1-15.
- *ATKINSON, M. Ménière's syndrome; observations on vitamin deficiency as a causative factor. 1. The vestibular disturbance. *Arch. Otolaryngology*, 49, Feb., 1949, pp. 151-174.
- *BADENOCH, A. W. Congenital obstruction at the bladder neck. *Ann. Roy. Coll. Surg. Eng.*, 4, May, 1949, pp. 295-307.
- *BARBOUR, A. B. (Whittingham, Sir Harold and others). Medical fitness for air travel. *Brit. Med. J.*, April 9, 1949, p. 603.
- BETT, W. R. Osler, the medical historian. *Med. Press*, July 13, 1949, pp. 35-7.
- *BICKFORD, B. J. Mediastinal cysts of gastric origin; report of a case. *Brit. J. Surg.*, 36, April, 1949, pp. 410-413.
- BROOK, Charles W. Hospital management committees. *Med. World*, 70, July 1, 1949, pp. 637-9.
- *CAVE, A. J. E. The nasal fossa in the primates. *Brit. Med. Assoc. Proc. Annual Meeting*, 1948, pp. 363-6.
- *COLT, G. H. Aneurysm of the aorta treated by wiring. *Soc. Internat. de Chir.*, 1948.
- CULLINAN, E. R. Classification of chronic diarrhoea. *Proc. Roy. Soc. Med.*, 42, April, 1949, pp. 235-9.
- *D'SILVA, J. L. Action of adrenaline-like substances on the serum potassium. *J. Physiol.*, 108, March 15, 1949, pp. 218-225.
- FENNING, J. See ATKIN, M. (and others).
- FRANKLIN, A. W. The Osler Club of London. *Med. Press*, July 13, 1949, pp. 32-4.
- FRANKLIN, K. J. Grace Revere, Lady Osler. *Brit. Med. J.*, July 9, 1949, pp. 47-8.

ENURESIS, by R. J. Batty. Staples Press, 1948. 2nd edition. Pp. 103. Price 9s. 6d.

This is an excellent book for the general practitioner and specialist, of which the first edition was published in 1933. There is still considerable difference of opinion about the innervation of the bladder but the description on physiology in this book is as likely as any other. There are only four pages on the psychological factors and this fact lends weight to a book in which the author underlines throughout the commonsense approach to this very troublesome complaint. In his historical outline the author quotes from the Alexandrian physician, Paul of Aegina, the following remedy:—

"Burn the crop of a cock and give to the patient to drink in tepid water when fasting, or the flowers of the white Chrysanthemum in like manner; or shave down the testicle of a hare into fragrant wine and give to drink . . . Let the privy member be anointed with Cimolian Earth mixed with the juice of Pellitory of the wall."

Osler's endocrine treatments are outlined but the fact remains that we still know of no panacea with which to regulate the ebb and flow of toilet control.

- *GIBB, W. Eric. Pulsus paradoxus and pleurisy. *Brit. J. Tuberculosis*, 43, Jan., 1949, pp. 1-6.
- *GILLIES, Sir Harold. Team surgery in cancer. *Proc. Roy. Soc. Med.*, 42, March, 1949, pp. 176-183.
- *GOULDEN, F. and TIPLER, M. M. Experiments on the identification of 3:4-benzopyrene in domestic soot by means of the fluorescence spectrum. *Brit. J. Cancer*, 3, March, 1949, pp. 157-160.
- See also ROBINSON, A. M. and—
- *HAMILTON, W. J. Early stages of human development. *Ann. Roy. Coll. Surg. Eng.*, 4, May, 1949, pp. 281-294.
- HEADY, J. A. See ATKIN, M. and others.
- HERNAMAN-JOHNSON, F. X-ray treatment in osteo-arthritis. *Rheumatism*, 5, April, 1949, pp. 44-7.
- *HEWER, C. Langton. Anaesthesia for thyroid surgery. *Proc. Roy. Soc. Med.*, 42, March, 1949, pp. 118-9.
- HORDER, Lord. My association with Osler. *Brit. Med. J.*, July, 9, 1949, p. 47.
- HOSFORD, J. P. Some aspects of partial gastrectomy. *Brit. Med. J.*, May 28, 1949, pp. 929-932.
- HOWELL, Trevor H. The A.B.C. of geriatrics. *Practitioner*, 163, July, 1949, pp. 67-9.
- Chronic rheumatic disease in the elderly. *Rheumatism*, 5, July, 1949, pp. 82-5.
- *— Geriatric rehabilitation. *Occupational Therapy and Rehabilitation*, 27, December, 1948, pp. 468-472.
- *HUBBLE, Douglas. Cushing's syndrome and thymic carcinoma. *Quart. J. Med.*, 18, April, 1949, pp. 133-147.
- *HUNT, Alan H. and MORGAN, C. Naunton. Complete rupture of the membranous urethra. *Lancet*, April 9, 1949, pp. 601-2.
- *— (Cole, P. P. and —). The treatment of cavernous haemangiomas and cirsoid aneurysms by the injection of boiling water. *Brit. J. Surg.*, 36, April, 1949, pp. 346-352.

- *KENNWAY, Sir Ernest L. (Elson, L. A. and others). The effect of 1:2:5:6-dibenzanthracene on the ascorbic acid content of the liver of rats maintained on high and low protein diets. *Brit. J. Cancer*, 3, March, 1949, pp. 148-156.
- See ATKIN, M. (and others).
- *KERSLEY, G. D. Dental sepsis and chronic rheumatism. *Proc. Roy. Soc. Med.*, 42, March, 1949, pp. 151-3.
- *MAINGOT, Rodney. The surgery of cardiospasm. *Post-Grad. Med. J.*, 25, May, 1949, pp. 197-202.
- *MORGAN, C. Naunton. The surgical anatomy of the ischio-rectal space. *Proc. Roy. Soc. Med.*, 42, March, 1949, pp. 189-200.
- See also HUNT, Alan H. and—
- MURRAY, P. D. F. and KODICEK, E. Bones, muscles and vitamin C. 1. The effect of a partial deficiency of vitamin C on the repair of bone and muscle in guinea-pigs. *J. Anat.*, 83, April, 1949, pp. 158-174.
- *PARKINSON, T. Eosinophilic xanthomatous granuloma with honeycomb lungs. *Brit. Med. J.*, June 11, 1949, pp. 1029-1030.
- *RAVEN, Ronald W. Partial hepatectomy. *Brit. J. Surg.*, 36, April, 1949, pp. 397-401.
- ROBINSON, A. M. and GOULDEN, F. A qualitative study of urinary ¹⁷-ketosteroids in normal males and in man with prostatic disease. *Brit. J. Cancer*, 3, March, 1949, pp. 62-71.
- RUSSELL, H. G. Bedford. Treatment of hay-fever by injection of nasal mucosa with alcohol. *Lancet*, June 25, 1949, pp. 1098-9.

- SCOTT, R. Bodley. The spleen and splenectomy. *Brit. Med. J.*, June 18, 1949, pp. 1063-1070.
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- THEOBALD, G. W. The rôle of the cerebral cortex in the perception of pain. *Lancet*, July 9 and 16, 1949, pp. 41-7, 94-6.
- TIPLER, M. M. See GOULDEN, F. and—; KENNWAY, Sir Ernest L. (Elson, L. A. and others).
- TURNER, J. W. Aldren. On amyotonia congenita. *Brain*, 72, 1949, pp. 25-34.
- WALKER, A. J. (Barcroft, H. and —). Return of tone in blood vessels of the upper limb after sympathectomy. *Lancet*, June 18, 1949, pp. 1035-9.
- WATTS, R. W. E. (MacKay-Dick, J. and —). Canicola fever in Germany; report of six cases. *Lancet*, May 28, 1949, pp. 907-910.
- WEBER, F. Parkes. Osler's love for obscure diseases. *Med. Press*, July 13, 1949, pp. 29-32.
- *WILLIAMS, I. G. Radiation therapy. *Med. Press*, May 25, 1949, pp. 501-4.

EXAMINATION RESULTS

UNIVERSITY OF OXFORD

2nd B.M. Examination

Trinity Term, 1949

Medicine, Surgery and Midwifery

- *Widdicombe, J. G. Simpson, E. A. D. W.
- *Completed examination for the degree.

UNIVERSITY OF LONDON

M.S. Examination

July, 1949

Branch I (Surgery)

Longland, C. J. Rickham, P. P.

Examination for the Academic Postgraduate Diploma in Medical Radiology

July, 1949

Part II

Hinds, S. J.

Examination for the Academic Postgraduate Diploma in Public Health

June, 1949

Hoskyn, C. H. Jones, S. A. Mayers, J. R.

Examination for the Academic Postgraduate Diploma in Bacteriology—1949

Westwood, J. C. N.

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Final Examination

June, 1949

Medicine

Horrocks, K. C.

Midwifery

Dibb, F. R. F.

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Horrocks, K. C.

Final Examination

July, 1949

Surgery

Giri, G. A. R.

Pathology

Leach, J. W.

Medicine

Hardy, C. G. J.



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HOSPITAL JOURNAL

Vol. LIII

NOVEMBER, 1949

No. 11

WORDS

LANGUAGE is the instrument of intelligence, the mark of the evolution of mind. It is the medium of thought, and adds a new dimension to the world of matter, space and instinct. Communication at a distance of time or space (*pace* the Piddingtons), the deliberate accumulation of knowledge, and reason itself would be impossible without the symbolism of words.

Yet words, the very cells of the mental organism, are constantly mis-handled and misinterpreted. Ideas are misconstrued, passion is permitted to sway judgment, and the star of truth is lost in a cloud of abstraction; sometimes consciously, more often not. For this the nature of words is partly responsible. Only proper names correspond to objective phenomena, capable of sensory definition: all universals and abstractions, it has been argued, are meaningless except by association with these *designata*. Even proper names carry with them a certain aura of emotional association, making their meaning by that amount indefinite. The meaning of an abstract word can be called a pattern of its use and interpretation, changing with time, variable with the verbal and emotional experience of the observer. The unconscious desires of a thinker can so determine his choice of words that his argument, to him consistent, logical, is meaningless to others.

The everyday commerce of conversation is not important enough to demand accuracy in phraseology, and the significance of its words can be infinitely modified by inflection, gesture, intuition. But doctors especially are liable to be taken at their word: the most trivial remark carries weight, and may have effects far beyond the speaker's intentions.

In thought, and in writing, precision is invaluable. Nor is it easily achieved. The common phrase is the trap for the lazy; the second-hand idea needs less care in exposition, the cliché is always lurking ready to fill a mental blank, the trivia of common usage require no effort of composition, nor of comprehension. And they are used, often, in self-defence. The verbiage of a bureaucrat, the padding of an examinee, are so much camouflage for lack of matter. Examiners may be hoodwinked, or the public conscience be stilled, but the danger of self-deception remains. The recent official insistence on "an alteration in the rate of exchange," in place of "devaluation," was not grounded on care for the accuracy of economic terminology; it was either wishful euphemism, or intellectual dishonesty.

The same phrase illustrates the danger of prolixity, which Sir Ernest Kennaway condemns on another page. It is an essential character of that language so aptly called "Jargantuan." Circumlocution, repetition, superfluous adverbs, deficient punctuation—these and many other faults make up a kind of official dialect. (The legal version is justifiable by the need to cover all contingencies, though it contrasts strangely with the declamatory style of counsel before a jury: a group of men, together, have not the rational power of the least of them alone, and must be swayed by oratory.) And the habit, or disease, spreads rapidly. It is most obvious, in medicine, in the new, vague fields of "personality-structure," "social co-ordination," "psycho-somatic integration." Medical terminology, always a part of the student's burden and the profession's prestige, grows and multiplies, and soon becomes

detached from its material references and quite unfit to be a part of the logical structure of science. Imprecision increases geometrically in successive stages of thought, so that an apparently unassailable conclusion may be, in fact, untenable.

Grandiloquence is easier to avoid. The decline of oratory has left rhetoric suspect, and the sounding period is tedious or incomprehensible to the habitual reader of newspaper headlines. Mr. Micawber, who on second thoughts explained simply what he had automatically elaborated, is acknowledged superior to Dr. Johnson himself, who always preferred above simplicity the orotund. Henry James is an outstanding exception to the rule that an author's style improves as he progresses through youthful exuberance to mature simplicity and directness. But simplicity of style does not imply restriction of vocabulary. It is the use of the right word that matters, and English is infinitely rich in words of slightly differing meaning. Latin is more concise, French is a better vehicle for individuality and wit, but English is capable of conquering the world. Eight hundred and fifty words of Basic English, however, are no more sufficient weapons in the armoury of mind than George Bernard Shaw would admit the twenty-six letters of the Roman alphabet sufficient to represent the range of the human voice. The glory of Shakespeare, the variety and delight of Ivor Brown, the power of Winston Churchill, all depend for their beauty and meaning on a right choice of words, and a full free choice from wide experience.

ROUND THE FOUNTAIN

The fifth edition of this anthology of verse and prose from the *Journal*, 1893-1949, will be ready at the end of this month.
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THE JOURNAL

Contributions must reach the Editor by the first Tuesday in the month for inclusion in the following number

The language is alive, and its components change as constantly as those of the body. Words are born, grow old, and die. Their birth is rare, by inspiration, out of existing words or the matrix of formless sound-imagery; their maturity comes of proper use; senescence, all too rapid now, of overwork; and death comes silently. But the vigour of a word bears no proportion to its age. Elizabethan words, forgotten here, return from exile in New England to new strength. A change of usage can restore a word to currency: the base metal of cliché fails to drive out all the gold. Even the hackneyed word may die so quickly of overuse that it is soon fit and able to be resuscitated.

The essentials of style may be achieved by the use of words that are few, familiar and precise. The value of each word must never be forgotten, nor its emotional context. And lest this essay show, by the example of its failure, as much of the difficulties of word-management as it was meant to expound the delights, let it close with a text from that modern evangelist against Philistia, Sir Osbert Sitwell:—

"Under everything that a sentient man with a soul fully awakened perceives and comprehends, the word persists: the word, spoken or unspoken, frames every feeling and, like the trumpet of a herald set on a tower, sounds to announce every new discovery, every conquest of fresh territory, and every new thought wrenched or reclaimed from the universal matrix, chaos."

A HUMAN DOCUMENT

By H. LL. P.

How would you react, my reader, if, suddenly out of the blue, the knowledge came to your unsuspecting self that the first tentacles of an incurable disease were already coiling round your limbs? What would you register; despair, hopelessness, utter frustration, a sensation that things were not so bad as they first appeared; or, perhaps, a feeling of relief that a diagnosis had at last been made of your condition, and there was no further need to struggle and fight in the front rank of life?

I think that you would be surprised at your courage in adversity and at your determination to keep your chin up and face "the slings and arrows of outrageous fortune."

In subsequent pages you will find an account of how I carried on under these conditions.

Life had, hitherto, gone pleasantly enough with me. Born in the delectable county of Dorset, I was educated at Weymouth College; then at St. Paul's School, that great metropolitan academy; and so to Bart.'s. While still a student the first great war caught me up, and as a result two wonderful years were spent as a Surgeon Probationer in destroyers. The first one with the Harwich "Striking Force," the second with those grey-painted leviathans forming "The Grand Fleet." Qualifying in 1918, and now a "pukka" surgeon in the Royal Navy, I was appointed to gunboats. One of these took me nine-hundred miles up the Si Kiang, "showing the Flag," and another over the murky waters of the Danube.

Leaving the navy with a gratuity of £500 I returned to civil life. From the very start tribulation fell upon me, in such contrast to the free-and-easy years in the senior service. I was hardly ashore when my eyesight went queer... seeing double. Things overlapped by two or three inches. This phenomenon was accompanied by slight evening temperature. A physician at the Derbyshire Royal Infirmary where I had taken up an appointment reassured me, saying it was only a temporary fatigue of the eye-muscles, and would soon clear up. I have since been told that was the start of all my future disabilities.

From my job at Derby I entered general practice, and soon discovered that my years spent in the Service were a poor preparation

for "civvy street." My late jolly messmates and all the folk I had hob-nobbed with all round the world were a different class altogether from the small-minded people of my little town, where the energies of everybody were spent on methods of drawing as many trippers as was possible to their money-making attractions.

The young medico never realises that he also is entering a business career as important to him as the curing of his patients. He should have some knowledge of book-keeping, being most meticulous in the sending out and receipting of bills and having some knowledge of the wiles of the Inland Revenue Officer. The student's time would not be wasted if one or two lectures were given on this side of his vocation. Pardon for this digression.

But I was making headway with my practice despite all the handicaps of youth and inexperience and was lucky enough to possess the quality which may well be expressed as "the human touch." Believe me, all you young medicos, this asset is worth more to you than hard-won honours such as the F.R.C.S. or M.R.C.P.; but whether this truism will still hold good in this age of state-medicine is doubtful.

Now, in 1928, two incidents occurred, trifling in themselves but full of ill-omen. I happened to be addressing a Rotary Club meeting—public-speaking was always an ordeal to me—when my right hand began to vibrate. The unruly member was thrust into my pocket and I went on with my speech.

The other manifestation made itself apparent when I was sailing my craft in a whole jostle of boats around a mark-buoy. My hand again commenced to shake in the midst of this excitement, and my grip wavered on the tiller; but normality was soon regained.

The next thing that made itself noticeable was a difficulty in writing. It caused me considerable annoyance; but this slowing up caused my "hand" to be much more legible. At this time I also had difficulty in recognising the faces of my patients, and an inability to remember what had been prescribed for them on previous visits. I was never much good at keeping notes. Now a sick doctor may command sympathy but not trust from his patients. Those words, "Physician heal

thyself" may well be used against him. So great was my demand for rest and recuperation that the telephone was disconnected at night from my bedside table. Hitherto a good mixer, society was now somewhat shunned.

I at last consulted my brother, a G.P. in the same neighbourhood. He took a serious view of the case and arranged an interview with Dr. Ruddock, the nerve-specialist, so lately cut off in the full flower of his attainments. He was coming down to Dorset to consult with my brother over the case of an equally celebrated neurologist, but of a former generation. The four of us met in an old manor-house, and over the teacups no one seemed to be taking much notice of me, but Ruddock had already diagnosed my complaint.

He and my puzzled self went into the garden, a pleasance, hidden by mellow, red brick walls, carpeted with century-old turf, the herbaceous borders blazing in the height of their summer-glory. Taking my arm in his, with all the kindness in the world he told me I was suffering from Sleepy Sickness. I italicize the final syllable of the word, sleepy, as people—even doctors—still write letters to me charged with indignation saying that the disease is African in origin and completely curable.

One fact sticks in my mind: he asked me if there was abnormal salivation. This characteristic symptom had not, however, manifested itself as yet.

Riddock did not tell me anything about the possible progress of the disease, and it has always been my practice to abstain from making inquiries as to its future course or to read any literature dealing with the complaint. By thus curbing all my natural curiosity I have saved myself a tremendous amount of evil anticipation.

General practice began to be too much for me, and then and there I did something remarkably foolish. Leaving civil life, I re-entered the Navy. Going up to the Admiralty, I perjured my soul by signing a document stating that to the best of my belief I was not suffering from any complaint, and submitted myself for a medical examination . . . it was then possible for me in the early stages of my illness to deceive if necessary the whole Royal College of Physicians. So I entered the Royal Navy again after an absence of four years.

My Lords, with a touch of humanity, supposed to be absent from a soulless board

of officials, appointed me to *H.M.S. Vulcan*, a submarine depot-ship lying in harbour based permanently at my home-port. Thus I was enabled to keep on my flat, get back to it most nights, and receive a welcome from my staunch little wife.

But, alas! the ward-room life which had suited me so well in the carefree days of not so long ago was now as a closed book to my changed self. The ward-room of one of His Majesty's ships is not a place for anybody a bit under-the-weather. There is a coming-and-going, conversation and merriment, horse play and high-spirits. It was too much for me! Especially when I was "medical-guard" for the whole fleet and had to stay on board for twenty-four hours with nothing to do except listen to submarine-jargon. I was compelled to chuck my hand in and was invalidated out of the Service . . . surely the shortest period of time ever spent in the Navy . . . exactly six weeks, the most unhappy period of my whole life.

That saw the end of my work for me, and I and my wife moved into the country where peace and comfort was granted me in full measure.

That dread symptom, salivation, now seized me. This affliction you might well consider to be a minor malady, but by its life may be rendered nearly impossible—saliva literally pours from the mouth. The curious nature of the symptom is that it remains usually in subjection while you are engaged in doing nothing, but as soon as the victim starts to concentrate on any business the liquid starts to flow. It is with me even now as I type these lines. Truly this continual watering is the worst part of the disease.

My right hand soon became almost entirely useless, and my wife took over the job of my morning shave. She has performed this tiresome business for twenty years, and never once has she even nicked me.

Another factor that troubled me greatly was tremor of the coarse variety in my right hand, and so at meal-times, when reading, typing or doing anything at all, it has to be sat upon. As a matter of fact I do not believe it would be very much less if it was amputated . . . the whole limb.

Now a period of adjustment had to be completed. This was a tedious business and took time. I had to realise that invalidism held sway over me, and I must have been a very unpleasant person to live with, as all the pleasures of life were gradually wrested from

me. My style was badly cramped when my car had to be sold; then tennis and golf were made impossible in quick succession. Still two boons were left: shooting and gardening. You may well wonder how I managed the former. I was slow on the trigger, but I had a double choke on my old 12-bore and caused amazement among my fellow Nimrods by killing game at phenomenal distances. Snap-shooting was not my forte.

Gardening was at first a pleasant recreation, but as the quiet years rolled by this became too much. The practice of horticulture is a tremendous labour and used to reduce me to a state of collapse.

The next trouble was difficulty in swallowing; this is a most trying feature of the disease. The result of this was that most of the pleasure of eating—believe me eating is one of the delights of life—was filched, to deal with an adequate meal sometimes taking an hour while the food is negotiated well past the tonsils, from which position it can be swallowed at last with some ease. For this reason all meals are taken in private.

Walking now became well nigh an impossibility. There is a difficulty in getting my "clutch" in. This is easily at its worst indoors where one can't continue in a straight line. My progress in my home is almost laughable as my body passes from one obstacle to another, swinging, staggering, reversing and finally more or less tumbling into my own armchair. Out in the garden it is easy to progress walking backwards. My theory about this curious method of perambulation is that it is so rare a way of progression that the muscles are less fatigued and therefore work so much the more easily. I have only fallen prostrate on four occasions, and from these tumbles my person escaped scatheless. When on the open road magnificent progress is made but if the ubiquitous pram or other obstruction is met with my legs stop functioning and there is the greatest trouble in getting my "clutch" in again . . . as already mentioned.

Now followed two intervals in hospital. The first was at Queen's Square, where happiness was not found and then as an in-patient at Bart's. At this latter institution the mantle of royalty might well have fallen on my shoulders, as my unworthy carcass was moved into "The State Bed" and all those little differences and kindnesses showered upon me, such as a special breakfast tray with an embroidered mat and

dainty china. I was under Lord Horder, and knew him well as I had clerked for him. He noticed my head supported by my neck only and asked "Sister," a dear soul, to make me comfortable. As a matter of fact, pillows are of little service, as due to the spastic condition of my neck muscles my head never needs support. Nothing could be done for me at Queen's Square or at my *Alma Mater*.

Now there developed another disability: difficulty in talking! People with ordinary hearing have trouble in construing my remarks, and others, if they are the slightest bit deaf find it impossible to understand me. What does "get my goat" is the curious fact that folk finding my speech indistinct associate my feeble conversation with deafness and always start bellowing at me . . . this is a well-known phenomenon.

Yet another annoying happening is that people striving to humour me answer my remarks with absolutely irrelevant replies. How much better it would be if they just remarked, "Sorry, I didn't quite catch that."

Now you may well ask, "Have you taken all this with equanimity . . . lying down? Done nothing about it?"

By no means!

The first drug I took was introduced to me by my brother . . . geno scopolamine, tiny blue pills. These worked like a charm for a period of three years. Then I must have worked up a resistance for it gradually became absolutely useless. I then toyed with two or three drugs, but my anchor proved to be stramonium. The particular variety used by myself is produced by Messrs. Ferris of Bristol, and is remarkable for the regularity of its action. There is a great temptation to take an overdose. Its action is delayed, sometimes the full effect is not reached for an hour or more. While awaiting the reaction there is the greatest temptation to take a little more to hurry things up especially when something important has to be done. The result of this folly is devastating: bone-dry mouth, feeble heart-beat, a sensation of the greatest distress. On one or two occasions my end seemed to be approaching.

But the drug if taken properly has the most beneficial action, reducing salivation, spasm and tremor. Without it my body would be confined to bed. Like all good things . . . there is a snag! The slightest overdose and hysteria is produced: one's

sense of humour is exaggerated, indeed you may find yourself laughing at nothing. This unwanted merriment is not to be desired, and it is all too narrow a path between the devil of insufficient dosage and the deep blue sea of too much.

I advise similar sufferers not to stick to the tablespoon, three times a day, as ordered by their doctors, if this dosage is not doing them much good; but with the medical man's collaboration and with the greatest caution to experiment with increased quantities, till they gain relief. Again, I say *with caution*.

Another method of preventing salivation mechanically, is by securing a piece of the thinnest rubber over the mouth with tapes. The source of this sheet rubber is a surgical glove, or thinner still from a less dignified French correspondence.

Owing to the active principle, Atropine, the pupils dilate and strong glasses are a necessity. The conjunctiva also tends to dry up; this is marked in winter when there is some heating apparatus functioning, and may become quite painful. A simple remedy is the old-fashioned steam kettle. By the end of the day a scum often forms over the cornea; this can be dealt with by opening the eyes under water or by closing them tightly and then releasing them.

To turn to another aspect of an invalid's life . . . what have I been doing with myself all these years? Gardening and writing! My piece of land when I first came to it was an allotment, as bare as the proverbial billiard ball. It is now shady with trees, green-turfed, cool with a pool, pleasant with pergolas, and complete seclusion. This last condition is welcome as my antics are arresting and it is just as well it has reached maturity as gardening is too much for me now and I confine myself to literary labour.

In five years fifty-five articles have been sold and not one piece of fiction. Not exactly true, as three plays have been sold to the B.B.C. This, though stated by myself, is good going! Rejections? Extend into scores. The free-lancer ought to be the most disappointed worker in the whole wide world. But during this last year things have been flowing my way. Success with such magazines as *The Countryman*, *Scottish Field*, *Angler*, *Country Sportsman*, *Lancet*, and many others, including thirteen accepted by *Chambers's Journal*.

But even this good fortune was not allowed to flourish, and the index finger of my left hand—the only one that will function—chucked its hand in and refused duty, being too feeble to strike the keys. For some months no work was done. Then I saw an article in *The Strand* describing an electric typewriter. Following this up I discovered that it was American made and could not be exported. Sir Alan Herbert—who I knew was a good fellow—used his influence with the Board of Trade on my behalf. An export licence was granted and the International Time Recording Company, a British firm, supplied me with one of these "robots." With this complicated piece of mechanism typing became easy . . . only a feather-weight touch being necessary.

I have tried to show in these previous paragraphs how the heat and burden of a trying life can be endured. Nearly everything is difficult to accomplish. Little things which are done without thought, automatically, by normal folk are to me puzzles, and sometimes are impossible, such as: putting on clothes, fastening shirt buttons, holding a brimming cup, tying knots, and many more . . . all these are obstacles. It is here that my devoted wife steps into the picture: encouraging, helping, "doing for me," even as that radio favourite, "Mrs. Mop."

So, here I am with all these disabilities, with a whole host of minor ailments, and yet—I am going to surprise you—a happy man with dozens of compensations.

How has this complaint affected my character? All for the better I consider. "A fellow feeling makes us wonderous kind." I can experience the keenest disappointment with almost complete equanimity; and this may happen two or three times a week when the big, buff envelopes come in through the specially enlarged letter-box containing rejected manuscripts; also when some new disability cracks down on my unsuspecting head. I am in a much better vantage point to sympathise with other folks' foibles, bothers and peculiarities. What an excellent preparation it would be for the average doctor's initiation into general practice if before he actually commenced the so difficult art he could be stricken down in turn with all the ailments he was about to treat . . . that is, if he survived.

"Creeping Paralysis"—the title already allotted to another disease—would be a suitable name for Encephalitis Lethargica.

which drags unrelentingly along on its predestined course. It is impossible for the victim to say, "I'm worse than I was a week ago," or to substitute a month for the former period. No, it is necessary for him to compare his present condition with that of a year ago; to think of things that could then be done with comparative ease and are now so difficult or altogether impossible to perform.

My conclusion that a man has a separate entity—soul if you like—apart from this

husk of a body has been greatly strengthened by my experiences. I sit in my carapace watching my person behaving in its vile fashion; while my being is a thing apart, held a prisoner for only a time. This queer sensation of being outside oneself has been exaggerated by my complaint and it is a helpful and hopeful thought, and strengthens my faith that there is not complete extinction ahead, but that a happier fate awaits one . . . a better deal in a new game!

A PEPIPATETIC PARAPLEGIC

OR

A CAUTIONARY TALE

By AUBREY LEACOCK

A MAN of 69 was admitted last year to the Barbados General Hospital with paraplegia of long standing and recent fractures of the right femoral shaft and of the lower third of the left tibia and fibula. While climbing out of bed in his hotel he had fallen between bed and wheel chair. An eminent authority (who happened to be on holiday in the same hotel) had advised that both his legs should be amputated, for the fractures would assuredly fail to unite.

In 1920 he had first noticed progressive weakness of both legs, and in 1922, after a contrast radiograph of his spine (probably one of the first cases in which this investigation was done) a laminectomy was performed by Sir Percy Sargent. An angioma of the cord was discovered but no attempt was made to remove it. Thereafter his paralysis slowly progressed until in 1924 it became stationary, with paralysis and anaesthesia below L 3-4 and retention of urine and faeces.

What savings he had he invested on very favourable terms in an annuity which brought him an income of £1,000 a year. Thenceforth, at the expense of his insurance company, with a wheel chair and a devoted Scottish nurse, he travelled in comfort through Europe, North America and the West Indies.

He survived two severe attacks of "dysentery," numerous bouts of urinary in-

fection, and unceasing medical prophecies of death next month or next year. His nurse, who eventually married him, kept bedsores under control, catheterised him twice daily and washed out the bowel once a day. Reflex micturition occurred at intervals but did not empty the bladder completely.

On admission to hospital his fractures were treated by rather inefficient immobilisation; the skin was protected by a pair of his wife's nylons over which was a pair of thick woollen stockings and then padded plasters. He was nursed on a bed of pillows and bedsores were prevented by constant turning. No attempt was made to alter the routine of catheterisation which had worked well for twenty-five years.

After six weeks both fractures showed clinical and radiological union. Three weeks later he was discharged and soon afterwards left Barbados for New York. Some months later his wife wrote to say that they had decided to build a small house and settle down on the Riviera.

For twenty-five years this patient had been warned that he had only a few months to live, but in spite of these prognostications he survived to enjoy the £25,000 he received from his insurance company.

MORAL.—Tell your patient that he will live, for if you are wrong he will never be able to abuse you.

DIVERTICULOSIS OF THE INTESTINE

By BERNARD MYERS

A CENTURY ago diverticulosis was almost unknown to medical practitioners although it must have been practically as prevalent then as now. Fifty years ago when I was a student at Bart.'s I have no recollection of having seen a single case of this disease, but nowadays no practitioner from Bart.'s or any other hospital would wish to practise without knowing its frequency, symptoms and treatment. I well remember in 1897 Sir Dyce Duckworth telling his students in the old Matthew ward that a medical man may be expected to give a much more accurate description of an illness from which he had himself suffered than would obtain in the case of an untrained observer. It is for this reason that after stating the essentials of diverticulosis I will describe my own experiences, having been a sufferer from this complaint for some thirty years.

Spriggs and Marxer¹ state that Fleischman, in 1815, gave an excellent description of the post-mortem appearances in three typical cases in the duodenum and colon. In 1884, Norman Moore described a specimen. Spriggs quotes E. Shaw "... lastly, other congenital anomalies, such as folds of the duodenum, Meckel's diverticulum, oesophageal diverticula, and sclerosis of the duodenum may coexist. But it may be noted that in congenital stenosis of the small intestine, although the bowel above the obstruction is commonly dilated, pouching of this type is not usually recorded." In 1917, Teeling and Gruner, at Moynihan's suggestion, studied the literature of diverticulosis and, summarising, stated "that diverticula have been noted by various observers for more than a century, but for the most part as isolated cases... the condition was looked on as a rare pathological curiosity of no real clinical importance." The Mayos made contributions in America and Moynihan in England. In 1907 Moynihan published the first case in this country of peridiverticulitis (a mimicry of carcinoma) and he emphasised the role of the diverticulum in causing non-malignant vesico-sigmoid fistulae. The work of Spriggs and Marxer demonstrated clearly, with the use of radiological examinations in those complaining of alimentary symptoms or

¹ Intestinal Diverticula by E. I. Spriggs & O. A. Marxer: Q. J. Med. 1925.

general ill-health, that diverticulosis was really a common disease.

Summarising their investigations, Spriggs and Marxer found that diverticula of the duodenum were not uncommon as observed with X-rays; that condition being found in 38 out of 1,000 consecutive radiological examinations. Eighteen of the patients were men and 20 women; the youngest was 21, the eldest 75, and the average age 55 years. The average size of the pouch was that of a walnut, but the largest measured $4\frac{1}{2}$ inches in the vertical diameter.

Re-examination of two patients, one after four and the other after seven years, showed that the pouch had developed from a small size to a considerable one.

In eighteen of the 38 cases mentioned the patients' symptoms were thought to be due to irritation from the pouch or pouches. Complete relief was stated to have been obtained by treatment in 13 out of the 18 patients, which consisted of lubrication of the bowel, disinfecting its contents and correcting any associated symptoms. Gastro-enterostomy was performed with success in one case of multiple duodenal and jejunal pouches.

In their series they observed diverticula of the jejunum in 7 cases, of the ileum in 7, and of the appendix in 6.

With regard to the large intestine, Spriggs and Marxer found diverticula to be frequent and noted them in 100 out of 1,000 consecutive cases; the diverticula being small and multiple and found in any part of the colon, although commonest in the pelvic colon. Twenty-nine of the hundred cases were women and 71 men (the average age was 58 years, the youngest being 35, and the oldest 77).

They were of opinion that a radiological recognition could show a prediverticular state by the characteristic fixity of the affected portion of the bowel wall, with small irregularities. This they describe as the first stage of the disease, where minute herniæ begin to develop. In the second stage of diverticulosis, formed diverticula are seen. They called the third state diverticulitis, inflammation having spread from the pouches to the bowel walls and surrounding parts. This stage was found to be well developed only in 5 of the 100 patients.

The question invites itself as to whether diverticulosis results from a degenerative or an inflammatory process. They found association with spondylitis of the lumbar spine in seventy per cent. of their diverticular patients, which, compared with the twenty per cent. of a control series, did not in their opinion merit any deduction being made. They thought, however, that taking the inflammatory appearances of the prediverticular state which they had observed in 35 patients, and the frequent association with abscesses at the apices of the teeth, together with other septic conditions in various parts of the body, it favoured the idea of an infective origin of diverticulosis, and not one due to passive extrusions in a weak but otherwise healthy gut. They may or may not be justified in their view on this matter.

Forty-five of their 100 patients complained of symptoms thought to be attributable to the diverticula.

They conclude, and I think very wisely, that the condition is amenable to treatment by lubrication, cleanliness and proper action of the bowel and the health of the body generally.

Bockus² gave his opinion that the duodenum is the second most common site for diverticulosis in the alimentary canal and agrees that its occurrence in the colon is much more frequent. He found that duodenal diverticula were single, but multiple cases sometimes occur. Regarding location, he mentions that over 95 per cent. of duodenal diverticula project from the inner concave or pancreatic border of the duodenal curve in the second, third and fourth portions of the duodenum. He calls attention to the simulation of peptic ulcer by a duodenal diverticulum, and which may perforate into the pancreas.

Spriggs and Marxer state that in 100 cases of diverticulosis of the large intestine the age of incidence is in the latter half of life. The average age of the 1,000 investigated was 45, whereas the average age of the 100 with diverticulosis was 58 years, the youngest being 35, and the oldest 77.

The distribution of diverticula in the 100 cases:—

Pelvic colon	58 cases
Descending colon	46 "
Iliac colon	16 "
Transverse colon	13 "
Ascending colon	10 "

Whole colon	8 "
Caecum	7 "
Appendix	5 "
Rectum	3 "

In the first stage (the prediverticular state) the appearance is characterised by a ragged outline of the wall of the bowel. This was observed in 20 of the 100 cases, varying from the caecum to the pelvic colon, most often in the latter. In the second stage it is believed that the pockets are filled by fluid motions and empty easily, thus undergoing more dilation. They are of the opinion that there is less retention in big pockets and less risk of irritative putrefaction, or of the formation of permanent residues or stercoroliths. Retention does not generally arise until after the little hernia has exceeded the depth of the outer peritoneal surface. After retention is established the emptying of the pocket is determined by the width of the neck and the consistency of the bowel contents. In the third stage inflammation and thickening of the wall of the bowel occurs (diverticulitis). It was present in five of their 100 consecutive cases. Of course, inflammation may arise in one diverticulum only. These hypertrophic changes may diminish or occlude the lumen of the bowel, and subacute obstruction will result. In one case narrowing of the bowel occurred where it was adherent to the bladder.

Spondylitis of lumbar vertebrae was present in many cases of diverticulosis, and frequently abscesses at the roots of the teeth. In the first stage constipation was present in practically every case. In the second stage there may be no symptoms in some cases, but in others flatulence with discomfort or pain may be present, dull or colicky. In the third stage some degree of inflammation with thickening is present, usually in the left iliac fossa. The inflammation may extend to the peritoneum and adjacent organs, but the progress may be slow.

Symptoms in the 71 cases:—

Constipation	53 times
Flatulence	22 "
Abdominal pain	21 "
Abdominal discomfort, distension or indigestion	21 "
Pain or discomfort, before or after defaecation	6 "
Diarrhoea	6 "
Irregular micturition	4 "
Alternating constipation and diarrhoea	3 "

² Gastro-enterology: Vol. II, by Henry C. Bockus.

The prognosis is usually good if efficient treatment be carried out.

The treatment of diverticulosis of the large intestine consists in the first place in cleansing the mouth, and any defective teeth should be removed or stopped and a well-fitting plate made and always used for mastication. An inflamed appendix or troublesome gall-bladder must be dealt with. Paraffin should be taken night and morning in doses of a tablespoonful to a teaspoonful, throughout life. Straining at stool must be rigidly avoided, and a pause of about ten seconds made between efforts. Improvement in the state of the bowels can be seen radiologically. The bowels can be further aided by a lacto-vegetarian diet with plenty of fruit and greens.

They advocate:—

- 7 a.m. $\frac{1}{2}$ oz. paraffin in 2 ozs. warm milk.
- 8 a.m. coffee and milk; one tablespoonful of milk-sugar; wholemeal bread; butter; honey or marmalade.
- 10.30 a.m. a glass of buttermilk; wholemeal bread and butter.
- 1 p.m. fish, cooked any way; butter sauce; salad and dressing; compote of fruit; cream; toast and butter.
- 4 p.m. coffee with milk or cream; marmalade; wholemeal bread (toasted, if desired) and butter.
- 7.30 p.m. vegetable soup; some egg dish (poached, scrambled or omelette) with vegetable or fruit; for instance, jam or jelly omelette, or omelette aux fines herbes; cream cheese; wholemeal bread and butter.

The diet would be modified to suit the individual patient. Suitable exercises should be ordered and in some cases massage to the limbs but not the abdomen. In some patients with flatulence, carminatives or tonics can be prescribed.

Edwards³ differentiates congenital diverticula like Meckel's from the acquired types: in the duodenum, jejunum, ileum, colon or vermiform appendix.

His conclusions, arrived at after naked-eye and microscopic examination of specimens of diverticulosis of the colon, are thus summarised:

The diverticula are herniations of the mucous membrane of the bowel through a gap in the musculature. The muscular coat of the bowel is continued into the wall of the diverticulum, but gets progressively thinner and is atrophic. Most of the sections show a layer only one or two fibres thick near the fundus. Edwards is of opinion that the gaps in the musculature are caused by the entry of the blood vessels, the largest of which enter the wall of the bowel at the mesenteric side of the anterior and postero-lateral taeniae. He states that there is no evidence of generalised atrophy of the muscular wall of the bowel. He continues: "In every hernia two conditions must be present: (1) an area of diminished resistance in the wall of the cavity; and (2) a pulsion force within the lumen of the cavity."

As he states, the further results of diverticulosis may be chronic diverticulitis, or pericolicitis, or adhesion to neighbouring organs, or obstruction, or again it may result in acute diverticulitis, or perforation and general peritonitis or localized abscess, or these may be tracking to the surface in the left iliac fossa, or rupture into the bladder (colovesical fistula) or other hollow organ, or into the peritoneal cavity.

With regard to any relationship between diverticular and new growths, I quote Edwards: "It would appear that no casual relationship between diverticulitis and cancer has so far been established, and that predisposition to malignant changes only occurs in so far that cancer is probably more liable to originate in tissues which are the seat of chronic inflammation than in normal tissues." I think his conclusion sound and likely to be agreed with by others experienced on this question.

In summing up treatment he states: "Prevent stasis, therefore, reduce bulk of undigested and indigestible foodstuff and by the use of colon lavage. Avoid nuts, fibrous root vegetables, tomatoes and hard fruits. As far as possible avoid red meat." He prescribes a breakfast of grapefruit juice or orange juice, cereal in small quantity with milk and sugar, egg dishes, toast, white bread, butter and marmalade. Tea or coffee, and milk. For tea, normal white bread is preferable to brown.

For lunch and dinner he allows smoked salmon, sardines, etc.: soups; fish and sauce; white meat, game, spinach or sprouts; egg puddings, milk puddings.

At lunch and dinner, lightly boiled plain puddings, savouries, coffee, beer, lemonade and whisky and soda.

Although I agree with most of his diet chart I have found from personal experience certain differences which I believe to be to the advantage of the patient, and these I will refer to later on.

Edwards states that the indications for operation (the operation suitable to most cases being colostomy) are:—

- (1) Recurrent exacerbation of inflammation.
- (2) Onset of symptoms of chronic obstruction.
- (3) The onset and persistence of bladder symptoms.

He believes a radical excision is only justified in certain limited cases, a statement with which I entirely agree. Other conditions necessitating operative procedure are: acute diverticulitis, with perforation and peritonitis; abscess, which may rupture into a neighbouring hollow organ such as the small intestine, the rectum, the vagina or the bladder; obstruction, usually due to stenosing peridiverticulitis; and colovesical fistula—a most dreaded complication.

About thirty years ago, when in the middle forties I was aware that the faeces had tended to become drier for several months and, this condition remaining with a tendency to constipation, a greater effort became necessary at stool. All went well until on one occasion an extra and sustained effort was made when a sensation as if something had suddenly given way in the left side of the abdomen was felt by me and which was accompanied by some half-dozen crackling sounds which evidently originated inside the abdomen. Two days later an X-ray of the alimentary tract demonstrated the fact that several pouches had appeared in the descending colon and sigmoid. It so happened that in an annual medical overhaul two months previously, which included a bismuth meal, no sign of diverticulosis in the bowel was then seen. Therefore, it would appear there can be little doubt that the above demonstrates the formation of intestinal diverticula in my own case, and if in one, may it not be true of many more which have not been recorded?

Since that time X-ray examinations have been made by Cecil Bull many times and demonstrated the gradual increase in the size of the diverticula and the appearance of several more in the sigmoid, descending colon and one or two in the transverse colon.

Sir Arbuthnot Lane advised me to take one to two tablespoonfuls of liquid paraffin thrice daily and certainly the treatment greatly relieved the discomfort, but the dose being excessive I reduced it to half that amount, and later to a dessertspoonful, morning and evening only. This proved ample, although on occasion it has had to be increased slightly, or reduced for a few days.

Mackenzie Wallis carefully examined the stool at Bart.'s within a year of the commencement of symptoms and found occult blood, and a similar result was obtained by Archer in the laboratory, five years later. No doubt the occult blood came from the diverticula. With this exception the stool proved to be normal on both occasions.

I have already mentioned that spondylitis has been noted by several observers as a possible causative condition of diverticulosis and it so happened that at about the same time as the diverticulosis appeared, or possibly a little previously, I had a fall on to my back resulting in the fissuring of the right lateral processes of the third and fourth lumbar vertebrae and a year or two later spondylitis was present in the affected lateral processes. The pain from the latter was severe in the lumbar region, and down the left thigh and leg, to the ankle, ultimately giving rise to loss of sensation above the ankle on the inner side. Further, septic teeth and other infective processes have been mentioned by the same observers as being possible causative. Having suffered from trouble from my right nasal sinuses for some time I was treated by Bedford Russell, who found all the right sinuses badly infected, and I owe him a debt of gratitude for effecting a perfect cure. Next my teeth were dealt with, and having septic roots, the dentist removed them all, and with a most satisfactory set of dentures I felt distinct relief and better in my general health, together with some lessening of the discomfort sometimes felt from the diverticulosis.

So soon as I became aware of my diverticular condition I avoided all undesirable and indigestible food, or which was so stated in the literature, and made a careful diet for myself, although it was evident that much of the information gained in this direction was to be looked upon as in the nature of an experiment, until the real facts were ascertained, and benefit could be taken of the knowledge carefully acquired.

³ Diverticula and diverticulitis of the intestine, by Harold Edwards.

For the most part the diverticulosis did not greatly trouble me, but after some eight to ten years I experienced my first attack of spasm in the region of the splenic flexure, probably from diverticulitis. That attack occurred before the sinusitis had been cured. I experienced a distinctly tight feeling in the splenic flexure, which did not relax, and neither flatus nor faeces were being passed. A barium meal showed the spasm at the splenic flexure, without doubt, and when the condition was relieved the faeces which had evidently been in the flexure demonstrated very definite evidence of compression, while the faeces preceding and following it were normal in size. The same thing happened on various occasions later on.

Pain, not of an acute type, accompanied the spasm, and was intermittent, being then replaced by a dull ache. We will call the splenic flexure spasm "A." The same symptoms occasionally occurred at a point two inches lower down the descending colon, "B," or at the lower end of the descending colon, "C." Usually the spasm at "B" only became evident when the splenic spasm relaxed, and at "C" when "B" relaxed. As a rule after the exhibition of an antispasmodic, and the passage of a motion, all these symptoms ceased. No blood was ever visible to the naked eye. On many occasions I noted referred pain on the right side of the body when spasm was present on the left, thus when "A" was involved there was also referred pain over the epigastrium, if at "B" it was just below the gall-bladder, while with involvement at "C" it was referred to the right loin, or occasionally the right iliac fossa. It is noteworthy that the referred pain was intermittent and always at a slightly higher level than the actual causative area. It ceased when the spasm was relieved. No abnormality has been discovered in any of the referred areas. Recently there was present with a spasm at "C," a tender point to the left of the lumbar spine in addition to the usual tender area in the right loin.

In the last 20 years pain and ache over the posterior part of the bladder has sometimes been present during defaecation, leaving an ache for an hour or two afterwards. It is rarely troublesome now and possibly the diverticulum causing the symptoms has been walled off by fibrous tissue.

Three years ago I had a fall on to the right side of my chest and broke the right fifth and sixth ribs in the mid-axillary line together

with much bruising of the tissues. This was followed by a firm spasm at the splenic flexure which prevented the passage of faeces or flatus and gave rise to pronounced meteorism adding greatly to the discomfort. This condition was finally relieved after taking four doses, at three-hourly intervals, of a mixture consisting of tinct. belladonna, m X, tinct. stramonium, mV, codeine phos., grain 1/8, and water to half ounce. This antispasmodic mixture has often been invaluable to me. Great was the relief given when the spasm relaxed and the meteorism disappeared, the relief being completed after a careful irrigation of the colon, a difficult and painful process under the unusual circumstances.

I have not found diverticulosis present any real difficulty to the carrying out of one's professional work, in fact the busier one became the less time there was to meditate on such things. I am convinced that attending carefully to the diet, keeping the bowels open twice daily, using such treatment as may be required, and keeping a happy state of mind, together with sufficient exercise and sleep, are the best ways to make light of the troubles due to diverticulosis.

In the treatment of diverticulosis there is nothing of greater importance than that the patient should be advised as to the most suitable diet, to which he should closely adhere. Of course it is understood that some persons may require slight modifications of the ordinary diet and which, if not likely to do any harm, can be allowed, as it is desirable to make his meals interesting as well as suitable for his complaint. It is essential that a dentist should thoroughly examine the teeth and deal efficiently with any needing treatment. After the mouth is cleaned up, if a denture be required it must fit perfectly, for good mastication is essential for these patients. The food allowed must be correctly prepared and well cooked. Then good use must be made of the knife and fork, to be followed by thorough mastication. He should cultivate the habit of eating slowly, and will soon find that it becomes automatic.

Briefly, all food should be non-irritating and digestible. Roughage of any kind is to be scrupulously avoided to prevent irritation of the diverticula. Fibrous roots, stringy vegetables and hardish food are not allowable. I am aware of a case where a man who should know better is in the habit of eating whatever he fancies at restaurants, regardless

of its suitability, stating that as he has irrigation of the colon every second day he can at least enjoy his life in between times. That sort of thing may go on without serious incident for a time but it is likely to lead to trouble sooner or later.

A suitable dietary has already been given in this article, but as I have not always adhered to it strictly myself, I will mention the dietary which has agreed with me, although I realise it may not be ideal for every sufferer from diverticulosis. Obviously the greater the care taken with the diet the more is the likelihood of the individual escaping the great discomfort following indiscretions. Only a bland diet is permitted when there are even the slightest symptoms of intestinal discomfort.

Plain soups or Bovril. White bread and toast without crusts, and butter. Fish of almost any kind, whether soles, plaice, turbot, cod or salmon, with appropriate simple sauces. Smoked salmon occasionally. Poultry, roast or boiled, with parsley sauce; game, if not high. Roast lamb, boiled mutton in small amount. Boiled or mashed potatoes; well-cooked cauliflower with sauce, or tender cabbage (only the inner leaves); early peas (broken by the fork before mastication); beans, if sufficiently tender and free from stringy pieces; asparagus, when first in season, with melted butter. I find no trouble from the tender inner leaves of young lettuce, providing it is well cut up and thoroughly masticated. Milk puddings are excellent, and steamed puddings agree with most people. Stewed fruit, free from skins, etc., go well with milk puddings. Blancmange and jellies can be recommended.

I have never had any trouble from spinach, which must first be put through a sieve, nor with tomatoes, if fresh and just perfectly ripe, whether cooked or otherwise, but the seeds must be quite soft. Eggs are most important and can be eaten boiled, poached or scrambled, or in custard. Personally I find no trouble even from a small quantity of porridge with milk and sugar, in cold weather.

Fruits such as bananas, if quite ripe, agree well and act as a laxative. So do plums and greengages. Cox's orange pippins, if thoroughly masticated, seem to agree, especially after breakfast. I can also recommend orange juice and grapefruit juice. Blackcurrant juice, quite free from seeds, makes a change sometimes. If any article of diet is causing flatulence it must either be taken in smaller amount or avoided altogether.

Regarding laxatives, there is no doubt that liquid paraffin, taken half an hour before breakfast and again before the evening meal, is most suitable; it is a lubricant and slight laxative. The usual dose is a dessertspoonful, but sometimes a little more or a little less just answers the necessity of the case. Several articles have appeared in the Medical Press suggesting that liquid paraffin is absorbed and deposited in the liver and lungs, but Professor Raper of Manchester University, who did the experiments, informed me in a personal communication that this statement is not true in the case of human beings. I have tried several other laxatives but have come to the conclusion that milk of magnesia is quite the most suitable. I like the tablet form and whenever it is required take five or six in water before a meal. Five or six teaspoonfuls of syrup of figs taken with the magnesia at night acts a little more quickly, but it is only required occasionally. Most important from the laxative point of view are stewed prunes, thoroughly cooked; ripe dates, when they first come in; cultivated rhubarb perfectly stewed and served as a puree; and, as already mentioned, ripe bananas. I have already mentioned an antispasmodic mixture which I have found valuable.

I see no harm in the smoking of two or three cigarettes daily, but would not advise cigars or pipes. The less alcohol taken the better, but I found a little whisky and water before retiring at night agrees quite well. Of course, tea or coffee, with milk and sugar, are allowed.

Regarding irrigation of the colon, which requires great skill and judgment, Mrs. Hare's procedure is as follows: She uses 12 to 16 gallons of weak sodae bicarb. solution (a teaspoonful to the quart) and makes the temperature 100 to 102°F. After the first eight gallons a very pale solution of permanganate is used. Great patience is essential and only a pressure of about 12 inches allowed. This is regulated by the height of the glass container above the bed. The tube is not inserted high up at first, but the lower bowel is washed out, or if necessary a small soap and water enema given beforehand, and then the tube gently put farther up by degrees, but no force is used. In some cases the result is quickly obtained but the greatest patience is necessary as it takes an appreciable time to wash out the bowel thoroughly.

The patient lies on his left side to begin with, and then turns on his back; sometimes moving over to the right side for a few

seconds and back to the left side again. In acute cases six ounces of olive oil is used, being retained an hour before treatment, and is very beneficial. Irrigation of the colon is better carried out at regular intervals, such as monthly, and of course when required by symptoms.

I think it necessary for every hospital of any size to have one or more nurses on the Nursing Staff who are skilled in the giving of colonic irrigation.

Summary. I have related some of the important points connected with Diverticulosis and referred to the literature, and then detailed my personal experiences as a sufferer

from this disease. The great importance of constipation in people in the forties or over is dealt with, also the evil of straining at stool. The possible relationship of sepsis and spondylitis as predisposing causes is mentioned. Dizziness of the faeces, and too much strain at stool may be exciting causes of diverticulosis, especially if there be a tight anal sphincter. Further, there is the question of referred pain from spasm of the colon, on the one hand, and from accidents such as fractured ribs causing spasm of the colon on the other, which need investigation. May I suggest that a most suitable centre for this investigation is at St. Bartholomew's Hospital?

DE MINIMIS

By JOSIAH OLDFIELD

ONE of the oldest of the English legal maxims is: "De minimis lex non curat."

The law against defacing the coins of the realm, for example, would not be put into force against a person who put a penny on a railway line for a train to flatten out or against anyone who bored a hole in a 4d. piece to hang it to their watch-chain.

Breaking the law is a crime, but the law, being sensible, says it takes no notice of the tiny crimes of life!

It is entirely different in connection with the medical profession.

It is the small things which so often make the difference between life and death, health and disease. It is the small grain of sand in the eye which sends a patient hurrying to his doctor, so that by skilful treatment a very painful future will be avoided.

Just at this time of the year everyone's mind is turning towards a holiday, and I would remind doctors that one of the most important things for them to do is to advise a patient how best to take advantage of this change in their routine of life.

All changes should be restful, and therefore as far as possible the change on a holiday should be complete, both as to surroundings and climate, as well as to comradeship, and, above all, one of the most important things is to get a change of food.

Nature is extremely careful about the small things of life.

In the grain of wheat as in every other packet of her food, she wraps up together with the germ all sorts of important elements. Not only does she provide the usual foods

for the germ such as starch, sugar, fat and protein, but she also encloses in her little envelope accessory food factors, minute and delicate but of extreme value both for the germ itself and for the human who uses the grain or seed as a food.

In modern life the tendency is to remove all substances which are looked upon as irritating or as rough, and therefore indigestible. In doing this so often the delicate elements of essential value are removed at the same time. It is this daily absence from the diet of one or other of the finer essences or elements provided by nature which tends slowly to undermine the stamina of the race.

The important thing about a holiday, therefore, is to go where the food is entirely different, to bid "good-bye" to ordinary routine diet to which one has been accustomed, to go if possible into one of the more primitive lands, such as Italy or Switzerland or Spain, or the countryside of France, and there live on the food of the people.

In this way the elements which are largely absent from the refined dietary obtained from tinned and milled and chemicalised foods, are replaced by those foods of nature in their more or less natural condition.

Personally, I always recommend a patient who wants to get the most out of a holiday to go where there is an ample supply of the simpler foods of life, and to bid, for the time, farewell to the white bread and bacon for breakfast and to the slice of meat for dinner.

I say to them: "Live like the people of the land live. Take Polenta or Wheaten porridge with honey for breakfast, get one of

the delightfully made omelettes or soufflés or macaroni au gratin for the central meal; and enjoy the opportunity of getting those delicate vegetable dishes cooked in oil or butter which are the pride of every good housewife and chef on the Continent."

Dishes like asparagus in butter, spinach and cream, onions in olive oil, bring a new enjoyment to the delights of the table.

Salads of all sorts when they are daintily prepared and served and with white wine vinegar and fine olive oil, provide one of the

daintiest and most delightful ways of getting the fresh elements of nutrition direct from the hand of Mother Nature!

On holiday, enjoy the open air; do not sit up dancing half the night, picnic out in the vineyards or on the borders of an Italian lake in the sunshine, quietly climb the hills and expand the lungs, sleep to the full all night and come back a 100 per cent. improved in health and vitality ready to face the winter.

CORRESPONDENCE

VIEW DAY

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

Dear Sir,

On reading Mr. Hick's reply to my remarks on View Day I feel certain it must have taken him a long time to produce this masterpiece. What a waste of time and energy (not to speak of paper), especially when both could have been more usefully employed in "an organised game or a pint of beer." I ask myself what the reason for this cheap, unwarranted attack could be. The only answer I can offer is, that Mr. Hick has adopted the policy of attack being the best defence—or in other words: If you cannot explain or meet an argument, merely be rude and aggressive—you are bound to succeed. Greater people than Mr. Hick have resorted to that principle in the last 15 years; no wonder, then, that he has been contaminated.

Mr. Hick does not agree with my remarks—well and good; it is his right to say so. He believes that the existence of View Day should have been known to me, that no gap exists between Pre-clinicals and Clinicals, and that I should take part in organised games (not to forget the pint of beer). All that could have been formulated in four or five clear, concise and simple sentences; instead we get half a page of childish nonsense which does Mr. Hick no credit.

I believe it is futile to carry the argument any further—as to my non-participation in games I am prepared to give Mr. Hick my reasons, should it ever dawn on him to try to find out. As to the non-advertisement of View Day and the existence of the gap (noticed by many more beside myself), he has offered no explanation or remedy whatsoever.

Finally, if Mr. Hick's sportsmanship (of which he seems to be so proud) is as cheap, tactless and unfair as his letters, I cannot help feeling sorry for the games in which he participates.

Yours faithfully,

H. A. ULLMANN.

Charterhouse Square.

E.C.1.

October 4, 1949.

[The Editor agrees with Mr. Ullmann that it is futile to carry the argument any further.]

CORRECTION

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

Dear Sir,

Would you allow me the luxury of correcting a minor mis-statement of fact in Mr. Hart's "Life and Works of Sir Archibald Garrod." In the September issue of the Journal Mr. Hart records that Osler arranged a series of meetings at the R.S.M. to discuss "P.U.O." and he adds in explanation, "Pyrexia of unknown origin." Now, anyone who has been in His Majesty's Armed Forces will know that the Official Mind tolerates the unknown even less happily than Nature's classical attitude towards a vacuum. Nothing, in short, can be permitted to remain unknown and it is with a view to instructing those of your readers who have yet to face National Service that I would like to put on record that the three letters stand for Pyrexia of Undetermined Origin.

Yours faithfully,

HOGARTH

41, Manor House,
N.W.1.

September 6, 1949.

AN EXERCISE IN LITERARY BREVITY

By PROFESSOR SIR ERNEST KENNAWAY

Recently Dr. G. A. Harrison remarked to me that most scientific papers could be shortened, by someone other than the author, to the extent of perhaps 30 per cent., by omission of superfluous words and the adoption of shorter constructions. The verbosity, and obscurity, of many official publications is well known (but people who talk about a multiplicity of rules and regulations as a recent invention of a Labour Government should read the Talmud). These considerations suggested an exercise in the art of conciseness in writing.

Two prose passages are given below: the first is surely one of the masterpieces of all literature, the second may be new to many readers. One might try to re-write these passages and (a) use fewer words (b) use simpler words, and (c) give a more vivid impression of the whole incident.

(1) John IV. 6-19.

"Jesus therefore, being wearied with his journey, sat thus by the well. It was about the sixth hour. There cometh a woman of Samaria to draw water: Jesus saith unto her, Give me to drink. For his disciples were gone away into the city to buy food. The Samaritan woman therefore saith unto him, How is it that thou, being a Jew, askest drink of me, which am a Samaritan woman? (For Jews have no dealings with Samaritans.) Jesus answered and said unto her, If thou knewest the gift of God, and who it is that saith to thee, Give me to drink; thou wouldest have asked of him, and he would have given thee living water. The woman saith unto him, Sir, thou hast nothing to draw with, and the well is deep: from whence then hast thou that living water? Art thou greater than our father Jacob, which gave us the well, and drank thereof himself, and his sons, and his cattle? Jesus answered and said unto her, Every one that drinketh of this water shall thirst again: but whosoever drinketh of the water that I shall give him shall never thirst; but the water that I shall give him shall become in him a well of water springing up unto eternal life. The woman saith unto him, Sir, give me this water, that I thirst not, neither come all the way hither to draw. Jesus saith unto her, Go, call thy husband, and come hither. The woman answered and said unto him, I have no husband. Jesus saith unto her, Thou

saidst well, I have no husband: for thou hast had five husbands; and he whom thou now hast is not thy husband: this hast thou said truly. The woman saith unto him, Sir, I perceive that thou art a prophet."

(2) The Robber of Khagan, in Tales of Travel, by the Marquess Curzon of Kedleston.

"On the second night we camped on a grassy slope just outside the principal village of Khagan. My own little Kabul tent was placed on the left side of the miniature terrace, and just above it was pitched the large tent of the Gurkha escort, four of whom were to be on duty by day and the remainder by night.

"Tired out by my long day's ride, I ate my simple dinner in the little tent, and after writing my diary, went to bed between ten and eleven. The bed consisted of a leather roll stretched on rings between the two yakduns or leather trunks, which are the most serviceable form of travelling baggage in those regions. Slung on mule-back in the day time, they serve both as packing cases, seat, and bedstead in the tent at night. I had placed the bed against the left-hand canvas of the tent, the open space in the centre and on the right being occupied with my saddle and holsters and the whole of my kit, lying in a litter on the floor. The Gurkha guards were presumably posted outside the tent.

"Soon after midnight I woke, not with a start, but with the consciousness of which I had often read, though I had never before experienced it, that I was not alone in the tent. The darkness was black as pitch and thick as velvet: and though I listened intently without moving a muscle, I heard no sound. Half unconsciously I put out my left hand and dropped it between the bed and the canvas wall of the tent which the bed all but touched. It fell plumb, as though my fingers had alighted upon a billiard ball, on the shaven head of a man. I could feel the prickle of the sprouting hair against my palm. But in the same moment the object slid out of my grasp and a rustle indicated the stealthy withdrawal of the intruder. By this time I was wide awake. Springing up, I struck a match, seized my revolver, and dashed in my pyjamas out of the tent shouting to the Gurkhas as I emerged. Not a

man was to be seen. I rushed up the short slope to the guard tent and tore aside the flap. The eight guards were all lying fast asleep on the ground."

I doubt whether anyone can improve Curzon's third paragraph; his economy of words conveys to the reader the speed of the actual incident. A drastic critic might say "Cut out the second paragraph altogether." However, this passage has considerable psycho-analytic value. Curzon was excessively particular, or, to use a shorter word, fussy, about domestic details, even at times

when he was concerned with the greatest affairs of the world. When changing his residence he would spend hours in making up parcels of cushions, antimacassars, and so on in the presence of a senior member of the political secretariat whom he had summoned to assist him; this person was allowed to do no more than place his finger upon each knot as the Marquess tied it.

A peculiarly vivid picture of two persons, namely Curzon and his intemperate butler, is to be found in Harold Nicolson's book, "Some People."

BULLSEYE

By ALAN TOIS

THE American Civil War produced emancipation of the slaves, Abraham Lincoln, and the best story mother ever heard. The tale was reported by the *American Medical Weekly*, the *Lancet*, and by Gould and Pyle. It runs as follows:

On a hot May morning in 1863 a battle was going on in Missouri round the residence of a fine Southern lady and her two daughters, who were aged fifteen and seventeen. Moved by patriotism and basic feminine instincts the trio were ministering to the wounds of their countrymen, all of whom were having a pretty thin time of it just then. A handsome and gallant young man who lived nearby had also plunged bravely into the fray, only to be brought down, very conveniently, at the compassionate ladies' doorstep. At the same moment a scream rang out from the house, and examination revealed a bullet had carried away the left testicle of the valiant irregular and gone on to pierce the lower abdomen of the elder young lady.

The daughter suffered an attack of peritonitis from which she recovered after two

months' treatment, but the bullet was never retrieved from her body. Now, just 278 days after the receipt of her wound the young woman was, to her considerable surprise, delivered successfully of an eight-pound boy. This naturally caused a bit of a stir among the family, but the innocent young mother protested that no one could be more amazed than herself, which is a fairly logical observation. Then, three weeks after this unheralded parturition, the doctor noticed a hard mass in the child's scrotum. He operated and extracted—by God he did!—the battered bullet.

The story, I am glad to say, had a happy ending. The young man recovered, and was introduced to the lady. As the child grew up it rapidly became obvious it was the split image of himself. And, capital chap that he was, he did the decent and married the girl. They had two other children, but didn't use bullets.

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ABERNETHIAN SOCIETY

The remaining meetings to be held this year are:—

November 10. Film: "Poliomyelitis—Diagnosis and Management."

November 17. Professor J. W. S. Blacklock—"Some Problems in the Pathology of Tuberculosis."

December 1. Mr. Reginald M. Vick—"A New Robe for Rahere."

Meetings will be at 5.30 p.m. on November 10, in Anatomy Lecture Theatre, Charterhouse Square, and on November 17 and December 1 in Clinical Lecture Theatre at the Hospital.

OBITUARY

VALERIE LIVINGSTONE

On September 9, 1949, a tragic accident robbed Bart.'s of a charming and noble character.

Valerie Livingstone had only been with us for 2½ years, but it needed a much shorter acquaintance than that to demonstrate the excellence of her personality.

It is very rare to discover in one so young a combination of cheerfulness, generosity, intelligence, an unimpeachable veracity, and, predominantly, a simplicity that carried all before it: she was wise beyond her years.

Twenty-one years is a very short span; yet, during that time, Valerie had seen more of the lands beyond the seas than many who have lived four times as long: to travel, and to see as much as possible, was one of her great ambitions. Amongst the places that she loved the most was the South of France, and it is there, in a quiet, sunlit cemetery near a tiny village facing the Pyrenees she is laid to rest.

To her friends and relations and, above all, to her parents, we extend our very deepest sympathy in their affliction. D. C.

SPORT

CRICKET CLUB

SUSSEX TOUR, 1949

A very enjoyable week was spent touring in the Brighton area in August this year, and the cricket played was more heartening than most we have had this season. There were five matches arranged, of which we won three, drew one and lost the other.

The side was captained by Moyes, who had a good time behind the wicket, making six stumpings, and taking two skied catches out of other people's less sizeable hands. He also played an invaluable innings against Barcombe, his eventual dismissal being rather unsatisfactory. Tomlinson was the most successful batsman, though even more temperamental than usual.

Aubin and Whitting opened the attack in all the games, though the former must be the teams most unlucky bowler this year. On tour, he was in great form with the bat. Whitting showed great improvement, though still too erratic at times. The "spin-attack" of Clappen and Haigh proved more than once a winning combination. At last, as they said, they had wickets giving them some help. Clappen was the most prolific wicket taker, and, in addition, twice made runs when they were sorely needed. Waterhouse was the most successful of the other batsmen, but Biddell, Chapman, Ross and May all fielded splendidly, and the last named was the outstanding social success of the tour.

RESULTS

August 9, v. Littlehampton C.C.

Lost by 4 wickets
St. Bart.'s: 125.
Littlehampton: 126 for 6.

August 10, v. Lindfield C.C.

Won by 3 wickets
Lindfield: 122. (P. G. Haigh 4 for 21. J. A. Clappen 4 for 39.)
St. Bart.'s: 123 for 7. (J. D. W. Tomlinson 45. J. A. Clappen 39 not out.)

August 11, v. Rottingdean C.C.

Match drawn
Rottingdean: 159 for 8 dec. (J. A. Clappen 4 for 59.)
St. Bart.'s: 142 for 9 (J. D. W. Tomlinson 65.)

August 12, v. Barcombe XI

Won by 130 runs
St. Bart.'s: 214 (J. A. Clappen 68. D. F. A. Aubin 47.)
Barcombe: 84 (J. A. Clappen 6 for 21.)

August 14, v. Chailey C.C.

Won by 5 wickets
Chailey: 63 (J. A. Clappen 7 for 10.)
St. Bart.'s: 64 for 5 (D. F. A. Aubin 28 not out.)

Sunday, August 21, v. Foreign Office C.C.

Match drawn
Foreign Office: 188 (B. Arthur 8 for 48).
St. Bart.'s: 179 for 8 (J. D. W. Tomlinson 97 not out. R. Odium 34).

Saturday, August 27, v. Hornsey C.C.

Match drawn
St. Bart.'s: 162 (J. D. W. Tomlinson 61. R. Odium 47 not out).
Hornsey: 108 for 7 (P. Train 3 for 17).

Sunday, September 4, v. H.Q. Eastern Command C.C.

Match drawn
H.Q. Eastern Command: 277 for 5 dec.
St. Bart.'s: 178 for 8 (M. Braimbridge 50.)

Saturday, September 10, v. Barking C.C.

Match drawn
St. Bart.'s: 193 for 4 dec. (M. Braimbridge 90. J. P. Waterhouse 61 not out.)
Barking: 116 for 6 (J. A. Clappen 3 for 33.)

Sunday, September 11, v. Finchley C.C.

Lost by 68 runs
Finchley: 149 (B. Arthur 5 for 48. J. A. Clappen 4 for 27.)
St. Bart.'s: 81.

BATTING AVERAGES, 1949

Qualification—10 Innings

	Runs	Innings	N.O.	Highest Score	Average
J. D. W. Tomlinson	1,162	25	6	161*	61.2
M. Braimbridge	600	15	0	95	40.0
J. A. Clappen	621	28	4	70*	25.9
D. F. A. Aubin	227	14	3	47	20.6
H. B. Ross	368	22	1	80	17.8
A. B. May	395	25	2	118	17.1
J. P. Waterhouse	245	20	2	61*	13.6
P. B. Biddell	260	19	0	38	13.4
P. D. Moyes	261	24	2	55	11.9
H. W. Whitting	134	13	1	66	11.2
P. G. Haigh	180	27	7	36*	9.0

* Not out

BOWLING AVERAGES, 1949

Qualification—100 Overs

	Overs	M.	Wickets	Runs	Average
J. A. Clappen	325	52	70	1,071	15.3
P. G. Haigh	344	58	66	1,127	17.0
J. D. W. Tomlinson	134	31	24	490	20.5
H. B. Ross	105	12	15	398	26.5
D. F. A. Aubin	162	28	15	523	34.9

RUGBY CLUB

The trials commenced on September 10, under brilliant skies and on a very hard ground. Good turn-outs have been the rule, the players being mostly clinical students, augmented by a few keen Pre-clinicals living near London. The full strength team cannot be composed until after October 1, when the new term starts.

1st XV v. R.E.M.E. Arborfield. Away. September 24.

WON 31-3.

The scoring was opened for Bart.'s after ten minutes play by a good run by Corbet, whose try was converted by Murphy. The latter himself scored a try towards the end of the first half, and the teams crossed over at 8-0. The forwards were not settling down in the set scrums, but did good work in both dribbling and short passing movements.

The backs were slow in reaching their man but the tackling was a great improvement on last year.

In the second half, tries were scored by Heylings (2), Moyes, Wynne-Jones, Corbet, Mathews and Dick. John converted one of these.

1st XV v. Woodford. Home. October 1

LOST 3-17.

This was a good game, and we were given an opportunity to learn from our mistakes. Woodford had the advantage of all-round weight and the extra fitness brought about by more match play. The ground was hard and our backs handled the lively ball well, twice in the first half they all but scored. The forwards were allowing their opponents to beat them in the line-outs, and must learn to drop on the loose ball. The half-time score was 0-11 against us, and at the beginning of the second half Bart.'s attacked strongly. Woodford made good use of their full-back in attack, thus producing an invaluable "extra man" in their line. Bart.'s were rewarded with a grand try by John, who also showed us the value of charging down an opponents place

kick. Woodford, however, kept up the pressure and scored another try in the last minute. The Bart.'s team showed great promise, and we hope will do better in future.

A scratch "A" team game was arranged with Saracen "A," who defeated us after a hard-fought game by 6 points to 3.

A record number of season tickets have been sold this year, which we hope is an indication of good support at Chislehurst by all members and friends of Bart.'s.

GOLF CLUB

An 18-hole bogey competition for the Sir Girling Ball Trophy was held at Addington Palace on Wednesday, August 24. The winner was M. Braimbridge (16) who returned a score of 3 up. L. R. H. Gracey (1) was runner-up with 2 up. An 18-hole medal competition for the Hospital Challenge Cup was held at Crew's Hill on Wednesday, September 14. It was won by R. V. Fiddian, who went round in the fine score of 75. The best handicap return was by C. J. R. Elliott (16) with a 70.

In matches the team made a poor start to the season. The standard of play has improved considerably, however, and by beating St. Mary's Hospital after a close struggle we have now reached the final of the inter-Hospital Beveridge Cup. Our opponents in the final are the holders, Guy's Hospital. The match will be played on Wednesday, October 26, at Addington Palace Golf Club.

Evidence of the improved standard of play is shown by the fact that three players have represented London University during the season. They are D. R. Rushton, R. V. Fiddian and L. R. H. Gracey. The latter has been elected Captain of the University Golf Club for the present season.

L. Gracey, Secretary of the Bart.'s Golf Club, was leading amateur in the Warwickshire Open Championship with rounds of 74 and 71.

ATHLETIC CLUB

At the close of the Athletic Season I would like to commend the Hospital athletes particularly on their success and their bearing in the Inter-Hospital Sports. Their decisive victory was the work of a good team, well trained, and admirably led by their Captain. It was most stimulating to see every man in that team go out from the start of each event to perform his task with confidence and courage.

The shield was won not by the work of one or two individuals but by those who fought tenaciously for the other places. We have our athletic giants of whom we are justly pleased and proud and we also salute and admire the others who form the main body of the team.

H. B. Stallard

EXAMINATION RESULTS
UNIVERSITY OF LONDON

First Examination

September, 1949

Physiology

Hill, A. N.	Stathers, D. N.	Watmough, G. C.
Pharmacology		
Bapty, A. A.	Cookson, T. S.	Husainee, M. M.
Birch, G.	Farley, J. D.	Jones, R. F.
Chuck, V. R.	Frears, R. E.	Lumley, P. W.
Clulow, G. E.	Fuller, A. P.	Montagnon, J. L.

Scott, A. E. R.
Shah, M. C.
Taylor, J.
Waterhouse, J. P.
Watson, L. P. E.

Special First Examination for Medical Degrees

June, 1949

Bashford, A. E.	Foy, B. N.	MacDonald, A. H.	Smith, M. G.
Castle, W. B.	Gampell, B. I.	Meredith, H. D.	Tamlyn, G. W.
Clements, R. D.	Gardiner, A. B.	Murrell, J. S.	Wadge, D. A.
Copplestone, J. F.	Gray, A. I.	Norbury, K. E. A.	Weir, D. A. D.
Cree, J. E.	Hurst, R. B.	Reid, A. L. A.	Wooding, D. F. P.
Ellison, C.	Lloyd, A. G.	Sanford, W.	Young, S. J.

The following External Candidate has completed exemption from First Medical:—
Wilkinson, D.

Special Second Examination for Medical Degree

July, 1949

Cochrane, R. C.	Harwood, K. A.	Mackinnon, K. E.	Small, G. I.
Cookson, T. S.	Heckford, J.	Maskell, J. F. A.	Stanford, R. M.
Corbet, J. L. M.	Hooker, D.	Nash, D. J. R. F.	Stoke, J. C. J.
Davies, J. R. E.	Hughes, K. R.	Ross, H. B.	Tabor, A. M.
Eastwood, J. J. H.	Huxley-Williams, P. L.	Ryan, A. M.	Taylor, M. G.
Elliott, C. J. R.	Jones, H. S.	Ryan, J. F.	Thomas, H. A. J.
Gompertz, R. M. H.	Lodge, A. B.	Scott, H. G.	Wilson, L. J. C.
Goode, J. H.	McKerrow, M. B.	Shire, G. M.	Wyner, S. E. A.

M.D. Examination

July, 1949

Branch I (Medicine)			
Bennett, D. H.	Bunje, H. W.	Harris-Jones, J. N.	Pranker, T. A. J.
Boyle, A. C.	Grimson, T. A.	Pitman, R. G.	(University Medal)
			Thorne, N. A.

Branch II (Pathology)

Linsell, W. D.

Branch III (Psychological Medicine)

Rey, J. H.

SOCIETY OF APOTHECARIES

Diploma in Industrial Health

July, 1949

Mathew, G. G.
Final Examination

Medicine

Giri, G. A. R.

August, 1949

The following candidate, having completed the Final examination, is granted the Diploma of the Society:—

Giri, G. A. R.

CONJOINT BOARD

Pre-Medical Examination

September, 1949

Physics

Menage, J. A.

BOOK REVIEWS

BAILEY'S TEXT-BOOK OF HISTOLOGY, edited by Philip E. Smith and Wilfred M. Copenhaver. Bailliere, Tindall & Cox, 1949. 12th edition. Pp. xix + 781, 455 illus. Price 38s. 6d.

Glancing through this well-known work, whose first edition was published in 1904, one is forcibly reminded of the painstaking work through the centuries by microscopists, using far inferior instruments to those we use to-day, in piecing together the finer anatomy of animals and plants. The discovery of the microscope is now ascribed to Zacharius Janssen in about the year 1590. During the next 100 years the early workers, notably Marcello Malpighi and Antonj van Leeuwenhoek, had described an enormous quantity of microscopic structure. With the improvement in the instrument came an ever-increasing body of detail, in particular that of intracellular anatomy. The earlier chapters of this book, which deal with the general features of cells and the methods of studying them are particularly good. The illustrations throughout the book are clear and far nearer the picture that one sees down the microscope than one is used to finding in Histological textbooks. To the English reader the slight differences in terminology used in America are at first disconcerting, especially with reference to blood formation. But the descriptive writing and the illustrations are so good that the continued popularity of this work is assured.

AIDS TO FEVERS FOR NURSES, by Joyce M. Watson. Bailliere, Tindall & Cox, pp. xii + 388. Price 5s.

The title of this book is little guide to its contents, which include the infectious skin conditions, pre- and post-operative nursing principles, surgical infections, many general nursing procedures, and a few odd items like the care of the baby at delivery. Venereal diseases are disposed of in six pages. However, the nurse who buys this book gets nearly four hundred pages of information for five shillings.

W. H.

AIDS TO TUBERCULOSIS NURSING, by L. E. Houghton and T. Holmes Sellors. 3rd edition. Bailliere, Tindall & Cox, 1949, pp. xii + 269. Price 5s.

This is a good little book on tuberculosis, touching all aspects of the disease, and written in a sincere and straightforward style. The only obvious omission is reference to the Gaffky count.

W. H.

AIDS TO THE NURSING OF VENEREAL DISEASES, by E. M. Ryle-Horwood. Bailliere, Tindall & Cox, 1949, pp. xi + 132. Price 5s.

This book has 123 pages, of which 39 are used to list all the places in England where treatment for venereal disease is given. As even an elementary textbook for nurses it is valueless, because of the total omission of any description of tertiary syphilis.

W. H.

A TEXTBOOK OF MEDICINE FOR NURSES, by E. Noble Chamberlain. Oxford Medical Publications, 1949. 5th edition, pp. xiv + 491. Price 21s.

Nurses always liked this book, and it has been out of date so long that it is pleasant to see this

new edition, well produced and easy to handle. There is a good section on the neuroses. It is still conservative in outlook, devoting as much space to movable kidney as to chronic nephritis. W. H.

SURGERY FOR NURSES, by James Kemble. Simpkin Marshall, pp. xvi + 348. Price 21s.

Mr. Kemble has an excellent idea of what the nurse needs, and a clear and business-like style. Sometimes brevity is allowed precedence over clarity, as when he states that in Rammstedt's operation "the . . . sphincter muscle is cut across," and when he puts the glioma without comment among the innocent tumours. Some statements would not be acceptable here, such as the retaining of the patient in Fowler's position by a knee pillow secured to the bed, or advocating getting up 10 to 21 days after an abdominal operation, or the use of a radiant heat bath for shock. The book is well produced and pleasant to handle.

W. H.

TREATMENT BY MANIPULATION, by A. G. Timbrell Fisher, M.C. 5th edition. Lewis, 1948, pp. 275. Price 25s.

The fifth edition of this well-known volume includes much new material and additional illustrations. It lays particular stress on the approach to the problem of rheumatic diseases, and, if manipulation as described in this volume is really a help to those crippled by rheumatoid arthritis, then a valuable contribution has been added to the treatment of this discouraging condition.

The criticism applies to this book, as to most monographs on manipulation, that it seems to place it in a watertight compartment, divorced from Orthopaedics and Medicine as a whole. It is based on the soundest anatomical principles, however, and fills a gap which ordinary hospital teaching leaves in the knowledge of most students.

COMMUNICABLE DISEASES AND THEIR NURSING CARE, by Evelyn Pearce. Faber & Faber, pp. 392. Price 14s. 6d.

Miss Pearce has written a comprehensive account of the infectious diseases, and the recent advances in the chemotherapy of these conditions are well shown. Some old-fashioned material has, however, been retained, as about the treatment of nephritis on pages 109 and 164, and the use of castor oil in the management of typhoid fever. The public health and preventive aspects of the communicable diseases are given the prominence they deserve.

BLOOD TRANSFUSION, edited by Geoffrey Keynes. John Wright, 1949, pp. xii + 574. Price 52s. 6d.

As the editor explains in his preface, the increase of knowledge in recent years has made it impossible for one author to cover the field of blood transfusion completely, though he did this himself as lately as 1922. Now, he has chosen experts to write within their own experience, and has introduced them with an admirable historical chapter. Dr. Bodley Scott writes on the Indications and Complications, and Dr. Brewer on the Blood Groups, the Blood Donor, and the Organisation of a Hospital Transfusion Department. The other chapters—on the London Blood Transfusion Service; Technique; Transfusion in

Infancy; Storage and Preservation; and Derivatives and Substitutes—are written respectively by F. W. Mills, Anthony Till, Professor Richard Ellis, Sir Lionel Whitby, and R. I. N. Greaves.

The achievement is commensurate with the plan. This is a complete textbook of blood transfusion, setting out modern practice along with its historical development, and giving all the important references to the literature. The only faults to be found are the few printing errors that seem to be inseparable from post-war book production, and must be regretted in such a well-made volume, which is a credit to editor, contributors and publisher.

ANÆSTHETICS FOR MEDICAL STUDENTS, by Gordon Ostlere. Churchill, 1949, pp. 108. Price 3s. 6d.

Each speciality in medicine demands the lion's share of a student's attention, and none of them deserves it. The books by which they are taught should accordingly be brief, dogmatic, and readable; not textbooks for reference. This new manual succeeds entirely in presenting the essentials of practical anaesthesia to the student, without frills of style or content. The methods described are those of present practice, and the author wisely concentrates on the thiopentone-gas-oxygen-ether sequence. He is careful to elucidate the signs by which the progress of anaesthesia can be judged; and he sets out the difficulties and complications.

This is a short and practical book, written in a conversational manner, and can be recommended to all students.

THE RHESUS FACTOR, by G. Fulton Roberts. 2nd edition. Heinemann, 1949, pp. 64. Price 3s. 6d.

The first impression of this little book went through five impressions in fifteen months, and the pace of recent advance has now made a revision necessary. The subject is complex from the research point of view, but relatively simple for the clinician. The author explains it clearly, with illustrative case histories. He gives a good account of the theory dependent on the Fisher nomenclature, which might well be more generally used. Any who find the Rhesus factor puzzling, and all who have to do with childbirth or transfusion, will find this book useful.

AIDS TO FORENSIC MEDICINE AND TOXICOLOGY, by J. H. Ryffel. 12th Edition. Baillière, Tindall & Cox. 1949, pp. x+170. Price 4s. 6d.

The textbooks of "Forensic" are not all so long that a condensation is necessary, though a good summary of such an easily defined subject would be welcome. In the case of this book, readability has been sacrificed to brevity, nor has the clarity that is born of analysis and tabulation been achieved. However, like all the "Aids" series, it will no doubt prove useful and popular.

A COMPANION IN SURGICAL STUDIES, by Professor Ian Aird. Edinburgh. E. & S. Livingstone, pp. 1.060. Price 63s.

It would be impossible to praise too highly this product of Professor Aird's surgical erudition, indefatigable industry, and literary skill. With the discernment of an experienced teacher, and the gift of lucid exposition he goes straight to the heart of most if not all of the difficulties which beset the surgical trainee, and gives him all the material aid

he needs to overcome them. To most of the problems the text supplies the whole answer, but to clear up any residue of doubt and to stimulate further study, numerous references are provided which will be recognised by anyone familiar with the special subject under review as the most up-to-date and the most likely to serve their purpose. It is this ability to maintain such a fine discrimination over so wide a field of surgery which must evoke the admiration and the gratitude of the reader.

The work is not intended for the undergraduate who is already well supplied with textbooks on surgery. Those who are studying for the higher surgical qualifications know how difficult it is to find a single textbook to cover the greater part of their reading at the proper level, and they are driven to consult monographs which they have neither the time nor the inclination to digest; it is to them that Professor Aird's "Companion" will be particularly welcome. It is true that even this does not cover all the surgical specialities, the most important omission from the point of view of the trainee in general surgery being orthopaedics and fractures. It must be generally agreed, however, that an adequate survey of these subjects would have added unduly to the bulk of the book, and in fact the advanced student must be prepared to make them a special study. Neurosurgery and Thoracic surgery are included, and there are many references to Plastic Surgery. The attractive literary style is so clear that illustrations have proved unnecessary; indeed it is only in the account of plastic operations that the lack of these aids to description is noticeable. The surgery of the eye, of the ear, nose and throat, and gynaecological surgery are mentioned only in their relationship to general surgery, and no attempt is made to deal with these subjects in detail.

The presentation of every subject is masterly, founded upon the pre-clinical sciences and leading up to a description of methods of treatment and an assessment of their value which is based upon well-considered personal experience and a knowledge of the experience of others. It is a book which will soon become indispensable to the discriminating young surgeon, and has already proved its worth as a companion not only in surgical studies but also in surgical teaching.

J. P. R.

RECENT PAPERS BY BART'S MEN

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WINTER SPORTS

They say that a fine summer brings a hard winter; but it is early yet to judge of the saying's fulfilment. Perhaps the hottest and driest summer on record will be followed by an equally memorable winter: if so, we shall need snow-shoes in the Square, and there will be skating round the Fountain. Will the Thames freeze, smooth and thick, from source to estuary? There could be no restoration to-day of the almost mythological custom of roasting oxen on the ice.

Each season has its joys, and the mist-wreathed colours of autumn are the herald of many pleasures. The greatest glory of winter is snow. Snow, even in a town, conceals dirt and ugliness, and reveals beauties of form otherwise only apprehended by moonlight. In the countryside it is the magician's wand. Bleak mud and leaveless trees dissolve behind a veil of snowflakes—their intricate masterpieces of design—and emerge again transfigured. All is lighter, simpler, even purer, as though a ritual asceticism were preparing for the riot of spring.

Mountains are the real home of snow. In the Alps and the Dolomites, the Caucasus and the Himalayas, snow is a living part of the scene. And yet it is a bare half-century since men learnt to use the snow-fields. They had been admired by tourists, cursed by travellers, and overcome by armies; and the Norwegians had practised the technique of moving across them on long flat boards: but the idea of ski-ing for pleasure was born in the minds of a few Englishmen in Switzerland in the 'nineties. From their first hesitant experiments a form of sport has grown which is second to none. Not just the open air, but the most invigorating air is its element, and

that eternally delightful contrast of hot sun on snow. The thrill of speed is doubled by the knowledge that the body alone is its own instrument and vehicle: no noise of petrol engine, nor complexity of apparatus. Physical co-ordination is required, and develops to become a joy in itself. Nor do the simpler bodily needs go unsatisfied. Mountain peoples are famous for good eating and drinking, and they are exemplars of hospitality.

We have no mountains in England, and little snow, and our winter pastimes must be different. But who shall call them less attractive? The huntsman's scarlet coat will never disappear while men retain the instinct of the chase; and the game-bag will still be filled by poachers when there are no more big shoots. Thousand upon thousand of city folk will crowd the football grounds on Saturday afternoons, to admire and criticise the skill of 23 professionals; and millions hold summer wasteful for its lack of football pools.

At Christmas, tradition comes into its own, and the family, the foundation stone of democracy, unites to solemnise in church and home the winter solstice. The children enjoy it thoroughly. Their parents are more likely to make good resolutions, and to forget them in time to repeat themselves the following year. On all sides there is good-will, and an increased incidence of dyspepsia.

And after Christmas, there are three months of winter still to go. Three months of rain and cold, of chilblains and pneumonia. Perhaps after all the French are more realistic, in a phrase designed for all the seasons: *L'amour fait passer le temps: le temps fait passer l'amour*.

SKI-ING INJURIES

By E. D. VERE NICOLL

AS another winter sports season approaches, it may be of interest to those who will be lucky enough to take a holiday in the Alps, to review some of the commoner ski-ing accidents, and to outline the treatment of those injuries most likely to occur. My own initiation to this exhilarating sport was in a village in the Alberg, in 1936, called Lech, since when I have never ceased to try to engineer visits to the Alps. I was privileged in 1945 to command a small military hospital in Cortina d'Ampezzo, in the Dolomites, where for five months we provided hospital treatment at a winter sports centre for the Allied Central Mediterranean Forces. A very high proportion of the visitors to this holiday resort stayed for only a week and most were complete novices. Between five and ten per cent. required hospital treatment for injuries sustained.

Apart from the Scottish Ski Club there are no reliable facilities for ski-ing in these islands, although I believe Derbyshire frequently supplies good sport. However, most Englishmen who decide to spend a winter holiday in the Alps have never skied before, and go out to Switzerland with the one idea of cramming the maximum amount of ski-ing into two or three weeks. Here lies the danger, for if you overdo it in the first few days, however capable a skier you are, you are much more likely to come to grief than if you allow a few days to get acclimatised and to get your muscles into good trim on the nursery slopes. Englishmen are always at a disadvantage in this respect. I remember with what pride I first managed to execute what I fondly believed to be a Christiania without a fall, when suddenly from behind came a high-pitched "Achtung!" as several minute Austrian children came past in a cloud of powder snow with little flat boards strapped to their feet. These were no novices, ski-ing was as natural a way of getting around as walking.

A distinguished member of the staff of this hospital once described to me in vivid tones how after doing one or two runs at Davos on his first day, he was met by an old friend who persuaded him against his better judgment to do just one last run before the light failed. All went well for the first few hundred yards until he began to realise how tired he felt,

and at the next moment he caught an edge and fell head-long. After picking himself up and shaking the snow out of his face and hair he gingerly proceeded on his way, but alas, his legs seemed to be incapable of doing what he wanted, and from then on was a constant succession of falls for no apparent reason. Horrible thoughts crept into his mind. What would it be like to find he had broken his leg, and would he have to wait in the cold snow till the Swiss Guides came to rescue him? Perhaps they would not be able to find him in the failing light! Eventually, however, he reached his hotel still more or less intact. Next morning, however, he was so stiff and covered in bruises that he was forced to roll out of bed on to his hands and knees.

In Cortina, which is rather low compared with most ski-ing resorts, and where most of the ski-ing is done on beaten tracks or "pistes," it was found that the number of cases coming to hospital was much greater when the snow was wet or icy than when the more ideal powder snow prevailed. With heavy, wet snow the ski gets stuck easily and sprained knees and ankles are common. With icy conditions there is a relatively higher proportion of more serious accidents with more injuries of the upper limbs.

Sprained Ankle. Sprained ankles, one of the commonest injuries, are frequently the result of awkward falls when trying to execute the "snow plough" and the "stem turn." With the knees bent, the ski are made to slide over the snow with their tips together and their heels wide apart, with the outer edges of the ski slightly raised, thus checking the forward progress of the skier. This manoeuvre can be turned into the "stem turn" by shifting the weight on to one ski and rotating the shoulders towards the opposite side; the ski with the weight on it then becomes the downhill ski. During these manoeuvres it is easy to catch an outside edge (particularly if steel edges are used), thus turning the foot into inversion, causing a partial or complete tear of the lateral ligament of the ankle. There is pain, tenderness and swelling over the lateral side of the ankle, maximal in front of or below the tip of the lateral malleolus. Severe cases should be X-rayed to exclude bone injury, and an antero-posterior view of

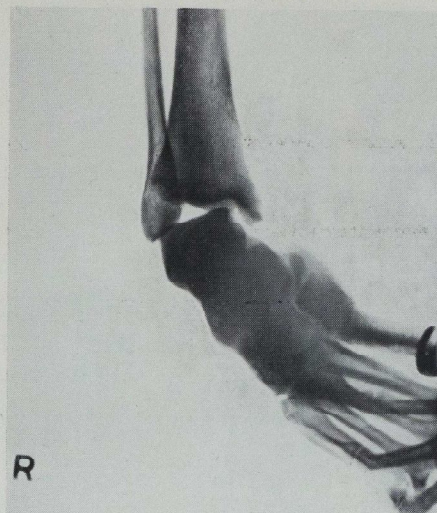


Fig. 1

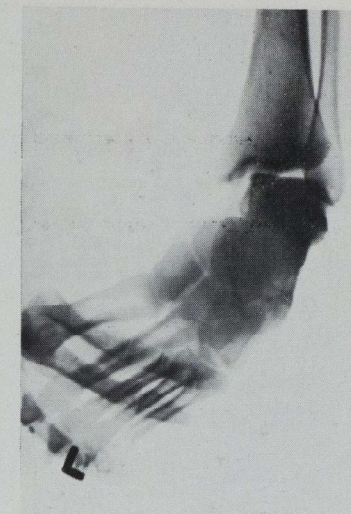


Fig. 2

both ankles in full inversion should be taken, if necessary under an anaesthetic, which may be local or general. If the lateral ligament of the ankle is ruptured the talus will tilt inwards (Fig. 1), whereas with a partial tear or sprain the talus will maintain its natural relationship with the tibio-fibular mortice (Fig. 2). A few people have rather mobile ankle joints and the talus may tilt on both sides.

Immediately following a severe sprain or fracture of the ankle, snow packs applied as a first-aid measure may hasten recovery by preventing excessive swelling. Subsequently the ankle is treated in strapping applied in such a way as to prevent full inversion. If very hairy, the leg is first shaved up to the knee, and then two-inch adhesive strapping (non-elastic) is applied in a "U" shape down the outer side of the leg, under the heel, and up to the same height on the inner side, with the foot at a right-angle and slightly everted (Figs. 3, 4). This is then covered by a continuous circular bandage of the same strapping, applied from above, down to the metatarsal phalangeal joints, making cuts across it at the ankle in order to make the turn without folds. If applied from above down, the edges do not get rolled up as socks are pulled over it. Severe sprains and complete rup-

A.P. View. Both Ankles in Inversion. This lady sprained her right ankle. There was marked tenderness and swelling over the lateral aspect maximal over the anterior band of the lateral ligament. These X-rays indicate a rupture of the lateral ligament.
(Photographs by kind permission of Mr. W. D. Coltart.)

tures of the lateral ligament should be treated in a plaster of paris cylinder extending from the tibial tubercle to the metatarsal heads and fitted with some form of walking rocker (Fig. 5). Some sprains will require this for two or three weeks and a complete rupture of the ligament should be treated in plaster for



Fig. 3



Fig. 4

six to eight weeks. Complete ruptures of the lateral ligament of the ankle are frequently missed and may give rise to a chronic recurrent dislocation of the ankle, which will require operative reconstruction of the lateral ligament.

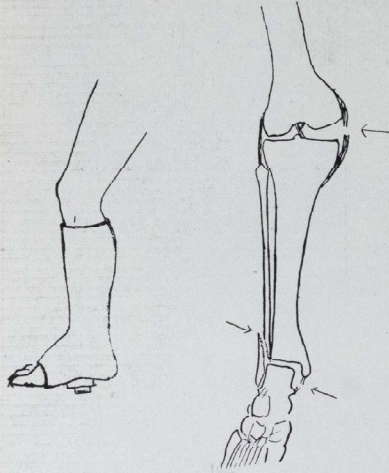


Fig. 5

Fig. 6

Sprained Knee. Sprain of the medial collateral ligament of the knee (the so-called "Swiss Kiss") is a very common skiing injury, and is frequently associated with a severe sprain of the ankle or fracture-dislocation of the ankle (Fig. 6). In these circumstances it may go unnoticed by the patient and his medical attendant while the more dramatic injury to the ankle is being dealt with. There is pain and tenderness over the medial collateral ligament of the knee, there may be some œdema here, and an effusion into the knee joint is common. Attempted passive abduction at the knee with the knee extended is very painful. If abduction is possible the ligament has been ruptured, but it must be remembered that some lateral mobility of the knee is also experienced with fracture of the tibial articular surface and X-rays must be taken to exclude this. These injuries to the knee joint may also be associated with rupture of the cruciate ligaments which will give increased antero-posterior laxity of the knee with the knee flexed to a right-angle. With rupture of the cruciate ligaments and frac-

tures extending into the knee joint there is usually a hæmartarosis and this, together with pain, may prevent manipulation of the knee in the acute stages for diagnostic purposes.

All injuries of the leg must be treated by active exercises to the quadriceps muscles. These muscles waste very rapidly, which will hinder recovery from an injury. Furthermore, a leg with a ruptured medial collateral or cruciate ligament of the knee can be made into a very strong and comparatively stable limb by development of the quadriceps muscles. Minor degrees of sprain of the medial collateral ligament can be treated with a crêpe bandage to the knee, and the inner side of the heel should be raised three-sixteenths of an inch. This makes a great difference to the comfort of walking. More severe sprains should be treated by applying a skin-tight plaster cylinder to the leg from the upper third of the thigh to just above the ankle.

Fractured Ankle. By far the commonest fracture in skiing is a fracture of the lateral malleolus. This fracture is usually an abduction or external rotation injury. It is important to examine the ankle on both sides, for there may be a fracture on one side and a rupture of the ligament on the other (Fig. 7), indicating that although there may be no displacement at the time of the X-ray, a fracture-dislocation or subluxation of the ankle joint has occurred and this is a much more severe injury than a simple fracture of the lateral malleolus without displacement, and requires longer treatment in plaster. Antero-posterior and lateral views of the



Fig. 7. A common skiing accident. External rotation injury to the ankle, with lateral subluxation of the talus. There must have been an injury to the medial ligament.



Fig. 8. Third degree fracture-dislocation of the ankle, with lateral displacement of the talus and malleoli.

ankle must be taken and an assessment of the fracture made. It is easy to miss minor lateral displacement of the talus and lateral malleolus in the common external rotation and abduction fractures (Fig. 8, 9); accurate antero-posterior and lateral X-rays must be available, and even minor degrees of lateral displacement of the talus must be reduced under anaesthesia and a plaster of paris cylinder applied from the tibial tubercle to the metatarsal heads, and an X-ray taken to confirm reduction. If the displacement has not been reduced there will usually be persistent swelling. Normally, however, the ankle will require replaster and check X-ray after about ten days, by which time the swelling will have subsided. X-rays are now taken at weekly intervals for four weeks to confirm the position. After about the fifth week it is safe to allow the patient to walk on the plaster, and some form of

walking heel should be applied. Most fracture dislocations of the ankle are firmly united in ten to twelve weeks, and the plaster may then be removed.

Fractures of the shafts of the Tibia and Fibula.

These fractures are less common than fractures of the ankle but contribute approximately 10 per cent. of all fractures sustained while skiing, and are likely to take the longest to unite. Some may be firmly united in three to four months, and some will still be ununited after six months and may require bone grafting. After reduction of the fracture the limb is encased in plaster of paris from the upper third of the thigh to the metatarsal heads with the knee slightly flexed and the foot at a right angle. When dealing with fractures of the shafts of long bones which require immobilisation it is always essential to immobilise the joints

above and below the fracture. A fracture of the shaft of the tibia should never be treated in a below-knee plaster, no matter how trivial the fracture appears to be. If displaced the fracture must be manipulated under anaesthesia with X-ray control. It may help to use Steinman's pins to exert traction on the lower fragment and it is better to put these through the lower tibial fragment than through the os calcis. Sometimes it will be of use to put another Steinman's pin through the upper fragment, and using this as counter traction manipulate the fracture on a Böhler's frame (Fig. 10).

When the fracture is in position the plaster may be applied incorporating the pins, or it may be applied in three pieces. The knee is put in plaster incorporating the upper pin,

the foot is then plastered incorporating the lower pin with the foot at 90° , leaving a gap between at the site of the fracture which is then manipulated and held in position by bandages acting as stays over the upper or lower fragment. When the fracture has been correctly reduced as regards alignment, angulation, and rotation the gap in the plaster is made good, and a final X-ray is taken in the theatre to confirm the position. The patient is now returned to the ward and the leg raised on a Braun's frame with about 5 lbs. traction on the lower fragment. X-rays are taken at weekly intervals for the first month, and a replaster under X-ray control will usually be required after two or three weeks as the plaster becomes loose owing to the swelling subsiding.

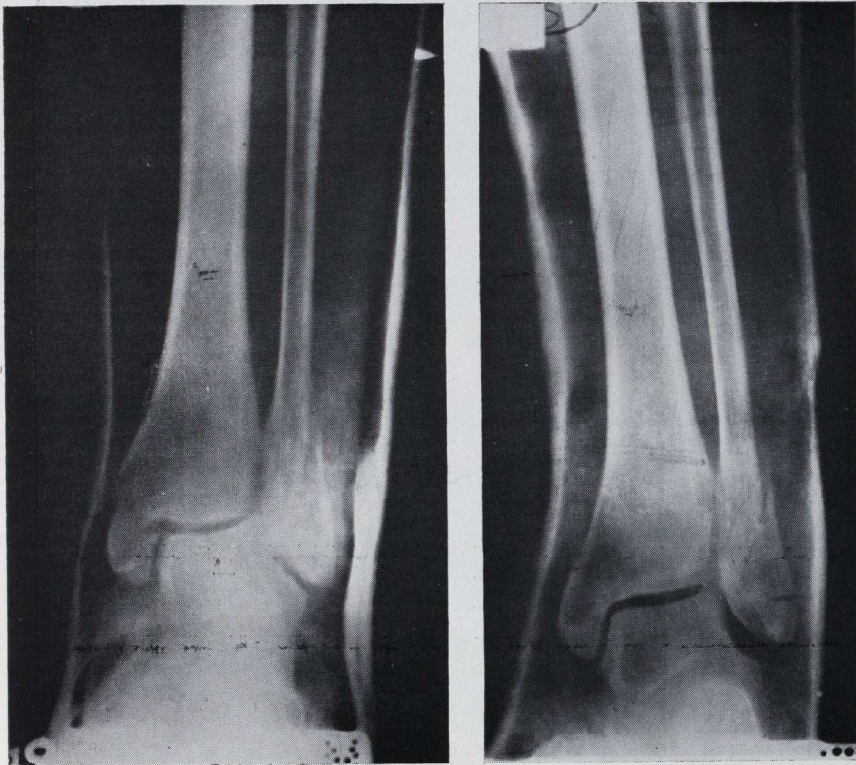


Fig. 9. The ankle has been manipulated and plaster applied, but the displacement persists (left). After a further attempt satisfactory reduction is obtained (right). Lateral views must also be taken, but have not been reproduced.

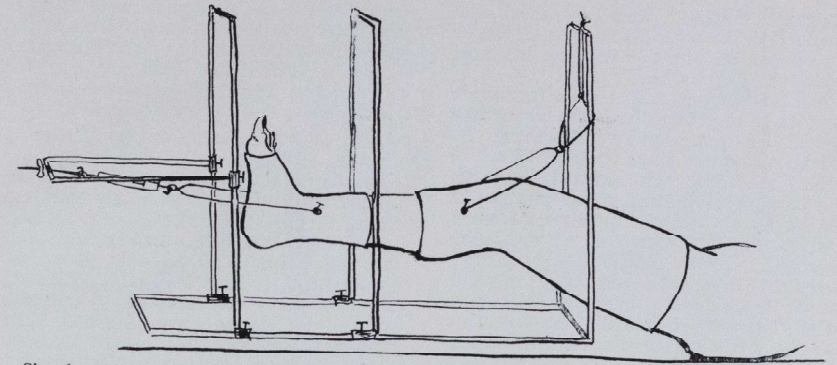


Fig. 10. **Böhler's Frame**
Skeletal traction and counter traction for reduction of a fracture of the middle third of the shaft of the tibia. Steinman's pins have been put through the upper and lower fragments and then incorporated in plaster of paris, leaving the side of the fracture bare. The fracture is now X-rayed, manipulated if necessary, and the plaster completed.

Simple oblique or spiral fractures of the shaft of the tibia, common in ski-ing, are very likely to displace and are difficult to hold in position even if two Steinman pins are used. These fractures are best treated by immediate open reduction and screw fixation (Fig. 11). One or two vitalium screws are placed across the fracture, and the leg is then encased in plaster until the fracture is united. This method makes anatomical reduction possible and reduces the time that it is necessary to keep the patient in hospital.

Fractures of the shaft of the fibula alone can usually be treated in strapping, elasto-plast or nothing. Some pain and discomfort is experienced when walking owing to the pull of muscles, but this bone is not a weight-bearing bone and unites readily if not



Fig. 11. **Spiral fracture of the shaft of the tibia.** The fracture of the fibula shaft is ignored, and an open reduction and screw fixation of the tibial shaft performed.

splinted. Similarly, when associated with fractures of the tibia, the fibula shaft can be ignored and the attention fixed on the more important tibial fracture.

While undergoing treatment for fractures it is of the utmost importance that the muscles should be prevented from wasting by exercises, and that joints not immobilised by splints should be exercised and frequently put through a full range of movements. In the leg for instance the quadriceps femoris and the hip and toes must be frequently exercised. These measures will prevent permanent stiffness or contractures and will hasten recovery, by shortening the time required to recover from the immobilisation and by improving the blood supply to the healing bone.

Other fractures of the lower limb:—Fractures of the femoral shaft and of the tibial condyles do occur but are uncommon, and crush fractures of the greater tuberosity of the femur (ski runner's hip) occur as the result of a fall on ice or the beaten snow of tracks and roads.

Fractures of the upper limb:—These are much less common in skiing than fractures of the lower limb, and in my experience constitute under five per cent. of all fractures. Some Continental authors give much higher figures, but I believe their cases probably included non-skiers falling on frozen roads, when fractures of the arm are extremely common, especially Colles fractures in women. Others, such as fractures of the neck of the humerus, the olecranon, and spiral fractures of the metacarpals are probably the commonest. Fractures of the metacarpals occur when the hand, gripping the ski stick, strikes the frozen snow as the skier falls.

Anterior compression fractures of the lumbar spine occur in ski jumping, but I have never seen one in ski running. Bruising or fracture of the coccyx is common and difficult to treat. Local anaesthetics may help, and the patient should be warned that pain or discomfort may be troublesome for some time, perhaps months, but that full recovery is to be expected. These patients find sitting on hard wooden chairs more comfortable than padded sprung easy chairs.

Dislocations:—Dislocations of joints are surgical emergencies that must be treated at the earliest possible moment. Reduction is easy within a few hours of the accident in most cases and is sometimes possible without

anaesthesia if the attempt is made at once. If left for twenty-four hours oedema of the synovium and surrounding structures makes reduction much more difficult, and if left for three or four days or longer, reduction may be impossible without open operation.

One of my assistants in the theatre at Cortina, an Italian who had helped the Germans in the same hospital before we arrived, was very sceptical of my ability to reduce a mid-tarsal dislocation, as he said the Germans had had a similar one which they had failed to reduce, even after continuous traction for several days. Actually my case was easily reduced at the first attempt by manual manipulation. The difference in the two cases was that we were able to deal with ours within a few hours of the accident occurring, whereas the Germans, no doubt, snowed under by the evacuation of battle casualties from a retreating army were unable to attempt reduction for several days.

Dislocation of the metacarpo-phalangeal joint of the thumb may occur if the wrist strap of the ski stick is twisted round the thumb (Fig. 12, 13). This is an extremely dangerous practice, for if the stick should get caught in a bush or on a stake, or under frozen crust, the whole of the skier's weight plus the momentum with which he is travelling comes on the thumb.

Other dislocations which may occur include the hip, temporo-mandibular joint, shoulder, elbow and carpal lunata. The latter may easily be missed on antero posterior X-ray but is apparent on the lateral view.

Wounds. Wounds caused by falling forwards onto the tips of the ski sometimes occur, and severe injuries to the eyes may result. Ski with sharp points or extra projections on the tips should not be used, or should be protected by rubber caps.

The sharp point of the ski stick may also cause unpleasant wounds, usually of other skiers, and the steel edges of ski are also a cause of injury. When dealing with wounds or compound fractures it must be remembered that many nursery slopes are on well manured ground, and especially if the snow is thin or in the spring when manure is actually being spread, the usual anti-tetanic serum must not be withheld under the mistaken idea that the wound will automatically be sterile.

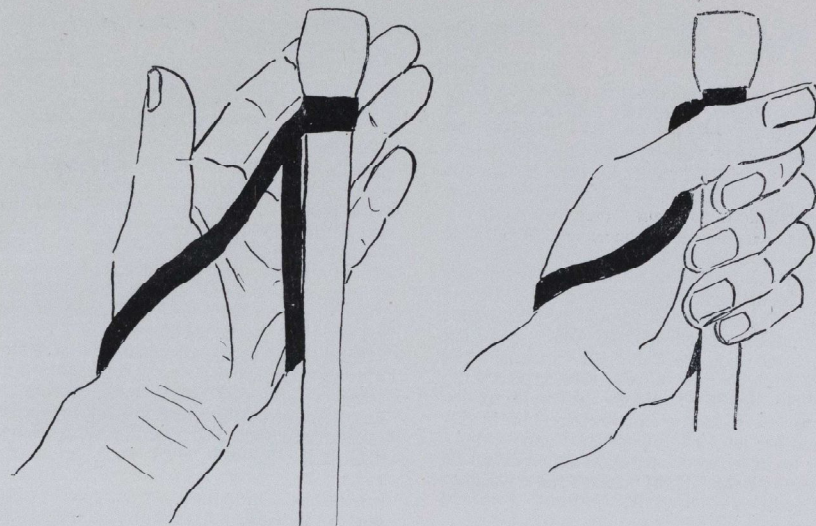
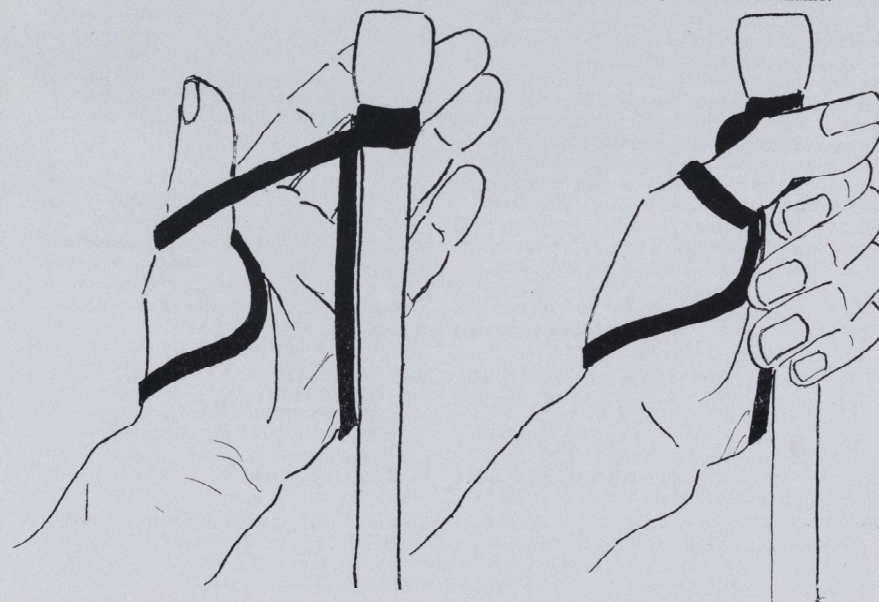


Fig. 12 (above). **The Right Way**

Fig. 13 (below). **The Wrong Way**
The wrist strap is too long and the slack has been taken up by winding it round the thumb.



First Aid. When a casualty occurs, the immediate difficulty is to get the injured skiers back to medical aid in the minimum time with the maximum degree of comfort. This service is extremely well organised in Switzerland, where I was once privileged to watch a lady being collected on a rescue sleigh. I was ski-ing down the Klosters run and came across a lady lying in the snow with a fractured femur. Her friend told me that their guide had gone ahead to arrange for a rescue sleigh to be brought. I had not waited for five minutes before a Swiss guide arrived at terrific speed with a sleigh behind him. With extraordinary skill he examined the patient, diagnosed the injury, gave her some tea from his knapsack, reassured her that she was now in good hands, placed her on the sleigh on which was an extension apparatus fixed to the sleigh, and having fixed her leg on this apparatus and wrapped her up in numerous blankets set off down the track with the help of another guide who had arrived.

In Cortina I had two months before the snow came to get to know the geography of the mountains, and after making a personal reconnaissance of all the ski runs with the British Ski Instructor and Signor Otto Menardi, the president of the Italian ski club, we made plans which worked very well in practice. With the help of the Royal Corps of Signals, telephones were laid onto various huts at the bottom of each run, and at other strategic places, bearing in mind the fact that it is always easier to go down rather than up to summon assistance, and easier to get the sleigh to the patient from above than from below. Rescue sleighs were left at strategic points with a minimum of first aid equipment which included a Thomas splint, Gouch

splinting, triangular bandages, shell dressings and a blanket.

All ski instructors, both British and Italian, were made familiar with the position and use of the equipment. When a casualty occurred the guide skied down to the telephone, summoned an ambulance from a central ambulance station, staffed by the Americans who were equipped with four-wheel drive ambulances, and then either telephoned the top of the run for another guide to bring down the sleigh or took a sleigh up to the patient, whichever was most convenient. Most guides are quite capable of carrying an injured man on their backs on ski, and this is what often happened in practice.

If on tour, local arrangements such as those described above are apt to break down. However it is possible to make a sort of sleigh out of one pair of ski for use on a hard surface such as ice or the beaten snow of a road; for soft snow such as is encountered on tours it is more difficult, and under these conditions two pairs of ski are required to make an efficient sleigh.

It is dangerous to ski alone, or to go off recognised runs without a guide, but it is quite possible to ski for years in all sorts of conditions of snow and never even sprain an ankle in spite of the most incredible falls in all kinds of positions.

I see from "Ski Notes and Queries," the periodical publication of the Ski Club of Great Britain, that Mr. R. I. Kiln claims to have one record which will not easily be beaten. During his second fortnight in Switzerland he broke a leg coming down the Hörnli Run at Arosa. By use of spares he was able to do two Carmenna runs after lunch, one in six minutes with no falls. A below-knee amputation has its compensations.

STUDENTS UNION BALL

The Students' Union Annual Ball will take place at the Dorchester Hotel on Friday, January 20, 8.30 p.m.—2. a.m. Tickets will be available shortly.

ROUND THE FOUNTAIN

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SIXTY YEARS ON

By W. G. W.

In the year 1889 I came into the wards of Bart.'s as House Physician to Sir Dyce Duckworth; in 1949 I have returned as a patient in a medical ward which is new to me. Although through my medical career I have naturally followed with interest changes and advances made, I was not prepared to see quite such notable alterations in the nature of the cases admitted, their treatment and progress.

The most evident change is in the type of case in the ward and in the lessened fatality. In 1889, of the 2,085 completed cases admitted to the medical wards, 383 were fatal. The patients suffered mainly from the following disorders, in order of frequency: endocarditis and other heart affections, pneumonia, bronchitis, pleurisy, rheumatic fever and rheumatism, acute nephritis and enteric fever (then admitted to the general wards). Forty-four admissions for anaemia or chlorosis were of young women mainly; the cases of "typhlitis" would now for the most part be in surgical wards and labelled appendicitis, and not as then treated by linseed-meal poultices! Aortic aneurysms were not uncommon and twenty-seven cases of hysteria and ten of rickets were admitted. Obviously, a general diagnosis was not difficult in such cases. From what I observe now from my bed, the majority of the cases are more complicated, are of more difficult diagnosis and though apparently not so ill, are as serious and difficult from the point of view of restoration to a normal condition. There are more patients out of bed for part of the day. In 1889 we made much use of the seventy beds for convalescents at Swanley.

Another conspicuous change is in the present-day use of mechanical aids to diagnosis and to a lesser extent to treatment. An entirely novel feature is the temporary disappearance from the ward of patients taken to special departments, particularly X-ray. We used to have a rudimentary sphygmograph, limited urine testing, mainly for the watching of the progress of nephritis patients, a microscope in each ward for counting of corpuscles in anaemia and observation of casts of tubules of the kidney—a very limited amount of bacteriology was commencing in phthisis and in enteric fever.

Blood pressure was judged without instruments. Our great instrument was the stethoscope and the classes in "Auscultation and Percussion" were most intense. In 1889, about one-third of the cases were of the heart and lungs, and most of the others involved the constant use of that instrument, and Dr. Gee was our great instructor. My own physician, Sir Dyce Duckworth, still used the wooden "trumpet," which fitted so well in the doctor's silk hat, but the double-tube pattern was in nearly universal use in 1889, so I had to use both forms.

One prominent feature of change in dieting is the total absence of beef tea, which used to be the staple diet of so many patients. There are "dieticians" now, specially engaged I believe, but I still lean to the ordering of each patient's diet by the physician himself, without intermediary.

A great change is obvious in treatment, both in its nature and application. Common odours in the ward in 1889 were those of linseed meal and of brandy. The latter was most useful in pneumonia and enteric fever and really was of great service.

Synthetic chemicals of great complexity seem to have ousted the old vegetable products so numerous in the old days and administration by hypodermic and other syringes has simplified matters. The use of mechanical forms of treatment is also a notable change, especially the periodical exercises and movements.

The fewer deaths and greater proportion of patients not in bed all day, conduce with the other present-day ward amenities to a much more cheerful ward atmosphere. The ward is a new one since my old days, admirably designed. My old wards, John, Elizabeth and Radcliffe have partly disappeared and the names of two at least lost. I find a ward orderly and two floor polishers doing the work which used to fall to the lot of junior nurses, a former useless and even harmful anomaly.

The great and dominating item of life in the ward, i.e., the nursing, has not changed in that the Bart.'s nurse remains, as of old, the best of all. The Sister, presiding genius, in some mysterious way seems to keep informed as to all the details affecting the welfare of each of the miscellaneous crowd

occupying the beds and is our friend and guide. The Staff Nurses have a similar intimate knowledge of our idiosyncrasies and so on through the assistants and probationers according to their respective responsibility. It is not possible adequately to express our appreciation of the unfailing kindness we receive. There are nursing changes, of course, for advantage has been taken of every advance in technique of nursing. I miss the old grey dress of the probationers, some of whom were known as "guinea-pigs," from the fact that they paid one guinea per week for six months for the privilege of being taken on to train! The present system of pre-ward training shows its value in the excellent treatment we receive. In 1889 the "raw" probationer had rather a "raw" deal.

On looking out of the ward window I see much change. The hospital entrance, the square and the fountain retain their charm, but I miss the crowd of men who thronged the square, especially just after lunch time. The occasional transit of a nurse was quite an event to the male population. Now, with the pre-clinical students at Charterhouse and part of the hospital in the country, the men are few and on the other hand the

A LETTER TO THE ABERNETHIAN SOCIETY

A MEDICO who is acquainted with all the technicalities of medicine and who even can quote correctly our most exotic syndromes but who is yet without that spark of kindness is really only a silly sort of quack and useless as a doctor. That clever guy who will recite you from Recent Advances directly it reaches print or who will diagnose obscure disorders from the end of the bed, is still a no-good in medicine if he lacks it. And by the same token the businessman who leaves his fortune for medical research would have been better advised to spend it on drink if research makes doctors forget how to be kind.

Kindliness is the first requirement of all patients. Unpretentious, it causes no rivalry but is a protection against sharp practice or commercialism, keeps up that nice doctor-patient relationship, and earns true gratitude. If there were more of it about there would be less jealousy in the profession, and the profession's ancient and really fine traditions might be better upheld. And kindliness helps

women in the new auxiliary departments are many. The great crowd of men was at just after one o'clock daily, for it was the fashion in 1889 for the Senior Staff to do the round of their wards at 1.30 p.m. The House Physicians and Surgeons and the "teams" and camp followers had to be in the Square to look out for them, and the pre-clinicals looked on in anticipation.

The arrival of the Chiefs from the West End in their two-horse ornate carriages with solemn coachmen was eagerly awaited. The Assistant Chiefs arrived in one-horse broughams. From the picturesque point of view the horses, the elaborate carriages, silver-plated harness compared favourably with the present-day car, arriving at all hours. As a dutiful H.P. I had to be at the carriage door to greet Sir Dyce Duckworth, and again later on to see him off the premises, and once again take on responsibility.

I have had the good fortune to attain to what must seem higher appointments since 1889, but I was never more professionally gratified than I was at being chosen for a year H.P. at Bart.'s, and never in a long career have I had a more congenial year of office.

a doctor to do his work because it gives him a belief in the value of it, and thus the strength to carry it out.

It is one really unchanging attribute of the good doctor. Recent advances become out-of-date, new methods of investigation change and even fundamental principles of physiology are liable to be superseded, but it goes on for ever. This must be so as yet, while knowledge is only superficial and at best over-simplified; as further advances are made our present beliefs will be swept away just as childhood fantasies and beliefs are left behind when adult life is reached. As it is, all the great advances in medicine are only simple approximations to the truth, as would be apparent if we had a complete understanding of nature.

Thus the three requisites of a good doctor are the same now as they always have been—honesty, patience, and kindness. Which, do you think, is the most important of these?

PAUL CLAYFOOT, M.D.

CORRESPONDENCE

AGONY COLUMN

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

I wonder whether you would permit the use of the correspondence columns for a notice of the agony column type? I am very anxious to obtain three books which are now out of print and it might be that some Bart.'s men would have on their shelves one or other of these books which they are no longer using.

The books are: the 3rd edition (only) of Zinssers "Infection and Resistance"; Topley's "Outline of Immunity" and Marrack's "Chemistry of Antigens and Antibodies," 1938 edition.

If anyone has any of these books and would dispose of them, I would be happy to purchase them.

Yours faithfully,

G. FULTON ROBERTS

Dept. of Pathology,
Cambridge.
October 31, 1949.

BAD TASTE

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

I thought this news item from a Dunkirk daily paper might be of interest:

LA PLAISANTERIE DE MAUVAIS GOUT
... ou ... "il-y-a des choses qui ne se font pas!"
Lundi soir, aux usines Leroy, d'Angoulême, un ouvrier de la fonderie s'est signalé par un exploit d'un goût plus que douteux. Il maniait un souffleur à l'air comprimé, lors que l'idée lui vint de faire une plaisanterie à son camarade de travail. Il lui plaça brusquement l'appareil à l'anus et ouvrit le débit. L'imprudent ne pensait certes pas aux graves conséquences que pouvait avoir son geste inconsidéré. Le jet d'air, sous forte pression, provoqua chez sa victime des lésions internes qui nécessitèrent son admission d'urgence à l'hôpital de Girac. Il y subit, dès son arrivée, une intervention chirurgicale, mais bien que depuis son état soit resté stationnaire, on n'est pas sans inquiétude sur son sort.

Le malheureux, un Espagnol nommé Infante, est père de neuf enfants. Quant à l'auteur de cette plaisanterie, il a été congédié sur-le-champ par la direction de la maison Leroy.

Yours faithfully,

P. M. S.

POT POURRI

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

May we draw the attention of your readers to the fact that the Pot Pourri of the Ward Shows, will be given at the Cripplegate Theatre on Friday, 30 December, 1949, at 8.15 p.m.

Tickets will be available at the Hospital on and after December 14.

Yours faithfully,

J. Q. MATTHIAS,

Resident Anaesthetist

J. C. PITTMAN,

Hon Sec., Dramatic Society

BOAT CLUB APPEAL

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

Last year, as you will remember, the Boat Club was very successful in the United Hospitals Regatta at Putney, winning the five senior events in the Regatta out of a total of eight. The Club hopes to maintain this high standard of achievement, but is seriously handicapped by lack of equipment.

Until recently the Club only possessed a fairly old shell eight and a set of blades. During the last year, however, we managed to raise enough money among ourselves to purchase a new set of blades. Even now the equipment we possess is quite inadequate to maintain two crews upon the river, which is a minimum requirement for the club's activities to be carried on from year to year.

Our urgent need at the moment is to acquire a new clinker eight in order to train and maintain a junior crew. To this end we have started a Boat Fund in the hope that the necessary money may be subscribed by present and past members of the College. There must be many Old Bart.'s Men who would be proud to see a Bart.'s Crew taking part in the many regattas on the river.

We have already received contributions totalling £70 from the present officers and members of the Club. The cost of the new boat will be £250.

I am writing to ask, through the medium of the Bart.'s Journal, if all Bart.'s men will rally to the aid of the Boat Club and send me any donations—however small—to help to put the name of BART.'S "on the river" in the Rowing World.

Yours faithfully,

B. W. TOWN,
President, St. B.H.B.C.

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CHILDRENS FANCY DRESS PARTY

A Fancy Dress Party for Children is again being organised by the "Busy Bees" (the junior branch of the St. Bartholomew's Hospital Women's Guild) and will be held in the Great Hall on Wednesday, January 4, at 3.30 p.m. Tickets (5s.) can be obtained from the Contributions Department, St. Bartholomew's Hospital. Proceeds are devoted to the Children's Department.

VASCO-VAGAL ATTACK

By H. W. BALME

X was a pleasant dependable fellow whose ability and conscientiousness were much respected. At the time when he became ill he was 31, and employed in a clerical capacity in the hospital, and his work was well within his powers; but in addition he was spending most of his spare time working for an examination, and his inherent intensity of manner was accentuated by the strain of excessive study and the fear of failing his examination. I did not know his relatives, but he later informed me that he had a brother with a duodenal ulcer and a maternal aunt with a toxic goitre; and it seemed likely from conversation with him that most of his family were of a similar high-strung nervous constitution like himself. He was born to be unlucky, too, with his father dying young and leaving his mother the impossible task of educating the two children along the lines originally planned for them. His newly married wife had recently been seriously ill, though she had by then recovered again, but in the last few weeks so many minor things had gone wrong with him that he used to say of himself that if there was a fly in the milk jug it would inevitably be poured out on to his own porridge.

I was having tea with him one day when he was more than usually silent, and I noticed he made two rapid journeys to the lavatory within a few minutes of each other. In answer to a ribald question he replied that he had been to pass water only, and that in fact he had on both occasions passed a considerable quantity for no very evident reason; and that he felt dreadfully queer. And indeed he rapidly came to look dreadfully ill as we watched him. He started to lift a piece of bread to his mouth, but could not go on with the performance, and with a face visibly drained of all expression, he laid it back on his plate. He half leant back in his chair, leant his two hands palm downwards on the edge of the table, and sat for a few seconds as if in a daze. As we watched, his normally pale face became undoubtedly green, beads of sweat stood out on his forehead, his pupils dilated so as to make his light grey-blue eyes appear to go quite black, and he stared round at us in bewilderment, moving one hand feebly to his epigastrium and pressing it unsteadily there.

At this we became alarmed, and went over to him and helped him to an easy chair. He seemed to be trying to say something definite to us as we did so, but only produced disjointed noises that had no meaning. When we got him to the chair he looked indeed ghastly, his face streaming with sweat, and he apparently not able to move a muscle to change the position in which we had put him. The terror in his face communicated itself to us, and I am afraid we clustered round asking what the matter was, but as he plainly was more disturbed by having a throng of people round him we soon dispersed again. His forehead was wet, clammy, and cold. I lifted his dripping forearm to feel his pulse and had the extraordinary shock of finding it apparently not there. Even as I reassured myself that he was still alive by looking up to his face again, the first pulse wave came through, and though I did not time it his pulse rate must have been in the region of 40 per minute, and a very feeble low-volume affair it was too. At this time he seemed to be conscious only of terror, and to be oblivious of us surrounding him, and he has said afterwards that his memory of it is all distorted, like the memory of a terrifying dream.

Fortunately this stage did not last more than two or three minutes, and then he quite quickly started to recover again, though by now he had soaked right through his shirt and his hair was lank with sweat. His first remark was that it was going off now, and he explained that he had had a pain in his chest which though not severe seemed to be part and parcel of such vivid terror that he had been in no doubt at all that he was dying. As he spoke, his voice was unnatural, flat, and devoid of intonations, and as he seemed completely exhausted we did not encourage him to speak, but let him stay in his chair for a while, quite silent, while colour and expression returned to his face, sweat no longer ran down from his forehead and he steadily became more composed. Then we quietly carried him off like an exhausted child to bed where he lay unsleeping, in complete comfort, with his eyes wide open.

We did an E.C.G. half an hour later, and repeated it twice at intervals of a few days, but neither it nor barium meals in all

positions nor any other investigations ever revealed any evidence of physical disease or helped in any way to elucidate the problem of this "vaso-vagal attack."

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A CUTTING AFFAIR

THE local hospital out-patient's clinic was jammed. How so many people could come on a lovely summer's day, when the sea was only a stone's throw away, was beyond one's imagination. Some were really ill, or wanted a quiet rest perhaps, or some a thrill with the sights of hospital. But others had real troubles, domestic or bodily ailments, and who better to tackle their problems than a doctor. The minister or solicitor, you may think, I wish they would!

Unfortunately, many people feel their troubles in a weak part of their bodies, if not the head, the tummy or the chest, or perhaps in a limb.

Working for a post-graduate examination, I sat at the elbow of the surgeon who was attending out patients. First, new patients, men, as they had to go about their affairs and earn their living, then the new women, lastly the old cases who did not require so much attention as a rule, often only just repeat medicines.

Staff nurses were in attendance, telephones were buzzing, patients were being hurried in, or sent into cubicles to undress, and those that were seen, were being hurried out again. Junior nurses were rushing around on behalf of their seniors, bells rang signals, coloured lights were flashing for different people; we had not got to the stage of loud-speakers, thank goodness!

My chief sat, massive, patient and unperturbed, reading, writing, examining, instructing and thinking. He looked up at an X-ray, and sure enough there was something there which required an operation. The woman's husband, a tall fellow with a large beard and moustache, carefully waxed at the ends, came forward. "Do I understand that you want to do an operation on my wife, doctor?" "Yes," said Mr. Blank (surgeons are Mr. in this country, although the habit is not always followed). "And would that involve making a cutting incision?" Quietly

and kindly the reply came back, "Yes." Something in the man's demeanour aroused my curiosity.

Everyone was listening attentively as if something was going to happen, and sure enough it did. "How long would the incision be?" "Never in my many years' experience had I heard such a question asked before, about how long would the incision be, doctor? That was a good one. Gently and kindly came back the reply, "Well, that must be left for us to decide, we cannot go into details." "Do tell me doctor, I would like to know." Still politely came the reply, "I'm afraid I cannot go into that." "Are these the X-rays of my wife?" said the middle-aged man with the large beard and carefully waxed moustaches. They were. "Can I have a look at them?" The atmosphere was beginning to tremble slightly. Yes, he could look at them. Everything quiet and nice still. "Can I take them away with me, doctor?" Everything very quiet and patient, everything continued under control. I thought the room would collapse in a moment. "I would like to take them home to think about and try another hospital," continued the waxed moustaches, "to see whether operation is really necessary." A few gentle words came back this time, there was no loss of temper; a bland countenance persisted; not everyone would have stood *this*, the ideal to be aimed at. "I am sorry, but we cannot let the X-rays go out of the hospital, and now I will have to get on with the other patients."

Gently and firmly the situation was over, and the atmosphere. The husband was shown out of the consulting room and the next patient shown in.

What a perfect object lesson in control, politeness, gentleness! How I envy him, I wish I could be like that, don't you?

J. H.

CHANGE OF ADDRESS

Mr. J. W. Cope to 73, Harley St., W.1. Telephone: Welbeck 9823.
Dr. H. C. Killingback to Nova Scotia Estate, Telok Anson, Perak, Malaya.

NAPT

Christmas cards, price 6d. each, and seals, price 4s. hundred, can be obtained from the Duchess of Portland, Chairman N.A.P.T., Tavistock House North, Tavistock Square, London, W.C.1, or in Scotland from the N.A.P.T. (Scottish branch), 65, Castle Street, Edinburgh 2.

THE BIRTH OF VENUS

OR KNEE PRESENTATION ?

By RAINER MARIA RILKE

The morning following that fearful night
that passed with shouting, restlessness, and uproar,
the sea burst open yet again and screamed.
And, as the scream ebbed slowly to its close,
and, from the sky's pale daybreak and beginning,
was falling back to the dumb fishes' darkness—
the sea gave birth.

The first rays shimmered on the foaming hair
of the wide wave-vagina, on whose rim
the maiden rose, white and confused and wet.
And, as a young green leaf bestirs itself,
stretches, and what was curled on slowly opens,
her body was unfolded with coolness
and into the unfingered wind of dawn.
Like moons the knees went climbing clearly upwards
to dive into the cloudbirms of the thighs;
the narrow shadow of the calves retreated,
the feet extended and grew luminous,
and all the joints became as much alive
as drinkers' throats.

And in the pelvis-chalice lay the belly,
like a young fruit within a childish hand.
And there, within its navel's narrow goblet,
was all this lucid life contained of darkness.
Thereunder lightly rose the little swell
and lapped continually towards the loins
where now and then a silent trickle glistened.
Translucent, though, and still without a shadow,
lay, like a group of silver birch in April,
warm, empty, all unhidden, the vagina.
And now the shoulders' mobile balance hung
in equipoise upon the wand-straight body,
which mounted from the pelvis like a fountain,
and in the long arms lingeringly descended,
and swiftilier in the hair's abundant fall.
Then, very slowly, came the face's progress,
from the fore-shortened dimness of its drooping
into clear horizontal exaltation,
brought to abrupt conclusion by the chin.
Now, when the neck was stretched out like a sunbeam
and like a flower-stalk where sap is mounting,
and the arms begin to stretch out too, like necks
of swans, when they are making for the shore.
Then entered the dim dawning of this body,
like matutinal wind, the first deep breath.
Within the tenderest branches of the vein-trees
a whispering arose, and then the blood
began to rustle over deeper places.

And this wind grew and grew, until it hurtled
with all its power of breath at the new breasts
and filled them up and forced itself within them,
and they, like filled sails full of the horizon,
impelled the lightsome maiden to the shore.
And thus the goddess landed.
And behind her,
who swiftly left behind the youthful shores,
kept springing up throughout the whole forenoon
the flowers and the grasses, warm, confused,
as from embracing. And she walked and ran.
But after noon, during the heaviest hour,
the sea rose up yet once again and flung
a dolphin out upon that self-same spot.
Dead, red, and open.

Translated by J. B. Leishman, and reprinted from "Selected Poems" (1945), by kind permission
of The Hogarth Press.

HYPOCHONDRIASIS

OR PHYSICIAN HEAL THYSELF

"You are ill, my good fellow," the student
mused,
As he looked at himself in the glass.
"Your poor head is ringing with thoughts
all confused.
Pray, what can be coming to pass."

"In my youth," the young dresser replied
to himself,
"My worries were luckily few.
Hamilton Bailey was not on my shelf.
And Queen's Square was never in view."

"You are ill," said the student, percussing his
chest
As he stepped in his bath with a wheeze.
"Your cough waxes chronic, and is at the
best
A symptom of Koch's disease."

"In my youth," said the dresser, reviewing
his case.
"My habits were never so vicious.
My lungs were not poisoned at quite such
a pace
By pipe-puffing practice pernicious."

"You are ill," said the youth, as his form
he surveyed,
"That nævus looks melanometric;
Your lymph glands I'm sure it's begun to
invade;
Your liver has lumps metastatic."

"Since my youth," he recalled, with a sigh
of relief,
"That mole has reposed on my torso.
The lymphadenopathy calls for no grief;
The organ hepatic no more so."

"You are ill, very ill," said the student,
palpating
His stomach for areas tender.
"Your pains epigastric are plainly just
stating
That ulcers are on the agenda."

"Tis strange," he returned, "I'd no
symptoms before
Gastrectomies turned up to vex us.
And of course the abdomen is apt to be sore
When one prods at the old solar plexus."

"Good gracious!" he cried, as he reached
for his towel,
"That pain pierced your pelvis like
lightning.
Perhaps you have tabes or a large bowel,
Or could it be something more frighten-
ing."

"All my ills, said the sage, "are too many
to tell,
And it's hard to say what can be causal.
But I can rest assured and be thankful as well
That they're certainly not menopausal."

J. A. W.

Jimmy Crame was very keen,
And kept his Apparatus clean.
He doubted everything he knew
(A thing that he'd been told to do)
Until he'd found out it was true
By testing it himself.

One day the lad was at his Place
An earnest look upon his Face.
That morning he'd especially dressed
(His tie was neat, his Trousers pressed)
To do real justice to the Test.

Suddenly a vivid Green
Swept across the tranquil Scene.
A deafening Explosion came
From the Bench where Jimmy Crame
Was working with his Bunsen Flame.
The Building shook, the Lights went out
The Women Students gave a Shout
Then screamed — and Pandemonium
reigned
(The Men were rather more restrained).

The Dust fell with deliberation
Upon a Scene of Devastation.
The loss of life was not Severe.
Two Demonstrators standing near
Were killed, and seven Students (who
Had shared the Bench with Jim) died
too.

Of the People that remained,
Only five, all told, were maimed
For life,—though one young lad named
Will,
Unfortunately is Missing still.

Jim, you'll be distressed to hear,
Was badly scratched upon the Ear.
And the Suit that he was wearing
Was torn and almost past repairing.

Moral.

When embarking on a Test,
Oldest Clothes are always Best.

O. S. MOSIS.

SPORT

RUGBY CLUB

October 15, v. Metropolitan Police. Lost 6-24

The Metropolitan Police beat Bart's at Colindale by 3 goals, 1 penalty goal and 2 tries (24 points) to 2 penalty goals (6 points). These unassailable facts would appear to tell the sad tale of a resounding defeat—and the home team were undoubtedly worthy victors—but it was a keenly-contested struggle for all but the last fifteen minutes when a tiring defence wilted under the onslaught of a final furious fusillade.

The forwards failed to fulfil their primary function of feeding the backs and must, therefore, accept a large share of the responsibility of defeat, but in other respects they played well. W. G. Holland performed wonders in attack and defence, and was the best forward on the field. D. G. Dick led his team well, performed a prodigious amount of work and kicked two capital penalty goals. C. W. Havard, a newcomer from Oxford, played extremely well and will be a very great asset to the side.

Of the backs little can be said except that they defended well. There was only one good three-quarter movement when M. Davies cut through in grand style and timed his pass well. The ball went along the line to the wing, and back inside to Holland, but that worthy was brought down just short of the line.

A. P. Wynne-Jones made a very good solo run, which nearly resulted in a try, and he and J. L. Corbet look as though they will continue well.

G. Picthall is a lively wing, capable of moving fast. He should score lots of tries when he is given the chances.

The Bart's score was made up by two long-range penalty goals kicked by D. G. Dick in the first half. Most of the Police scoring was done in the last fifteen minutes when their scrum-half,

a sturdy member of the force, threw off neck tacklers with the greatest of ease and scored all too often. A pity this, but we must learn from our mistakes, for this could be the best team the hospital has had since the early war years.

October 10, v. Kenilworth. Lost 8-14

This was a most enjoyable game to watch and it was encouraging to see some real spirit in the Hospital side, who played hard to the final whistle. Kenilworth opened the scoring seven minutes after the start from a short kick ahead: the try was not converted. Fifteen minutes later they scored again on the result of a neat reverse pass from the fly-half to the wing who came inside—the goal points were added. Up to this point the Hospital play had been a little ragged but after this try there seemed to be more co-ordination.

After the kick out there was a good movement when the ball passed along the three-quarter line, reached Picthall who cut through, nicely passing inside to John who made a considerable amount of ground before passing to Clare who was pulled down inches from the line. Soon after this D. G. Dick dribbled the ball 25 yards to score a good try to which he added the goal points. Five minutes after the start of the second half Kenilworth scored—the kick being charged down by John. Fifteen minutes later Castle, after a good dribble, managed to pick up the ball, passed inside to R. F. N. Jones who scored—the kick failed. Shortly after this Roberts retired with a damaged knee—and the Hospital utility man, W. Holland, was put on the right wing. With the score at 11-8 in Kenilworth's favour Bart's pressed really hard and on more than one occasion were very unfortunate not to have levelled the scores. About ten minutes from time the Hospital lost Davies at full back who left the field injured and five minutes later Kenilworth scored under the posts, the kick again being charged down by John.

October 22, v. Aldershot Services. Drawn 6-6

St. Bart's Hospital drew with the Aldershot Services here this afternoon by two tries to a penalty goal and a dropped goal. Though the scoreboard at no-side showed six points to each team the hospital had the satisfaction of having prevented their opponents crossing their line.

It was a good open game and the fine loose play of the Bart's pack was ably supported by the devastating tackling of their backs. The hospital have good reason to be encouraged by today's performance for they have here a good team in the making. G. Picthall's tackling was superb. M. Davies was always constructive in attack, and J. L. M. Corbett was thoroughly sound—and with a useful left kick too. Of the forwards H. John and G. Dick showed enormous energy, and capacity for work, and the merciless tackling of B. Montgomery and A. Thirid in the line outs was a treat to watch.

The weakness of the hospital team lay in their set scrumming for the Aldershot Services had far more than their fair share of these, which gave their backs greater opportunities.

Bart's attacked right from the start and in the first ten minutes had crossed the Service's line as a result of a fine run by Murphy who scored near the corner flag. A few minutes later a good run by R. Jones took the play into the Service's 25—where A. John, who was always prominent—seized the ball from an Aldershot mis-kick and fought his way over the line to score.

Then the Aldershot Services attacked and swift three-quarter movement took them within feet of the Bart's line, but the home team's defence rose to the occasion; G. Picthall brought his man to the ground in exemplary fashion and J. Corbet's fine kicking relieved a tense situation.

A few moments later a penalty in the Bart's 25 was converted by C. Himistead for the Services—a welcome break as he had already had two penalty kicks hit the post. At half time the score was 6-3 to the hospital.

In the second half the Aldershot weight was telling in the scrums, though the Bart's pack had more of the ball in the loose. A good forward movement started by A. John and ably carried on by G. Dick, took the play very near to the Service's line but the Aldershot defence was able to relieve the pressure. A few moments later M. Davies intercepted an Aldershot pass and after a well timed kick ahead the Bart's pack with H. Thirid in the lead dashed after it but it was over the dead ball line before it could be touched down.

As a result of a quick heel from a set scrum in the Bart's 25, H. Ban dropped a beautiful goal for the Services. This brought the score to 6-6 and the remaining few minutes saw anxious moments for both sides but no alteration in the score.

THE CORNISH TOUR

This was a good expedition. We met old friends and made new ones. We enjoyed ourselves. We beat Redruth for the first time in 21 years, and played four other fine games of football. Every member of the party played excellently and if a lesson could be learned from this tour it is surely a simple one. If all were to play as they did then, Bart's football will assuredly reach heights worthy of past days.

Played	Won	Lost	Drawn	Pts. for	Pts. against
5	1	3	1	17	32

October 29th, 1st XV v. Penzance—Newlyn.

Drawn 6-6

Bad weather and a heavy ground. The pack was slow for the first twenty minutes, and the play was mostly in our half. After half time Penzance scored with a try. Our pack was now roused and Dick, Havard and Montgomery played well. The backs played good football in attack and defence, and Murphy made a run down the wing to score. Soon after Clare made a fine opening for himself and ran 25 yards to score. Both tries were unconverted. In the last minute of the game Penzance were awarded a penalty try. Caiger at full back handled the wet ball beautifully.

October 31, v. Redruth. Won 3-0

November 1st, v. Hayle. Lost 0-11

A glorious day, but the ground in places was a quagmire. Milligan at full back was injured early on. The pack again was slow to start. Hayle opened the scoring with a penalty. The backs, without exception, played splendidly, and the pack held their bustling rivals in the scrums. Hayle increased their lead with a forward rush. In the second half Dick, Mears, and Montgomery did a tremendous amount of work. The backs, Clare, Davies, and Picthall were here, there and everywhere, in defence and in attack. Hayle scored a try and converted it just before the final whistle.

November 3, v. Paignton. Lost 8-9

Bart's were on the defensive for the first few minutes. Dick kicked a fine penalty early on, but Paignton equalled with a try. Shortly afterwards they again scored. The pack lived up in the second half and battled away vigorously with Dick, Mears and Heylings to the fore. The backs again were good. Davies weaved his way through the Paignton defence and passed to Clare who scored a good try. Play went backwards and forwards until the last minute of the game when Paignton again scored to win the game.

November 5, v Torquay. Lost 0-6

A muddy ground for the last game. Although obviously somewhat tired after the week's endeavours the pack played well and held a heavier side. This was really a defensive game and first-class it was. The tackling of the backs was superb—it was so throughout the tour. Matthews at centre was the hero. At least a dozen times did he crash his opposite man. Torquay opened with a penalty and shortly afterwards their scrum half nipped round the blind side and scored. In the second half we pushed Torquay into their own half and Dick all but kicked a fine penalty. Torquay would surely have scored again towards the end but for the first-rate Bart's defence.

HOCKEY CLUB

Saturday, October 8, 1st XI v. Lensbury (away)

Lost 4-1

It was unfortunate that in this, the opening match of the season, one of our forwards should go astray, so that the attack was a man short until half time. Lensbury attacked strongly from the start, but the Hospital defence, in which the captain was outstanding, held firm, while the forwards made occasional but dangerous sallies. It was from one of these that Bart's drew first blood,

Batterham running through and scoring. Lensbury soon equalised, and went ahead just before half time. In the second half, lack of training took its toll, and Lensbury were able to add two further goals against a very tired side.

Wednesday, October 12, 1st XI v. R.N.C. Greenwich (away). Lost 3-2

Since this match was fully, not to say admirably reported in that other fine organ of the Press, the "Times," it would be an impertinence to add further comment, save to say that a greatly weakened mid-week Hospital team did far better than was expected.

Saturday, October 15, 1st XI v. R.M.A. Sandhurst (away). Drawn 1-1

It is worthy of note that on this occasion Bart's reported on time and all present and correct. The game started at tremendous pace, and both goalkeepers were soon in action. Bart's opened the scoring with a goal by Batterham from a penalty corner. R.M.A., encouraged by a fine flow of invective from the Senior Officer, soon replied, and at half time honours were even. Soon after the interval, Bart's almost took the lead, but the opposing goalkeeper inadvertently got his stomach in the way of a scorcher. In spite of renewed efforts on the part of both sides, there was no further score, and a draw seemed a very fair result.

Saturday, October 29, 1st XI v. Sevenoaks (away)

Lost 6-0

Second Eleven

October 8, v. Lensbury II (home). Lost 0-4.

October 15, v. R.M.A. Sandhurst II (home).

Lost 0-5

October 29, v. Sevenoaks II (home). Lost 1-2

GOLF CLUB

The Beveridge Cup Final

The final of the London University Inter Collegiate Golf Tournament for the Beveridge Cup was played at Addington Palace on Wednesday, October 26th, between Guy's Hospital, the holders, and Bart's. The match was by eight singles of eighteen holes.

Conditions for play were very bad. There was heavy and continuous rain, and a fairly strong wind. Consequently the standard of play suffered, but there were several good performances, and the team as a whole played up very well against opponents who were stronger on paper and firm favourites to win.

In the top single, I. R. Gracey played steadily against Ian Caldwell, a Walker Cup Trialist. Though stymied at the first he was out in 37 and three up. Caldwell won the eleventh with a birdie four to reduce the margin to two holes. At the sixteenth he played a great shot from a water-logged bunker, holing out for a two. The last two holes were halved in par figures, leaving Gracey the winner by one hole.

In the second match, R. V. Fiddian came up against some brilliant golf from J. H. D. Grant, a London University player. Never recovering from a bad start, Fiddian was unable to get on terms, and went out at the thirteenth. D. R. Rushton played well in the third match, just losing a close game to J. Anderson, another London University player, by 2/1. In the fourth single, D. Aubin, somewhat out of practice, lost to J. Wilson 5/4.

At this stage the position seemed black for

Bart's. It was soon changed however. First, M. Braimbridge, playing fine golf, overwhelmed R. Park 5/4. D. R. Dreaper, a last minute choice, did likewise to M. Quelch, and as C. J. R. Elliott secured a walkover, Bart's now led by 4-3.

On the result of the final single between J. C. Graham-Stewart and J. Hepsted, therefore, the whole outcome of the day eventually rested. Graham-Stewart was one up with six to play, but at this juncture his opponent put in a strong spurt and won on the seventeenth, making the score four all and the match a draw.

The match will be replayed on Wednesday, November 16 at Sundridge Park. We congratulate the team on their fine performance in holding the strong Guy's side to a draw, and wish them good luck for the replay.

R. V. Fiddian has been elected Secretary of the London University Golf Society. L. R. H. Gracey is Vice-President.

SAILING CLUB

The United Hospitals Sailing Club had an extremely successful 1949 season. Sailing at Burnham-on-Crouch started in April and continued until the end of September.

On April 30, and May 1, a team triangular match was sailed at Burnham, in U.H.S.C. boats, against Oxford U.Y.C. and Cambridge U.C.C. Oxford won with 25½ points, Cambridge were second with 19½ points and U.H.S.C. were third with 18½ points. The University races for the Young Cup held on Garloch and raced in Dragons on August 15 and 19, was won by Oxford. U.H.S.C. were fourth, there being 17 entries. In all, the U.H.S.C. sailed in ten club matches during the season. Miss E. S. Tomlinson of S.B.H.S.C. sailed for the U.H.S.C. against Hayling Island.

In the inter-hospital weekend races the response from S.B.H.S.C. was disappointing and on only one occasion were we able to put out a team. The Bannister Cup for inter-hospital races was won by St. Thomas's Hospital.

Apart from the activities within our own club, members of the U.H.S.C. have crewed in all the ocean races this summer. Those who enjoyed the hospitality in ocean racers will wish to join in thanking the owners most cordially.

The U.H.S.C. Annual Ball will be held on December 9, at B.M.A. House.

WOMENS HOCKEY CLUB

Season 1949-50

President: Prof. A. Wormall.

Captain: Miss J. Cree.

Secretary: Miss N. Heywood.

Match Sec.: Miss G. France.

Treasurer: Miss P. Humphris.

Committee: Miss A. Caldwell.

October 1 to December 31, 1949

The Club has played two matches during October, against U.C.H. and Middlesex hospital. The first game was won 2-0, the second, 5-1.

Greater support has been forthcoming this season and, as a result, it is hoped to run a second team next term. One member of the Club, Miss N. Bott, is playing for London University.

Efforts are being made to organise an inter-hospital women's hockey tournament this season.

BOOK REVIEWS

AN EPITOME OF THE LABORATORY DIAGNOSIS AND TREATMENT OF TROPICAL DISEASE, by Horace M. Shelley. Staples Press, 1949, pp. 147. Price 10s. 6d.

This is a well-constructed book that warranted better presentation. The author adheres rigidly to his title, presenting each chapter with clear sub-headings which make the reading of it a pleasure. The limited subject facilitates the extremely detailed description of laboratory methods, which does not, however, interfere with the continuity. Treatment is not dealt with to the same degree of meticulousness, but it is adequate. This very useful handbook merits better treatment at the hands of the publishers—paper is poor quality and the few illustrations are not impressive.

CYSTOSCOPY AND UROGRAPHY, by J. B. Macalpine. 3rd Edition. John Wright, Bristol, 1949, pp. xiii+554, 15 plates. Price 63s.

This is the most practical and best produced book on the subject of cystoscopy in the English language. It also includes the routine investigation of a urological patient, and covers urography both intravenous and instrumental in considerable detail. Its scope has been enlarged, and several sections have been re-written since the last edition. The latter has been unobtainable for some years, as all the remaining copies of the second edition of 1936, were destroyed during the bombing of London.

There is a short sketch of the history of the cystoscope, and a full description of various instruments, and their construction. The whole field of cystoscopic technique is covered in detail, and all the common and rare conditions which may be met with in the bladder are given their proper place.

Besides dealing with investigation, the endoscopic treatment of bladder growths and prostatic obstruction is described, and a section by R. H. O. B. Robinson on punch prostatectomy is also included. There is a chapter on the pathology of tuberculosis of the urinary tract which is helpful in considering the necessity for various investigations which are subsequently described.

This volume can be thoroughly recommended to both the urological and general surgeon. A.W.B.

TUBERCULOSIS NURSING, by Jessie G. Eyre. Lewis, pp. xii+292. Price 21s.

All branches of tuberculosis nursing are described with sense and in a practical manner. One of the best sections is on the surgical treatment of pulmonary tuberculosis, and the nurse's duties in post-operative management. Miss Eyre has a clear readable style, and the publishers have produced a good-looking and well-illustrated book.

HANDBOOK OF ELECTROENCEPHALOGRAPHY, by Robert S. Ogilvie. Addison-Wesley Press, Inc., Cambridge, Mass., 1949, pp. xvi+137.

This small book has been written by Mr. Ogilvie, who was technician in the E.E.G. department of Dr. and Mrs. Gibbs in Boston, where much of the pioneer work on electroencephalography was carried out. It has been written primarily for technicians in E.E.G. departments rather than for medical students or doctors. A full description is given of the methods of obtaining E.E.G. records and of the difficulties and artifacts which may be

encountered, and a number of illustrative tracings are reproduced. No attempt is made to describe the interpretation of E.E.G. records. The book appears to carry out its limited purpose well and should be of value to technicians in E.E.G. departments. J.W.A.T.

THE INVERT AND HIS SOCIAL ADJUSTMENT, by "Anomaly." Introduction by R. H. Thouless. Ballière, Tindall & Cox. Reprinted with sequel, 1948, pp. 275. Price 8s. 6d.

Homosexuality ranks with impotence or sterility as a tragic disorder, and though less susceptible to treatment, demands equally intelligent consideration. This small—and regrettably expensive—book is therefore valuable as a sincere attempt to review the position of the invert in society.

The author makes it clear that, together with other sexual anomalies, the nature of this disorder is frequently misunderstood. As a result, advice is often valueless and legal administrators impose savage penalties to be endured under conditions which do not dispose to treatment.

This book is written with personal insight, and with a degree of literary skill that shames most medical authors. Occasionally his conclusions are rash. For example, he affirms that adolescent homosexuality, although widespread among all classes, is less well known among the workers because they are illiterate and inarticulate. He disregards the fact that the adolescent artisan has more opportunities for hetero-sexual friendship than his counterpart at a boarding school.

Since some medical practitioners will not feel disposed to spend an hour or two reading this book, we suggest that they should confidently recommend it to inverts and others requiring helpful and sympathetic advice on a disorder the misery of which is not alleviated by excessive ribaldry or bad advice.

PRINCIPLES OF HUMAN PHYSIOLOGY (STARLING), edited by C. Lovatt Evans. 10th Edition. J. A. Churchill, 1949, pp. xii+1,193. Illus. 693. Price 42s.

Physiology is a language readily learnt once the thread running through it, on which the facts are hung, has been understood. It is this issue that Starling does his best to confuse. All the necessary—and much, from the point of view of the student, that is unnecessary—information is present but combined in such a way as to make its successful comprehension a matter of some difficulty. Small print abounds, illustrations are often incomprehensible and as a final absurdity a series of stereoscopic pairs are included. On the other hand, the chapter on the heart—as it should be—is the best of all the commonly used textbooks and in other chapters individual facts are presented with lucidity. For the physiology adept this is undoubtedly a useful book; for an already over-worked student it is an added burden.

WESSEX RAHERE CLUB

The second Annual Dinner of the Wessex Rahere Club was held at the Spa Hotel, Bath, on October 15th, 1949. Professor Sir James Paterson Ross, K.C.V.O., was present as Guest of Honour and some 39 members attended under the chair-

manship of Mr. C. E. Kindersley. A message was received from the President, Sir Holburt Waring, C.B.E., regretting his inability to attend.

Dealing with the "business," the Secretary reported that membership of the Club, which was open without subscription to all Bart's men in the South-West, was now well over the 100 and increasing steadily. Professor R. A. Brocklehurst (Bristol) was unanimously elected Chairman for 1949/50 and the Hon. Secretary re-elected.

It was agreed that the 3rd Annual Dinner would be held in Bristol on October 21st, 1950. It was unanimously resolved that a second Dinner should be held in one of the more peripheral centres during April of each year and that in 1950 this Dinner should be at Taunton.

The toast of the Hospital was proposed by Mr. C. E. Kindersley and linked with the name of Sir James Paterson Ross to whom he extended the thanks of the company and their appreciation of his presence.

In reply, Sir James outlined the present situation as regards reconstruction and development of Bart's and in particular the great progress which was being made at the Charterhouse site and in the provision of a residential hostel. He emphasised that the quality of the students entering the Hospital was as high as ever and that the standard was maintained by the vast number of applicants for the comparatively few vacancies.

A vote of thanks to the Guest of Honour was carried with acclamation.

It is hoped that any Bart's men who are interested and not yet in touch with the Club, will notify their whereabouts to the Hon. Secretary (Mr. A. Daunt Bateman, 3, Circus, Bath) so that they can be kept informed of future meetings.

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EXAMINATION RESULTS

Final Examination

CONJOINT BOARD

October, 1949

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Burn, J. I.	Hale, B. C.	Marsh, G. W.	Vickers, R.
Chandler, G. C. H.	Hibbard, B. M.	Mason-Walshaw, K. R.	Warlow, P. F. M.
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Cardwell, J. S.	Holland, W. G.	McCloy, J. W.	Simpson, E. A. D. W.
Cox, J. S.	Jackson, P. G.	Menon, J. A.	Thomas, D. H. C.
Dickerson, R. P. G.	Jones, N.	Montfort, F. G.	Vercoe, M. G. S.
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Gosling, R. E. G.	Kaye, M.	Pedersen, D. L.	

Surgery

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Baddoo, M. A.	Cox, J. S.	Jones, N.	Rees, I. D.
Brest, B. I.	Crook, R. A.	McCloy, J. W.	
Brown, H. S.	Davies, W. H. G.	Menon, J. A.	
Carter, F. G. T.	Dickerson, R. P. G.	Raines, R. J. H.	

Midwifery

Cooper, M. B. S.	Pedersen, D. L.	Rees, J. H.
Evans, T. L.	Smyly, D. P.	Rosen, I.

The following students have completed the examination for the Diplomas M.R.C.S., L.R.C.P. :-

Andrews, J. D. B.	Dickerson, R. P. G.	Jones, N.	Morley, D. F.
Brown, H. S.	Evans, T. L.	Jowett, J. H. G.	Reckless, M.
Capstick, N. S.	Facer, J. L.	Kazantzis, G.	Sahakian, J. G.
Cox, J. S.	Griffiths, J. D.	Menon, J. A.	Simpson, E. A. D. W.
Crook, R. A.	Jackson, P. G.	Montfort, F. G.	Thomas, D. H. C.

