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LECTURES

Taking the overall view, the standard of lectures at Bart.'s is poor. We have, of course, notable exceptions, and it is not the high standard of these few but the general level that leaves so much room for improvement.

It is interesting to know by what means the hospital magnate becomes eligible for his Rolls-Royce and chauffeur, and acquires the power of tyranny for three quarters of an hour over the minds of a somewhat variable number of students. To begin with, he practically must be a Bart.'s man. Excepting the Dental Department, there are only twelve of a clinical staff of sixty from outside hospitals. One-third are from Oxford and Cambridge, the majority of these from the latter. He must have served his time in subordinate posts, the length of time varying with his ability and with luck—the applicant's geographical position at the moment of a post becoming vacant having considerable importance. The official procedure is that notice of a vacancy on the Staff must be published in two medical journals, and applications submitted to an Advisory Appointments Committee consisting of seven members, five appointed by the Hospital and two by the University of London. The percentage of Bart.'s men on the Staff is thus explained.

Thus are our lecturers chosen, as in all scientific institutions, for their technical rather than their rhetorical ability. The requirements of a good speaker are few and readily attained, yet it is disturbing to see how often these elementary criteria are neglected. He must speak slowly, clearly and loud enough for the backbenchers to hear. He should avoid mannerisms—we have our quota at Hospital. The pointer at the empty blackboard, the chalk adjuster, the bashful, facing directly away from his audience, the recumbent, the peripatetic, the moustache stroker, the juggler, all pursue their foibles enthusiastically.

The good speaker must present his subject in an intelligible framework, capable of interpretation by those most voracious of note takers, the ladies. Lecture notes help towards this end, but defeat their purpose if merely read. If he can produce jokes that are funny, so much the better, but it is as well to remember that nothing falls so flat as a poor joke at half past five of a summer evening. The reading of previously issued précis makes for the dullest of all lectures. A few slides, however irrelevant, always enliven a talk, not to mention the value of a few minutes of darkness for readjustment in the numbers of the back bench population. Above all, let him not exceed the recognised time limit. Finally there is that something that will always distinguish the orator from the mere lecturer—that gift of the gab, that drop of Irish blood that can convert a talk on sanitary science into an hour's sheer fascination.

Appreciation of a lecturer varies directly with the convenience of the accommodation —it is not surprising that attention wanders in our present apology for a lecture theatre.

A flickering mercury vapour lamp during a hot evening must have acted as the trigger mechanism for more than one psychosis.

There is, however, a general delusion among students that all lectures are compulsory in spite of numerous statements to the contrary by the Dean. Certain lectures are considered compulsory by the examining bodies—to wit, Practical Pharmacy, Public Health, Forensic Medicine and Mental Diseases. Other than these there is no element of compulsion whatsoever. It is due to this misconception that the disgraceful scenes occur of mass emigrations with each lantern slide, and of lecturers having to order the more loquacious of their audience from the room. If these students knew that their presence serves merely to harass the speaker and those who come to listen, and that their coveted "sign-up" is worth exactly nothing, they might have the courtesy to spend a little more time at Lord's.

There is much, then, that could readily be improved in the standard of our lectures—let there be a rhetorical Means Test before appointment to the Staff, let speakers take more care over their material and delivery, let there be a modicum of comfort in the theatre, and finally let there be an atmosphere of attention and scholarly calm during those few lectures that we do attend.

VISIT OF H.R.H THE DUCHESS OF GLOUCESTER

H.R.H. The Duchess of Gloucester visited St. Bartholomew's Hospital on the afternoon of May 23, 1950, and inaugurated the new Outpatient Trolley Service presented by the Ladies' Guild. She was presented with a bouquet by Miss Juliette Franklin, aged six. After the inauguration she visited Harmsworth, Dalziel and Martha Wards, and inspected the exhibition of Ladies' Guild needlework in the Great Hall.

HIGH AND LOW OUTPUT HEART FAILURE - A CRITICAL NOTE

By GEOFFREY BOURNE

When language places neatness before exactness of definition, confusion of thought is apt to follow. Phrases such as "hyperglycæmic coma" and "hypoglycæmic coma" have a meretricious balance which is very apt to deceive the mind. Coma always follows a sufficient degree of hypoglycæmia and never follows hyperglycæmia at all. A similar desire for terminological slickness is seen in the classification of heart failure into the two groups, high and low output failure.

When the heart muscle fails or when the heart for some other reason is unable to maintain its proper output of blood, the signs and symptoms of heart failure will follow. Thus the term "low output failure" indicates that as a result of heart failure the efficiency of the heart is diminished. High output, however, never is, never has, and never will be a *result* of heart failure. It is this difference in the basic meaning of the terms which leads to mental confusion and makes them hard to explain and to understand.

The matter can best be illustrated by thinking first of a patient who has a diminished cardiac output from myocardial disease. Whereas the cardiac output in a normal resting adult is in the neighbourhood of three to four-and-a-half litres per minute, this figure is increased six or seven times at least from vigorous exercise. When myocardial insufficiency has occurred, the effect of this same increase in exercise, even although the output rises only to three or four times the resting level, may be to bring on first the symptoms and later the physical signs of heart failure, both symptomatic and later congestive. If such an individual is forced by circumstances to keep up and about and to do work which increases the output above a critical figure, swelling of the feet, legs, thighs, and the other manifestations of congestive heart failure will occur, although the output during such exercise is obviously considerably increased above the resting figure. A picture analogous to this is produced in the condition described by the spuriously attractive term "high output failure." In such a case there is a cause present which increases the cardiac activity even although the patient is at rest, and simultaneously there is present a factor which has a deleterious effect upon the health and physical state of the heart muscle. The result is thus two-fold, an increased cardiac output, and the symptoms and signs of heart failure.

Conditions Causing "High Output Failure"

There are three clinical groups of cases in which this sequence of events is commonly found. Patients with a sufficiently profound degree of *anæmia*, even at rest, can be proved by laboratory processes to have a much increased cardiac output. The physical signs of this are also present in many such cases. The heart rate is increased, the vigour of the heart beat is also increased, there is an exaggerated pulsation of the peripheral veins and sometimes of the arteries, and the whole impression of the patient suggests someone who has recently ceased from fairly vigorous exercise. Furthermore, post mortem examination of nearly every sufficiently anæmic patient shows that the heart is afflicted by hyaline and fatty degeneration of the muscle. Clinically the signs of heart failure are quite common in such patients.

A second group is that in which the lack of oxygen is produced, not by a deficiency in the blood, but by an insufficiency of the respiratory mechanism. Severe emphysema, chronic bronchitis, an extreme degree of pulmonary fibrosis, all these and similar conditions which interfere with lung function, will produce what is called *cor pulmonale*, either in an acute or a chronic form. Cor pulmonale is the second large group of cases in which the activity of the heart is stimulated to a level above normal, even although the patient may be at rest, and in this condition, too, lack of oxygen intake is apt to interfere with the health of the heart muscle. In such patients signs of congestive failure will appear even earlier, being due to the enforced increased activity of the diseased heart.

The third common clinical example of an increased circulation rate, both at rest, and of course all the more during exercise, is that of *thyrotoxicosis*. Here the increased cardiac activity is a result of the raised basal metabolic rate; and the effect of this factor upon the heart is accentuated by the probable action of thyroxin upon the heart muscle. It is a matter of belief rather than proof that thyroxin has such an effect, but

I have seen a case in which I believe this to have been proved. The patient was an extremely healthy woman in her forties, a very vigorous housewife with also a busy profession. Her holidays were as vigorous as her ordinary life. Having previously examined her from time to time and found her perfectly healthy, she suddenly developed auricular fibrillation as a result of taking tablets which contained thyroid extract to reduce her weight. The tablets were stopped, the fibrillation was banished, and fifteen years after she remains equally vigorous and well. The heart remains normal in size and shape radiologically, and the cardiogram is normal also.

Conclusions

In what is sometimes called "high output failure," the high output is the cause of the failure, whereas in low output failure the low output is the result of the failure. It is therefore better to keep to exact terms expressing exact thoughts than to make neat clichés do inaccurate work for a lazy cerebrum. There is no objection to describing the heart in anæmia, in thyrotoxicosis, and in chronic lung disease as suffering from a high output; but when such a heart fails its output falls in relation to the output necessary to keep such a patient free from failure. Thus in both types failure is associated with an output which is lower than that present before failure supervened.

The chief reason for the introduction of these terms into clinical medicine is that it is alleged that whereas digitalis has a most beneficial action in low output failure, that is to say in the vast majority of all cases of heart failure following myocardial and valvular lesions, in high output failure this effect may be deleterious. The theoretical reason for this deduction is that in so far as digitalis lowers venous pressure it will beneficially relieve the over-distention of the right heart, so often present in severe low output failure. On the other hand, this lowering of the venous pressure in high output failure will prevent adequate diastolic auricular stretching, so that the heart will fill inadequately, and the output from the left ventricle will fall, thus accentuating the symptoms of failure. This pharmacological thesis does not always hold good. The lowering of the venous pressure is by no means the only action of digitalis, and it has only been proved, by experiment in the human being, to occur for a period of half to one hour after the intravenous injection of digoxin. Whether it persists longer is unknown. In addition to this action the drug certainly lowers the heart rate by reducing the conductivity of the Bundle of His in auricular fibrillation, and it also has in many cases a definite effect on the strength of the ventricular muscle.

A further reason for the unreliability of the theoretical rule is that the aetiology of cases of cor pulmonale and thyrotoxicosis is frequently a mixed one. Examples of pure right heart failure are thus comparatively rare; there is so often in addition evidence of left ventricular disease. Therefore in individual patients predominantly suffering from right heart failure digitalis cannot be sweepingly excluded as a useful drug. Aminophylline, oxygen inhalation, and the mercurial diuretics should be tried first. If there is then no improvement digitalis should be given without hesitation.

TO BROWNEYES

Those wondrous eyes, now lit by elfin grin;
Now, open window to the soul within,
So soft with pity for another's pain;
Or, shyly smiling, happy once again,
Full-charged with love and joyous giving;
Now sweetly gentle in a quick forgiving;
Now flashing fiery sparks—rage, scorn, or pride—
Such as Vulcan struck on Mount Olympus' side
Fashioning the armour of the God of War.
Not twice a thousand tongues nor many more
Had made you eloquent as those twin gems
From whose soft brown lustrous beauty stems
The lovely innocence and lack of guile
That light your laughter and your smile.

DAN WOODING.

THE CEREBRAL CORTEX AND THE AUTONOMIC NERVOUS SYSTEM

By D. A. MacDonald

It is well established that the autonomic nervous system, in spite of the independence implied by its name, is under central nervous control. Early work on this was done by Karplus and Kreidl who, in 1910, described a "sympathetic centre" in the posterior hypothalamus, and later Beattie (about 1930) reported a "parasympathetic centre" in the anterior hypothalamus. Hess, in the meantime, had begun, in 1924, that long series of stimulation experiments, in both conscious and anæsthetized animals, in which he showed the controlling influence of the hypothalamus for regulation both of the circulation and of respiration and other autonomic functions, and for which he was awarded a half share of the Nobel prize for physiology and medicine in 1949. It was also in the 1930s that Ranson and his associates in Chicago produced much confirmatory evidence, and in particular elucidated the rôles of the hypothalamus in regulating the secretion of anti-diuretic hormone, and in co-ordinating temperature control mechanisms in warm-blooded animals.

While the importance of the diencephalon for the nervous control of the viscera is generally accepted, the possibility of the cerebral cortex playing a part is much more controversial. This doubt possibly arises from the association in our minds of the corex with willed movements and consciously controlled activities, while the normal regulation of the viscera is not subject to voluntary modification. Yet a moment's thought is enough to show that things that stimulate the cortex can have marked visceral effects. The sight of a pretty girl that accelerates the heart beat, the sound of an examiner's voice that reduces gastric tone, or the news of a bereavement that brings tears to the eyes, are all obvious examples. The conditioned responses that Pavlov studied were of the same nature, and shown to be mediated by the cortex. Experimental evidence of cortical autonomic function has not been lacking, for from 1870, when the discovery that excitation of the cortex would produce movements of the limbs was made, a host of investigators has recorded a great variety of effects on blood-pressure, heart-rate, sweating, pupillary size, and so on from cortical stimulation. Furthermore, there have been many clinical observations leading to the same conclusions; for example, that hemiplegia is often associated with vasomotor disturbances of the affected limbs. But, until comparatively recently, critical workers have tended to ignore this body of work, for it was unsystematic and rather crudely performed.

However, in consequence of the long series of investigations by J. F. Fulton and his collaborators into the functions of the frontal lobes (1930 onwards), and the introduction of leucotomy by Moniz in 1935, the subject has been investigated again much more intensively. As I had the privilege of working in Zurich last summer * with Professor Hess and Dr. R. B. Livingston, a distinguished worker from Prof. Fulton's laboratory, I take this opportunity of presenting a short review of past and present work, which apart from its own interest, has a wide bearing on clinical problems in the field of psychosomatic medicine.

Recent Experimental Work

The first cortical regions to be studied were the pre-central areas. In the course of ablation experiments at Yale, Margaret Kennard noted that the corresponding crossed limbs showed vaso-constriction, so that the temperature of those extremities always tended to be below that of the unaffected side. Conversely, Green and Hoff showed that stimulation of the same areas caused an increase of blood-flow to the muscles of the limbs while the vessels of the splanchnic region constricted. Further important work by Axel Lund in Copenhagen makes it clear that this is a means of adapting the circulation to the demands of muscular activity resulting from excitation of the same pre-central motor cortex. Respiratory changes arising from the same areas (Smith 1938) clearly serve a similar function. From the precincts of the face area salivation may be caused by stimulation, and from the eye-fields lachrymation and pupillary changes result. Darrow has shown a close correspondence of the "psycho-galvanic" reflex and sweat-gland activity, and in cats this has been found to depend on the integrity of the

* This was only made possible by a generous grant from the Leverhulme Foundation, for which I am very grateful.

premotor region and the temporal pole. Gastro-intestinal activity is apparently subdued by the cortex. An observation which led to early interest in this was that of Watts and Fulton (1934) who found that some monkeys with the frontal lobes removed died of intussusception — fortunately a rare occurrence in human beings after frontal leucotomy—while Sheehan caused inhibition of peristalsis by stimulation of the premotor cortex. In general, with regard to these results we can say that there is a considerable overlapping of the autonomic foci with the corresponding areas serving somatic functions.

The Orbital Surface of the Frontal Lobes

Since 1938, however, interest has turned away from the easily accessible lateral surface of the hemisphere to the orbital surface and the cingular gyrus on the medial surface. Attention was drawn to the relations of the orbital surface to automonic functions by the observation of Bailey and Bremer (1938) that stimulation of the vagus caused electrical activity in the lateral orbital gyris and nowhere else in the cerebral cortex. Two years later Bailey and Sweet demonstrated that stimulation would cause arrest of the respiration—this was originally described by W. G. Spencer, one of Sir Victor Horsley's colleagues, in 1894—together with changes in blood-pressure and in gastro-intestinal activity. These responses have been fully investigated by Delgado and Livingston (1948) who describe the pressure effect as being either a slow rise with relatively long latency, or a short, sharp fall. Associated vasomotor responses are marked, and may be set off by thermal stimulation, such as the application of cold pledgets of cotton wool, as well as by electrical stimulation. This hints at a possible rôle in temperature regulation if the cortex is sensitive to changes in the temperature of the blood, as certain regions of the hypothalamus are known to be. Stimulation of the corresponding regions in patients about to undergo leucotomy have also shown similar effects. (Livingston and others, 1948.) Ablation of the lateral orbital gyrus causes a rise in temperature in the opposite limbs due to vasodilatation, and so presumably has a vasomotor influence antagonistic to the premotor zone. This has led to the suggestion that section of the radiations from this area might be beneficial in hypertension patients, and it is interesting to note that, in view of the possible relation of the renal "Oxford shunt" to the cause of essential hypertension, prolonged stimulation of the orbital surface seems to produce the diversion of blood from the kidney cortex. (Cort, cited by Fulton, 1949a.) It is also said that orbital ablation will make schizophrenic patients more extroverted and sociable. However, in monkeys, bilateral ablation of the orbital gyri has been followed by five-fold, apparently purposeless increase in activity (Ruch and Shenkin, 1943), and in cats it causes "sham rage" reactions, neither of which would be a very desirable alternative to the disease for which it was proposed as a cure.

The Cingular Gyrus

Another region that has attracted considerable attention in the past few years is the anterior cingular gyrus on the medial surface of the hemisphere, next the corpus callosum. This is of interest, because it is the area of the cortex which has the most well-defined anatomical connection with the hypothalamus (through the mammillothalamic tract to the anterior nucleus of the thalamus, and thence to the cingular gyrus). Stimulation of various points in this region (Smith 1945) produces cardiovascular effects, either a fall in blood-pressure with slowing of the heart, or a rise with cardio-acceleration; it causes respiratory arrest, and pilo-erection and dilatation of the pupils. This gyrus has also been shown to be a "suppressor" zone by McCulloch, and activation of it by strychnine or electrical stimulation will depress cortical activity in other regions and inhibit the tone of the skeletal musculature, although it has recently been denied that this occurs in the unanaesthetized animal. Ablation experiments have been done by Smith, who found that it produced monkeys that were tame and especially easy to handle, and Ward has given a detailed description of this behaviour. He says that they lose their normal fear of man, and are more forward and inquisitive. At the same time they tend to treat other animals as inanimate objects, walking over them and taking food from them, but apparently being surprised at the hostility it evokes. Ward summed it up by saying that the operated animals had lost their "social conscience." But, because this was interpreted as a loss of fears and anxiety, localized excision of this gyrus has been performed on psychotic patients in preference to the more severe operation of lobectomy.

However, no impressive results have yet been reported.

Artefacts to Beware Of

A feature that has become apparent in all these investigations is that the response of the cerebral cortex to electrical stimulation varies very greatly with the anæsthesia employed, and with the character of the stimulus, especially as regards frequency and duration of the pulses. Changes in frequency may not only reverse an effect completely, but may produce something quite different. For instance, Livingston has shown that different rates used in stimulating a single point in the cortical eye-fields may elicit deviations of the eye to either side, or pupil changes, or lachrymation. The effects of anæsthesia, although they would seem so obvious, have not, in fact, been at all fully investigated.

The technique evolved by Prof. Hess in which fine electrodes are implanted in the brain under nitrous-oxide anæsthesia, and stimulation is carried out when the animal (cat) has recovered consciousness, is, therefore, of great interest. Hess was also one of the first neurophysiologists to appreciate the careful control of stimulation frequency. The results of the work done last year are not yet published, but some of the findings are as follows. Stimulation of the orbital and cingular gyri in cats, under barbiturate anæsthesia, with kymographic recording of blood-pressure and respiration, showed arrest or slowing of breathing on stimulation of any effective point in these two zones. Blood-pressure was also altered, a rise or fall being obtained on stimulating discreetly separate points in these two regions. Orbital gyrus stimulation in places caused profuse salivation, while from the cingular gyrus pupillary dilatation was common. In the unanæsthetized cat, the blood pressure could not be recorded, but respiration was never seen to be arrested as it was in the narcotized animal; indeed, it frequently became both faster and deeper. The pupil reaction from the cingular gyrus depended on frequency; 4 stimuli per second produced constriction, whereas 8 per second caused dilatation. This was accompanied by deviation of the eyes, and there is evidence that the cortical representation of eye movements in the cat is on the medial surface of the hemisphere.

The Anatomist's Contribution

The anatomical basis of these effects mediated by the cortex is not at all certain. Classical histological methods only revealed such tracts as the fornix, from the hippocampus to the mammillary bodies of the hypothalamus, and the mammillo-thalamic tract of Vicq d'Azyr. In 1933 Le Gros Clark and Boggon demonstrated fine fibres running in the wall of the third ventricle from the hypothalamus to the dorso-medial nucleus of the thalamus, which has widespread connections with the frontal cortex. Finally, extensive studies with strychninization ("physiological neuronography") indicate that the frontal and orbital areas directly activate the nuclei of the hypothalamus. No one can say whether corticifugal pathways not involving the hypothalamus play any part in mediating autonomic effects.

Architecturally, with the exception of the premotor area, all the cortical areas from which autonomic effects have been obtained are similar in that they are simpler in structure than the six-layered cortex of the most highly developed regions. Together they have been styled the mesopallium, or mesocortex. This surrounds the upper end of the brain-stem and includes all the areas that until recently were called the smell-brain (rhinencephalon) such as the hippocampus, uncus and the cingular gyrus. The projection pathways are probably short with frequent relay-stations (Yakovlev). Thus an anatomical unity is beginning to appear in what were thought to be completely diverse cortical areas. A recent report describes autonomic responses from the temporal lobe near the uncus and the island of Reil while the more inaccessible hippocampus can be predicted to be similar in function.

What Does it all Mean?

The interpretation of the experimental findings in terms of normal function is not easy. Eliciting a response by electrical stimulation merely shows that a physiological connection is a possibility, but does not prove that it is the normal mechanism. The hypothalamus is the lowest (most caudal) level in the brain where all autonomic effects can be produced by stimulation, though some, notably respiratory, vasomotor and cardiac activities are integrated to a considerable extent in the medulla oblongata. About the part played by the cortex in relation to the hypothalamus one cannot dogmatize. One view is that the hypothalamus organizes the day-to-day running of the visceral activity.

and that the cortex intervenes only insofar as adaptations are needed in response to sensory stimuli from the external environment, for it is the cortex that receives all sensory messages from outside. In Sherringtonian language we may say that "the hypothalamus is the head ganglion of the autonomic system," but that it is influenced by the cerebral hemispheres which are " the head ganglia of the distance receptors." This is close to Hess's views. Other workers, however, notably Fulton, consider that the cerebral cortex represents the highest level of integration of nervous activity, and so the representation of the autonomic nervous system in the cortex must be the dominant factor in its control. The two views are not, in fact, mutually exclusive, for reciprocal influence between higher and lower centres, between cortex and hypothalamus, undoubtedly exists. Destruction of hypothalamic nuclei reduces activity over the whole of the cortex very greatly, and conversely, epileptic fits of a quite typical "grand mal " type can be set off by stimulation of the diencephalon—Penfield, for example, now thinks that generalized epilepsy arises from this part of the brain. Thus a constant mutual activation probably occurs, the hypothalamus being in an especially important position at the upper end of the brain-stem, through which all radiations must pass.

All this would be merely dry academic controversy, if it had not been shown that operations, on just these parts of the brain that we have been discussing, do have a profound influence on patients with psychoses, neuroses or intractable emotional disorders. The special importance of operating on the foci of autonomic activity is not altogether surprising, for the subjective sensation of an emotion is inseparable from the visceral changes accompanying it. It pervades our ideas of emotion; remember the cold sweat and sinking feeling of fear—the stomach and bowels are traditionally and metaphorically always linked with it. We cannot conceive of excitement without a rapid, bounding pulse and dilated, shining pupils; or of anxious anticipation without cold feet, or of pleasant culinary anticipation without salivation. May it not be that the quality of our feeling *depends* on the visceral changes that accompany it? If that is so, we can say that we have been discussing the physiology of human happiness.

References

Reviews of especial value are:—

Fulton, J. F. (1949a), Functional localization in the Frontal lobes and Cerebellum. Chapter 2. Oxford, pp. 140.

idem. (1949b), Physiology of the Nervous System. 3rd edn. O.U.P.

Livingston, R. B. (1950), Autonomic Nervous System. *Ann. Rev. Physiol.* **12,** 445-468.

Various authors (1948), The Frontal Lobes. *Res. Publ. Ass. nerv. ment. Dis.* **27.**

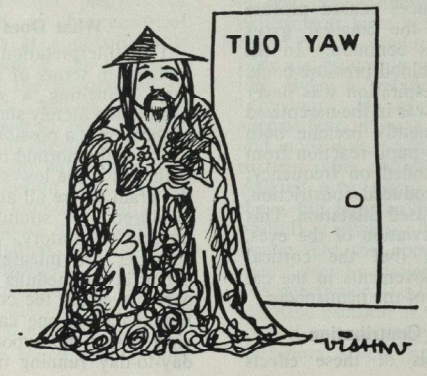
(See contributions by Livingston *et al.*, Delgado, and by Ward.)

Hess, W. R. (1949), Das Zwischenhirn. Schwabr. Basel, pp. 187.

Papez, J. W. (1937). A proposed mechanism of emotion. *Arch. Neurol. Psych.*, Chicago. **38,** 725-743.

Yakovlev, P. I. (1948). Motility, behaviour and the brain. *J. Nerv. Ment. Dis.* **107,** 313-335.

For other references, see Fulton (1949 a & b).



NEUROMANIA

OR

THE PHYSIOLOGICAL BASIS OF PSYCHIATRIC PRACTICE

By M. HOLLIDAY EVANS

I STRODE swiftly from the lift, marched boldly up to the door, and without a moment's hesitation . . . I hesitated. The lettering on the frosted glass panel said " Dr. Anatole Gurk, Psychiatrist."

" Be a man, Stainton," I said. "After all, it is him whom you have come to consult. Him it is with whom you have to consult with," I said, for I like to experiment with my grammar. I was talking to myself: there was no one else in the vicinity. Frequently I talk to myself these days. And nights, too. The reason for this is that I am the most brilliant conversationalist I know. More brilliant than Oscar Wilde, Alexander Woollcott, or the gentlemen who gaze into the cosmic crystal before the one o'clock news. And I do so love good conversation.

For a moment I stood there, wrapt, like Macbeth when he heard about his promotion. Then the door opened, and with a sudden quickening of the senses I realised that I was definitely, irrevocably, on the threshold. A man stood before me. I knew it was a man: he had all the earmarks. Imagine my unastonishment when he said, " Come in." I sidled past him, hurled myself upon the couch, and tried not to look at the " Men Only " calendar on the wall.

" The dream, Doctor," I cried, " it's the dream!" I hazarded a guess as to his identity. He came over to the couch wearing an enigmatic expression, pince-nez, and a liberal dressing of Vaseline hair tonic. Plus, of course, the usual gent.'s double-breasted. " Where were you born?" he asked. " In a maelstrom," I replied. " Or it may have been a femaelstrom, I'm not quite sure. I was too young to appreciate fine distinctions, at the time." The doctor nodded. " That accounts for it," he remarked, " or part of it, at least. But go on."

" I shall try to present the events of my dream in logical sequence," I began.

" Chronological or biological?" he asked.

" Yes," I replied, " it starts with a girl."

" Does it, though!" exclaimed the doctor, slapping his thigh. I made haste to continue, before he should get completely out of hand.

" In my dream," I explained, " the girl is seated in a chair facing the foot of my bed. It is winter, and there are icicles hanging down on either side."

" Of the end?"

" Of my moustache."

" But you are clean-shaven!" cried the doctor, tugging at my upper lip to make sure.

" Not when I dream," I told him. " Once in the arms of Morpheus I become the acme of masculine maleness. I even have hairs on my chest. Four," I added, in the interests of scientific accuracy. " And then it happens!" I continued climatically. " Suddenly I notice the big toe on my right foot. It is sticking out from beneath the blanket. I try to draw it under again, but do you think I am able?"

" I don't know," said the doctor, " you've been raising Cain ever since you've been here."

" No!" I cried, answering my own question. " Up it stands. Or, rather, out it sticks. So quiescent! So vulnerable! So . . . ! "

" Toe-like?" suggested the doctor.

" Precisely so," I agreed. "And then . . . " Beads of sweat rolled off my brow as the memory came flooding back. "And then she begins moving towards it. Effortlessly, relentlessly . . . "

" The girl?"

" The girl. With a quick flick of her torso she stoops and sinks her teeth into it."

" The toe?"

" The toe," I muttered feebly. The effort of recital had exhausted me, and I fell back in a state of semi-colon.

The doctor made an effort to restore me to consciousness. "And then?" he asked, rapping me on the Adam's apple, with a well-thumbed copy of Freud.

"And then I wake up," I whispered.

"Any marks on the toe?" asked the doctor, rubbing his hands together in a brisk, professional manner. "Any abrasions or conclusions?"

" Yes!" I exclaimed, roused by his uncanny insight. " There are marks on the toe. Distinct traces of nocturnal maltreatment."

"Uh—huh!" commented the doctor, with a significant pause between the " uh " and the " huh." He rose and began pacing the floor, lines of concentration or indigestion furrowing his otherwise ascetic countenance. At last! I thought, the un-subbing of my

conscious. The subtle, seemingly irrelevant question . . .

"Tell me," he rapped.

"Yes, doctor?" I said, breathless with anticipation as he paused before me.

"Has your landlady a cat?"

I was in a state of bemusement. What line of thought was this? However, I answered his question: it was the polite thing to do.

"Yes," I said, "she has a cat."

A look of relief crossed the doctor's face. "Well, that's it," he said. "Shut your door at night and you'll be O.K."

"But doctor," I interposed, "she has no teeth."

"Who, the landlady?" asked the doctor, loth to abandon his lightning diagnosis without a struggle.

"No," I said, "the cat. I knocked them out with a boot one day when I found her polishing off the plate of salmon which I had put out for my supper."

"What about claws?" snarled the doctor, biting his finger nails down to the metacarpals.

"She ripped them out trying to get at me after I knocked her teeth out with a boot one day when I found . . ."

"I heard you the first time," said the doctor, brusquely. "Well, I'm afraid we'll have to do the chores, after all. Any unfortunate experiences in early life?" There must be a woodshed somewhere behind that misshapen ego.

"Any old woodshed?" he added cajolingly.

"No doctor," I replied. "Our third floor flat didn't run to woodsheds. Why, we even had to share the bathroom."

"BATHROOM!!!!"

As I spake that simple word a bolt shot back in my brain, sweeping away with its illumining beams the encrusted sediment of Time.

"That's it!" I cried. "not a woodshed. doctor, a bathroom!"

"Well!" said the man of science. "Well, well!! It's not every day we run across a good clean complex like that. Tell me more."

"It was Auntie Rosie's fault," I began. "she wasn't as deaf as I thought. She wasn't really my aunt," I explained. "She lived along the passage from us, and used to give me pennies for running errands, so I called her auntie out of respect. One day she gave me sixpence and my respect increased so much that I wanted to give her a boost up the family tree. I offered to call her grannie."

"I'm positive she didn't take you up on that," said the doctor. I was amazed at his omnivorous knowledge of the human heart.

"How do you know so much about women?" I asked.

He lowered his eyes. "I've done some research," he replied modestly. "But go on."

"Well," I said, "one day my father called me into his study. He was bending a young sapling over his knee, testing it for pliability. Some sixth sense warned me of an approaching ripple on the domestic millpond.

"'Stainton,' said my father, rolling up his shirt-sleeves, 'what's this about you looking through the bathroom keyhole?'"

"How old were you at the time?" asked the doctor.

"Nine," I replied. The doctor looked at me with a new-found respect.

"The spirit of scientific enquiry," he said, "we have much in common." I was gratified by his approval.

"I looked my father straight in the face," I continued, "without one flinch, blinch, or bat of an eyelid. 'Father,' I said 'who is responsible for this malicious report?"

"'You are,' he replied. 'Rosie says she heard you scuffling about outside the door while she was taking a bath last night. Did you or didn't you?'

"'What?' I asked wildly. My young sensitive soul was not yet proof against the world's calumny. Also I was playing for time.

"'Look through the keyhole!' repeated my father.

"'Alas,' I cried, 'I am but a simple lad. I know nothing of accusation, and refutation, of circumstantial evidence, or habeas corpus, save what few gleanings I have glone from the legal section of the British Museum. Yet, if answer I must, I base my defence on three points.

"'First, I never went near the bathroom on the night in question. Second, I was only bending down to tie my shoe-lace. And third, she always blocks the keyhole with paper anyway. Would you believe this woman, this stranger,' I cried, 'rather than your own flesh and blood?'"

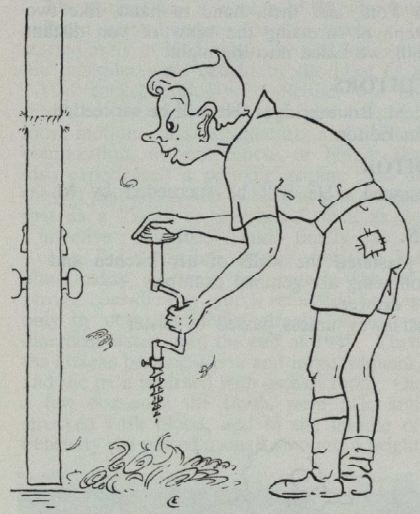
"'Of course not,' replied my father, standing up and flexing the short head of biceps, 'but just in case . . .' I apologise for breaking off at this point, doctor," I told him, "but over what followed I prefer to draw a veil."

The doctor let out a gasp of indignation.

"Monstrous!" he exclaimed, "perfectly monstrous! To accuse an innocent boy, nay, scarce more than a child of such crudeness, such insensitivity, such lack of perception!"

"Yes," I broke in, "that . . . that was what really hurt. As if I didn't KNOW she blocked the keyhole!" A look of shy pride lit my features. "That's why I bored a hole through the door."

The doctor's face turned ashen. He looked quite burned up. "What?" he muttered hollowly.



"Through the bottom left hand panel," I explained, "right in the corner, where it wouldn't show. With my father's hand-drill," I added, giggling brazenly.

The doctor passed a damp hand over his brow. "Tell me," he said, "are you normally at your ease with women?"

I tried to answer, but my mouth went dry, and my tongue felt as big as a marrow. There was a copy of *La Vie Parisienne* on the doctor's desk. I had been trying not to notice it for the past ten minutes, and the strain was telling.

"The opposite sex!" exclaimed the doctor, relapsing into technical jargon. "Are you comfortable in the presence of the opposite sex?"

My reply was not entirely convincing. "Phmm . . ." I said. "Ngaaa . . ."

The doctor put his fingertips together and closed his eyes. "At a guess," he said, "at a guess I should say that you are allergic to women who take baths. Or even showers," he added.

As if by magic, a weight suddenly lifted from my cerebral hemispheres. "Well, in hell's name!!" I shouted. No wonder my girl friends have never been socially acceptable!" My feelings were so indescribable as to be beyond description. I shot a bold glance at the doctor's desk. A strange sense of power flowed through me. Well, why not? I asked myself. I rose from the couch, sauntered over to the desk, and picked up *La Vie Parisienne*.

"Hmm . . . not bad!" I remarked. "Trifle on the skinny side. I like a woman to BE a woman, myself."

The doctor regarded me with unqualified admiration.

"Now we've brushed away that little cobweb we shouldn't have any more trouble," he said.

He walked round the desk, and stood in front of me. His hands were going through a quaint little pantomime, as though they were folding a succession of crisp pound notes and then transferring them to his breast pocket. I wondered if I dared mention the sordid subject . . .

"By the way, what is your fee, doctor?" I asked, risking it.

"WELL!" he replied, booming out his words, except for one or two which slipped in as if by accident, "WELL! IN VIEW OF THE LONG AND EXPENSIVE COURSE OF STUDY WHICH WE MEDICINE MEN, THAT IS TO SAY, WHICH WE MEN OF MEDICINE MUST UNDERGO, AND NOT FORGETTING THE INVALUABLE SERVICE I HAVE JUST RENDERED YOU, I DON'T THINK, ON MATURE CONSIDERATION, THAT twenty guineas IS ASKING TOO MUCH."

There was a pause, hushed and expectant.

"Doctor," I said, "did you ever have any unfortunate experiences in your youth?" He favoured me with the tolerant smile of one who is not averse to a little light badinage before collecting twenty-one quid.

"Of course," he replied. "We of the profession are no more immune, no more insulated from external stimuli, than, shall I say, hoi polloi? We just build up more resistance that's all."

"And how is your resistance now?" I pressed him.

"Oh, grand," he assured me. "simply grand. Nothing can shake my composure now."

"Would you like to make a small wager on that?" I asked. Before he could reply, I picked up a priceless old Sèvres warming-pan and stunned him with one God-Almighty blow.

And then, dancing lightly out of the office I bumped into positively the most gorgeous redhead that ever poured herself into a black strapless evening gown.

"Bay-bee!" I said, in a deep husky baritone tone that I didn't know I had in me. I held her gently but firmly by the elbows, and as I looked deep into her long-lashed green eyes I felt that at last I had found the Real Thing. In less time than it takes to tell, her satiny arms were round my neck and her cherry lips were glued to mine. Suddenly I held her roughly at arms length. Or, rather, roughly I held her at arms length. That is to say, I held her at arms length, roughly. Hell! she wasn't worrying about the position of the adverb.

"Honey child, honey pie, honey bee," I said (for I was sweet on her by this time), "enough of this love-making! Come!"

She paused only long enough to repair her make-up, change her nylons, and give herself a Toni, and then, hand in hand, like two zephyrs caressing the brow of yon distant hill, we faded into the night.

CHANGE OF EDITORS

We announce the resignation of the Editor, M. Braimbridge. He will be succeeded by J. A. Williams. M. B. McKerrow is Assistant Editor.

SPORTS EDITOR

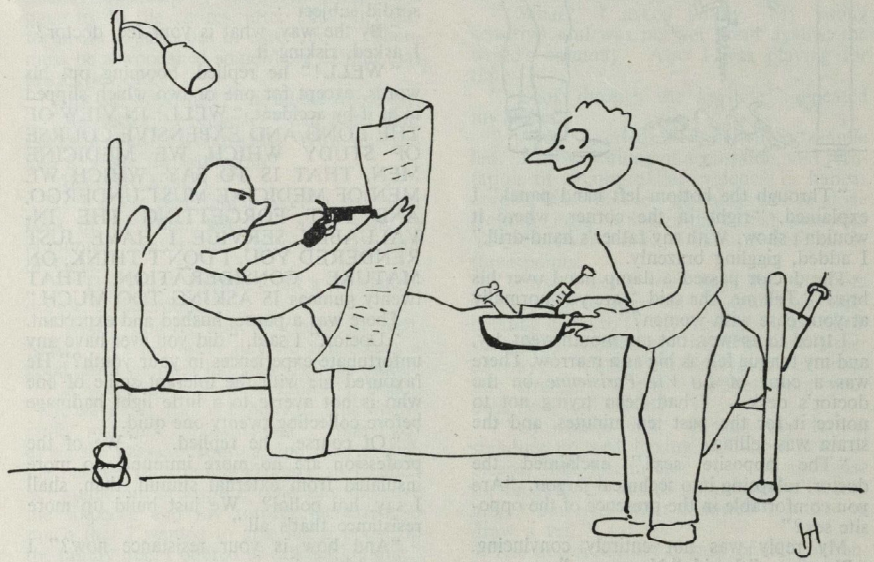
The Sports Editor, P. D. Moyes, has resigned. He will be succeeded by M. Braimbridge.

NOTICES.

There was recently a Sister at Bart.'s who plastered the walls of her kitchen and Path. Room with small notices, of which the following are genuine examples:—

"Housemen must not fiddle in Sister's drawers."

"Samples of urine must not be thrown away unless passed by Sister."



Just another test, Mr. Biggs.

ADENOMATOUS POLYP OF THE COLON

By G. C. R. MORRIS

BENIGN neoplasms of the gastro-intestinal tract are not uncommon, but few of them cause symptoms. The large intestine is the commonest site, and adenoma the commonest histological type. The tumour is usually polypoid, projecting into the lumen of the bowel; intramural and subserous tumours are rare. The following clinical history illustrates the course of a polyp high in the pelvic colon.

Case History

The patient was a woman of 38 who had suffered with diarrhœa for five years. It started early in 1945, when she and her year-old daughter were caught by the blast of a "V2" rocket explosion. Neither was injured, but the mother began to pass frequent loose motions, of small quantity and normal composition, without mucus or blood; she also experienced a periodic griping pain in the left iliac fossa. Her condition was treated first as a "nervous diarrhœa," then as an "infective enteritis," and finally as a "colitis": a barium enema revealed no abnormality. After a few months she improved considerably, and a remission broken only by occasional brief attacks of watery diarrhœa lasted until the end of 1949. Then the attacks became worse and more frequent, and the pain returned with greater force. On a few occasions the stools were pale and streaked wtih blood, and in the middle of February she passed a small amount of bright blood. When she was seen in the out-patient department of this hospital on February 21 her sigmoid colon was palpable, but no other abnormality was detected.

Sigmoidoscopy a fortnight later was negative, but a barium enema examination, at which the sigmoid colon was both palpable and tender, "revealed the presence of a large polyp in the descending colon which after evacuation was seen to have produced some degree of intussusception. This measured approximately 10 cm. in length" (Fig. 1, 2.)

She was admitted under the care of the Surgical Unit at the end of March. She had lost a little weight in the previous months. There was no family history of neoplasm, either benign or malignant. She had had a lump removed from her right breast at the age of 22, and had otherwise always been well.

Examination showed a slender woman of pale complexion with no abnormal physical signs. A course of sulphathalidine (G 2 six-hourly) was begun. Sigmoidoscopy (4.4.1950) did not reveal any abnormality.

At operation two days later the abdomen was opened through a left muscle-splitting incision under thiopentone, gas, oxygen and ether. The colon was examined, and a soft round mass without a pedicle was felt at the junction of the descending and pelvic parts of the colon, attached to the mesenteric border and filling the lumen. Fæcal masses

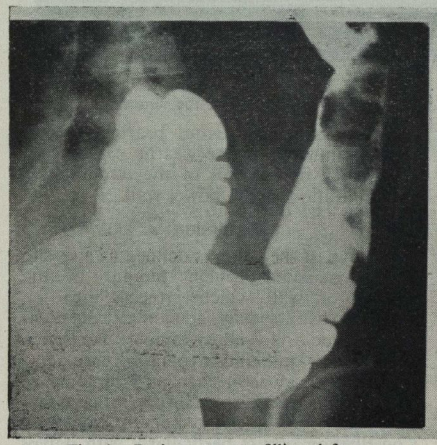


Fig. 1. Barium enema; filling defect.

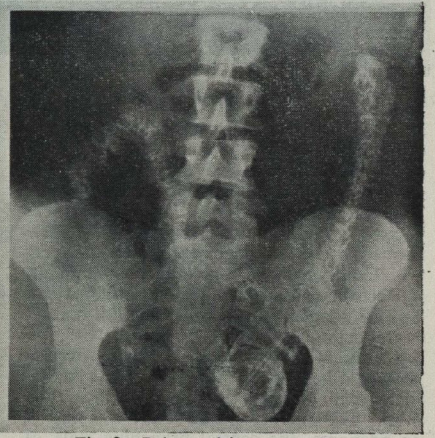


Fig. 2. Polyp and intussusception.

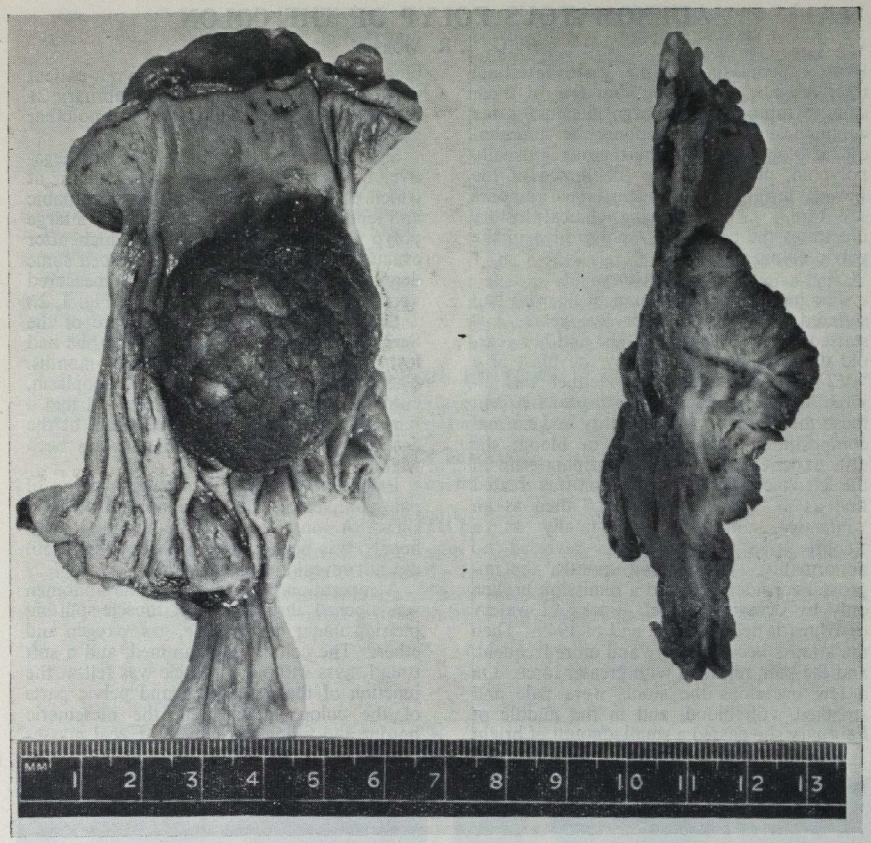


Fig. 3. The specimen excised.

Fig. 4. Section of the tumour.

proximal to the polyp were pushed past it, and manipulation demonstrated that the polyp could easily lead an intussusception into the thin and distended part of the bowel. The segment of colon bearing the polyp was excised, and an end-to-end anastomosis performed. The abdomen was closed in layers with peritoneal and subcutaneous drainage.

Recovery was satisfactory, and the patient was discharged after two weeks with normal bowel action.

Examination of the specimen excised showed a hemispherical tumour 5 cm. in diameter with a finely lobulated surface (Fig. 3, 4). The microscopic structure was that of an adenoma, the central branching stalk of vascular connective tissue bearing normal secreting mucosa: there was no evidence of malignancy in the cells of the tumour, nor any infiltration of the bowel wall.

Discussion

A polyp of the colon is defined as a sessile or pedunculated benign tumour of the mucosa or wall which projects into the lumen.[10] Histologically, adenoma is the commonest type, followed by lipoma; papilloma, fibroma, angioma and myoma are rare.[7, 8].

All may produce mechanical symptoms, of subacute obstruction or chronic intussusception, and bleeding per rectum is common.[1] Constipation occurs particularly with polyps in the region of the rectosigmoid junction: other possible symptoms are tenesmus, protrusion of a mass per anum, and pruritus. Diarrhœa is unusual, and the exact significance of it in this patient is open to question; but the colic and the bleeding suggest the correct diagnosis.

Diagnosis depends on careful investigation. The tumour or the intussusception may rarely be felt per abdomen, and more often per rectum. About half of the polyps occur in the rectum and sigmoid, within reach of the sigmoidoscope;[3] the remainder must be sought by the radiologist. The larger ones will show as filling defects in a barium enema, but evacuation and air replacement is advisable, and repeated examination useful.[5] In this patient both the polyp and the intussusception were clearly seen: the negative report in 1945 is not evidence that no polyp was present at that time, although the sudden onset of symptoms implies something other than a purely mechanical origin.

The natural history of such a condition is not yet defined, but there is strong evidence that all polyps of the colon and rectum should be regarded as pre-malignant.[9] Ulceration of the surface or induration of the base is diagnostic of malignancy, and the histological change may occur in any part of an adenoma of any size at any age.[4]

Inspection and palpation are insufficient to determine innocence, and biopsy is often inadequate. Excision, whether by colotomy or by diathermy snare through a sigmoidoscope, should be followed by serial section to decide the advisability of a more radical procedure: fulguration of rectal polyps demands careful follow-up.[9]

The incidence of polyps of the large bowel has varied from two to ten per cent. in long post-mortem series,[3, 4, 6] and more than one polyp is found in half the cases. The proportion of these polyps which cause symptoms is small, as is probably the proportion which exist long enough to become malignant; but it is clear that they should be suspected, sought and treated.

My thanks are due to Professor Sir James Paterson Ross for his permission and encouragement to report this case: also to Dr. R. A. Kemp-Harper and Dr. G. D. Cunningham for their advice and the radiological and pathological reports.

The photographs were taken by the Department of Medical Photography.

References

1 Brust, J. C. M. Proc. Staff Meet. Mayo Clin. 9,625 (1934).
2 Dukes, C. E. Brit. J. Surg. 13,720 (1927).
3 Haug, A. D. & Swinton, N. W. Lahey Clin. Bull. 5,84 (1947).
4 Helwig, E. B. Surg., Gynec. & Obstet. 84,36 (1947).
5 Hughes, C. R. & O'Malley, E. J. M. Clin. N. America. 32,428 (1948).
6 Lawrence, J. C. Am. J. Surg. 31,499 (1936).
7 Pemberton, J. de J. & McCormack, C. J. Am. J. Surg. 37,205 (1937).
8 Saint, J. H. Brit. J. Surg. 15,99 (1927).
9 Swinton, N. W. Am. J. Surg. 75,369 (1948).
10 Swinton, N. W. Am. Pract. 2,603 (1948).

AN AUTHENTIC LETTER

From an African employee at the Groundnut Scheme in Tanganyika:—

Dear Sir,

Kindly allow me to have only a little opportunity to say what I have seen in my life this year.

Through bad luck my upper teeth got broken recently. That they got broken during 3.3.49. They were broken as follows:—

(a) The four small teeth had gone.
(b) The three big did the same to my left mouth.
(c) I mean from the first small tooth to the third to the third big tooth left.
(d) Six teeth remained to my right mouth.
(e) Three teeth remained to my left mouth.

There are only nine teeth remained to my mouth. I wonder:

Sir, the seven teeth of mine are wanted by me the chance of getting any occurs in your Department.

The kinds I want are the first Class. The excellent, permanete teeth. The one which can not be pulled off during any meal please.

Be kind enough and tell me the price of the seven teeth; so I may be able to post moncy to you immediately I receive the reply. You too you many be able to post the seven teeth to me as soon as my money appears to you please.

Please make my fourth small tooth left yellow (*gold!*) in colour sir. See that I am ready waiting for the result only, even if the price is expensive I do not mind concerning that I get my seven teeth as past.

I am losing quite a lot of my appearance because of my absentise teeth. Therefore may I know the result within this week please.

Yours sincerely servant,

XYZ.

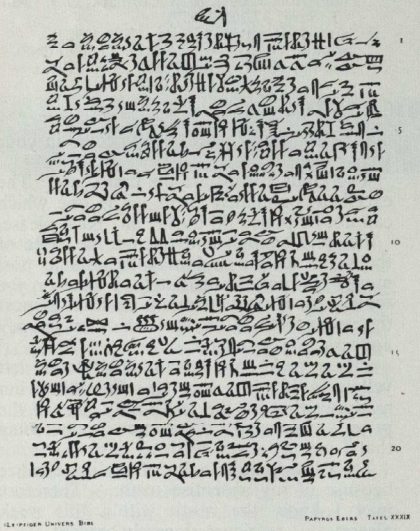
PERSONALITIES AND PROGRESS IN THE STORY OF DIABETES MELLITUS

By S. F. MARWOOD

(*Continued*)

Before proceeding to an account of the more accurate pin-pointing of the morbid process, we may spare a thought for those who made the manifestations of ketosis and diabetic coma less mysterious. Names are many. Petter discovered acetone in the urine of diabetics in 1857. There were Adolf Kussmaul and his great successor, Bernard Naunyn, and Naunyn's pupil, Magnus Levy who wrote on diabetic coma and its treatment, and postulated that acetone bodies are found when carbohydrate is lacking or not being utilised in a normal way. There was Rosenfeld who said "fats burn in the flame of carbohydrates," and there were many others such as Ebstein, Kaufman, van Noorden, and Hirshfield, but the names of Kussmaul and Naunyn particularly demand recognition.

Adolf Kussmaul was born in 1822 and died in 1902. An army surgeon for some years after qualification, he successively became professor at Heidelburg, Freiburg, and Strasburg. One of medicine's great



Ebers Papyrus.

pioneers, he was the first to describe periarteritis nodosa and progressive muscular paralysis, to diagnose mesenteric embolism, to attempt œsophagoscopy and gastroscopy, and to do gastric lavage. Fifteen years after Petter's discovery of acetonuria, Kussmaul demonstrated acetone in the blood, and it is in connection with diabetic coma and the chain of events leading thereto that he is best known to us. The characteristic dyspnœa of the comatose diabetic bears and perpetuates his name, and extracts from his own writings on the subject make interesting reading. Thus he says:—

> "Since I have seen three diabetics in the course of a year die with remarkably similar symptoms in which there was a peculiar comatose condition preceded and accompanied by dyspnœa, I believe that it is not merely a play of chance, but has to do with a form of death in diabetics which bears the closest relationship to the disturbances in the metabolism."

He then carefully describes the three cases, and notes "the great loud breathing preceding death." He stresses the absence of any suggestion of obstruction to breathing, and particularly notes the contrast between the marked general weakness of the patient and the strength of the respiratory movements. He draws these conclusions:—

(1) The dyspnoea is not the product of reflex excitation of the respiratory centre from vagus or laryngeal nerve, but is due to direct central stimulation.

(2) It is not due to lack of oxygen in the respiratory centre.

(3) It is not the result of an inordinate increase of carbon dioxide in the blood.

(4) It can only have its cause in an intoxication of another sort which stands in close relationship to the chemical disturbances of the body in diabetes. Concerning the nature of this toxic agent, nothing can be said for a certainty at present.

Even at that relatively distant period, Kussmaul knew that the intoxication was the expression of a profound metabolic disturbance. Knowledge of the disordered metabolism of fats was yet to come, but he

was nearing the truth, and his observations entitle him to a place among the elite.

Bernard Naunyn succeeded Kussmaul at Strasburg. Well known for his work on gallstones and diseases of the liver and gallbladder, he is even better known for his metabolic and other researches in diabetes. In 1892 he wrote his famous monograph and, in 1906 introduced the term acidosis. Enunciating principles of diet which are mostly applicable today, he advocated reduction of total calories as well as carbohydrates. His aim was to make and keep patients sugar-free, for he had noted the rise in sugar tolerance when the urine was kept free of sugar for long periods. Naunyn established the principle that the treatment of diabetic coma, actual or threatened, is the basic treatment of diabetes and not merely that of acidosis, and thereby discredited the alkali treatment which was fashionable. He recognised the innocent occurrence of glycosuria in individuals whose renal leak-point was subnormal, and he stressed the unity of the disease, insisting that all diabetics were united by the common bond of diabetic heritage. Naunyn's influence on the development of a rational outlook in the treatment of diabetes mellitus was immense, and his place in medical history is assured.

In the meantime, equally important researches were resulting in the incrimination of the islet cells as a principal seat of the morbid process. In 1873, Eugene Lindsay Opie who was later to become Professor of Pathology successively at Washington, Pennsylvania, and Cornell, noted, whilst still a demonstrator at Johns Hopkins University, that the islet cells of a girl who had died of diabetes were in a state of hyaline degeneration. So pronounced was the change that, even in the tail of the pancreas, they were scarcely recognisable, whereas the acinar structure was little affected. The importance of this observation needs no emphasis.

In 1889, Vassale ligated the duct of Wirsung in a rabbit. The animal survived for 150 days, and at no time exhibited glycosuria. Post-mortem examination revealed healthy islets in a ruin of atrophied acini.

The evidence was accumulating and, during the next twenty years, numerous observers were to confirm these findings. The names of Diamara the Italian, and McCullum of America figure prominently, but it was another Italian, Massaglia, who finally removed the subject from the realms of hypothesis and inference, and demonstrated positively that a lesion of the islet cells in the presence of healthy acini would cause diabetes. This he did in 1912 by a most ingenious series of experiments on dogs and

Translator receiving an Arabic work of Rhazes.

rabbits. Time does not permit a description of his methods, and only his conclusions may be given. He states that the pancreas governs carbohydrate metabolism by virtue of an internal secretion from the pancreatic islets, a view only tentatively advanced a short time previously by Opie and Schäfer. He further asserts that a certain proportion of the islets have to be eliminated before diabetes ensues, and that alimentary glycosuria is the result of hypofunction of the islets. Here is the full flowering of experimental medicine, and its successful application to a problem which had long baffled us. All too little credit has been given to Massaglia, and it is a pleasure to pay tribute, in this brief and modest review, to one who occupies an essential place in diabetic history.

The next major and almost inevitable advance was the preparation of an extract of the islets which would replace the missing secretion, and restore the metabolic balance. Meanwhile, however, considerable strides had been made in the dietetic treatment of the disease. In America, F. M. Allen had been greatly impressed by his observations that diabetes regressed or even disappeared in cachectic states, and that fasting relieved the symptoms and increased the carbohydrate tolerance of depancreatised dogs, and he had become a great advocate of under-nutrition diets. His emphasis was on total metabolism, and reduction had to be general and not limited merely to carbohydrates. Allen's findings were supported by Joslin who had noted the diminution of glycosuria and ketosis in a patient suffering from acute pulmonary tuberculosis.

In England, Graham had arrived independently at conclusions differing only in detail from those of Allen. It was he who explained the apparently contradictory observations that fasting tended to produce ketosis in healthy subjects, yet lessened that of diabetics. He pointed out that, before treatment, the metabolism in diabetics is high—Benedict and Joslin had shown it to be 20 per cent. above normal—largely as a result of the abnormal fat metabolism and production of aceto-acetic acid, and it is this deranged metabolism of fats which is favourably affected by fasting.

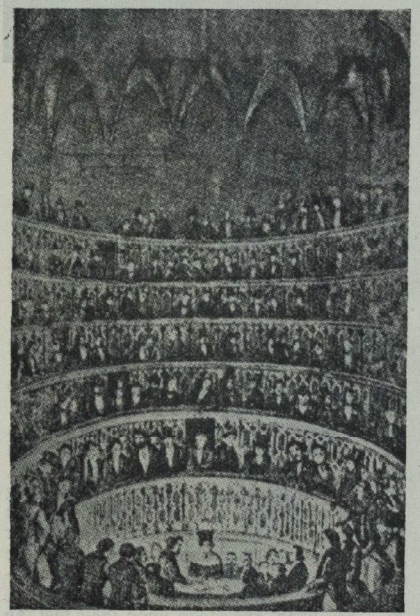
Allen's system and Graham's well-known ladder diet consolidated a regime of treatment which was remarkably successful in mild cases, particularly in the older obese type, and reasonably so in moderately severe cases. In acute cases, however, and especially in the young, it was impossible to maintain body weight on the very restricted diets necessary to keep the urine sugar-free, and the patients either died of intercurrent disease consequent on starvation, or, more commonly, failed to continue treatment, and, imposing more and more strain on the already depleted islet cells, went rapidly downhill, dying either in coma or as a result of pulmonary tuberculosis. Nevertheless, the dietetic discipline imposed by Allen, Graham, Joslin, McClean and others, and elaborated from principles enunciated first by Naunyn, brought new life to diabetics, and enabled large numbers to survive into the relative security of the new era which was so near at hand.

The scene now shifts to Professor Macleod's laboratory at Toronto in 1921, where Frederick Grant Banting had started work with the help and encouragement of Macleod, and with the assistance of C. H. Best, a second year medical student, and Collip, the bio-chemist. All four were to play a prominent part in the work of research that followed, but it is well to remember that it was Banting's inspiration in the first place which gave to humanity a treatment as dramatic as any in the history of medicine.

Banting was born in November 1891 on a farm outside Alliston, Ontario, and he qualified with the M.D. of Toronto university in 1916. Contemporaries say that he was not exceptionally clever, but was possessed of a very enquiring mind and a quiet determination always to see things through. In other words, he was a good sound man. He served overseas in the first world war, won the M.C., and was severely wounded. Returning to Canada in 1920, he first practised as an orthopædic surgeon in London, Ontario, and at the same time, acted as a demonstrator of physiology at the university of Western Ontario. Becoming interested in the problems of diabetes mellitus, and particularly in isletin, as Scharpey-Schäfer had named the hypothetical secretion of the pancreatic islets, he gave up his unsuccessful practice and started work in Macleod's laboratory. Had he by any chance heard of Zuelzer who, inspired by the far-reaching experiments of Massaglia, had, ten years earlier, come very near to the discovery of a method for preparing an islet extract? After various chemical treatments, Zuelzer obtained an extract which reduced the hyperglycæmia on

injection into depancreatised dogs. Thus encouraged, he tried the treatment on human diabetics and successfully reduced glycosuria and ketonuria. Unfortunately it was attended by unpleasant and dangerous side-effects such as rigors and pyrexia which were believed to be due to impurities but some of which were doubtlessly the result of hypoglycæmia. The treatment was abandoned, and it is curious that in Banting's writings are to be found no reference to the experiments of either Massaglia or Zuelzer. Be that as it may, Banting and his co-workers commenced their experiments and, in a short time, were fortunate enough to meet with startling success. They published their first results in 1922.

Briefly summarised, these tell us that the pancreatic duct of a dog was ligated and the normal secretory tissue allowed to degenerate. The dog was then killed by chloroform, and the degenerated pancreas swiftly removed and sliced into a chilled mortar containing Ringer's solution. The half frozen gland was then thoroughly macerated and the mixture filtered through



Anatomical Theatre at Padua

paper. The extract, raised to body temperature, was then injected intravenously into recently depancreatised dogs, and a marked reduction of hyperglycæmia and glycosuria noted. Banting enjoyed a well-deserved good fortune, for success came from his first experiment. In a number of subsequent experiments, it was found impossible to exhaust the pancreas sufficiently to obtain an extract free from considerable impurities with their dangerous side-effects. Had it not been for this lucky chance, who knows but that Banting's work might have suffered the same fate as Zuelzer's.

The clinical test had yet to come. A suitable patient was selected for the all-absorbing experiment, but at the last moment he declined to be a subject, and thereby missed his chance of immortality. Not so a doctor, seriously ill with diabetes. He gladly offered himself and, in a short time, was restored to almost full vigour. The year was 1922, and the beginning of a new epoch in the history of diabetes mellitus. Experiments were continued, and it was soon possible to prepare the newly named insulin from normal healthy pancreas. Before long it was being manufactured on a commercial scale. As was to be expected, and as so often happens with a new and revolutionary treatment, there were, in the early days, many accidents due to impurities and to hypoglycæmia but, with the passing of time, they have largely been eliminated by improvements in the technique of manufacture, and by experience in the use of the extract.

Recognition came swiftly. In 1923, the Nobel prize was awarded jointly to Banting and Macleod. Banting, hurt by the apparent lack of recognition of the part played by Best, insisted on dividing his share equally with him as did Macleod with Collip. Numerous medals were awarded him, among them that of the Society of Apothecaries, and many honorary degrees conferred on him by universities on both sides of the Atlantic. He was made an honorary fellow of both the Royal College of Surgeons of England and the American College of Surgeons, and, in 1930, elected F.R.S. He was knighted four years later. In 1930, Toronto University established an institute for research which was named after him, and he was made permanent Director of the Department of Medical Research to which he gave his share of the Nobel prize to provide a scholarship for young scientists. Lord Moynihan opened

the Banting Institute and gave what those who have been privileged to hear him speak would know was a most eloquent address, and, in speaking of Banting, he quoted Arthur O'Shaughnessy's couplet, "One man with a dream, at pleasure shall go forth and conquer a crown."

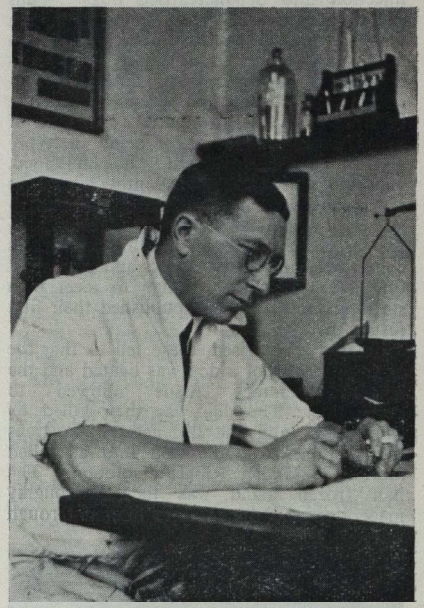
His death in an aeroplane crash in the Newfoundland wastes caused comparatively little stir happening as it did in the midst of the tragedy of the recent world war. Banting was a simple man, and would have been the last to claim the attributes of genius. Greater scientists, more brilliant and versatile investigators there had been, but at least the faith, inspiration, and tenacity which led him to a great success were equal to theirs, and countless thousands had reason to mourn the passing of a man whose name will be honoured for all time.

Much work remained and still remains to be done. The original insulin, improved upon, is still with us and, thanks to the researches of Hagedorn in the first place, has been supplemented with more slowly acting insulins possessing delayed and prolonged actions. All of these we are learning to use, either singly or in various combinations, and it is the low blood sugar rather than the raised which more often provides moments of drama.

The doctor who permits complete freedom in diet is more culpable than the patient who welcomes it. Most of us realise that, although dietetic discipline need no longer be irksome except perhaps for grossly overweight patients, there is still a need for control. So also should patients who trouble to study the directions issued by clinics such as that at St. Bartholomew's Hospital, or books written for their benefit such as *The Diabetic Life* by R. D. Lawrence. Obesity is a well recognised danger not only in diabetics themselves but in those who come of diabetic stock, and to prevent is often easier than to cure.

The changing picture of diabetic death increasingly focusses the attention of physicians on the many problems of cardio-vascular degeneration, a further acknowledgement of the part played by the new therapy in prolonging diabetic life.

The emphasis in research has tended to shift from the pancreas to the other endocrines, particularly the anterior pituitary, and the work of Houssay and Potick, Young, Lukins, and of Haist, Campbell, and Best on depancreatised, hypophysectomised, and



Portrait of Banting.

adrenalectomised dogs justifies the new conception of diabetes mellitus as a syndrome. As Himsworth reminded us in his Oliver-Scharpey lectures at the Royal College of Physicians, such a conception envisages an interruption of the chain of metabolic processes at any one of several points, and therefore permits of several causations rather than the specific cause and cure for which one searches in a disease entity.

Banting's discovery was epochal, for it signalled the end of an era and the beginning of a new, and, as it provides a natural climax to a story which covers a period of 2000 years, this account virtually closes with it. What follows is contemporary history and a task possibly for another day. In the second Banting memorial lecture at Toronto in 1943, Joslin quoted what he termed the Banting chapter of the Bible. This consists of the first ten verses of the thirty-seventh chapter of the book of the prophet, Ezekiel, and the last verse reads, "So I prophesied as he commanded me, and the breath came into them, and they lived, and stood upon their feet, an exceeding great army."

My grateful thanks are due to Dr. Kenneth Black, to Mr. John L. Thornton, Librarian at St. Bartholomew's Hospital, and Mr. W. J. Bishop, Librarian of the Wellcome Historical Medical Library, and to Dr. E. Ashworth Underwood.

REFERENCES

Barach (J.H.), Historical Facts in Diabetes. *Ann. Med. History*. 1928. (10) 387-401.

Castiglione (Arturo), *A History of Medicine, translated from the Italian and edited by E. B. Krumbhaar*. New York, 1946.

Duncan (Garfield G.), *Diseases of Metabolism*, 2nd edition, 1947. 699-702.

Fitz (R), The Changing Picture of Diabetes. *Jour. Michigan State Med Soc.*, 1941. (40) 345-355.

Garrison (Fielding H.), *An Introduction to the History of Medicine*, 4th edition, 1929.

Graham (G), The Goulstonian Lectures on Glycæmia and Glycosuria. *Lancet*, 1921. (1) 951-5, 1003-7, 1059-65.

Guthrie (Douglas), *A History of Medicine*, 1945.

Himsworth (H.P.), The Oliver-Scharpey Lectures on The Syndrome of Diabetes Mellitus and Its Causes. *Lancet*, 1949. (1) 465-472.

Joslin (E.P.), Diabetes Today and Tomorrow. *Ann. Intern. Med.*, 1936-1937. (10) 179-193.

Joslin (E. P.), The Diabetic. Second Banting Memorial Lecture. *Canadian Med. Ass. Jour.*, 1943. (48) 488-497.

Lawrence (R.D.), *The Diabetic Life*, 13th edition, 1945.

Leopold (E. J.), Aretæus the Cappadocian. His Contribution to Diabetes Mellitus. *Ann. Med. History*, 1930 (N.S.2) 424-435.

McCradie (A. R.), The Discoveries in the Field of Diabetes Mellitus and Their Investigators. *Med. Life*, 1924. (31) 215-250.

Major (R. H.), The Papyrus Ebers. *Ann. Med. History*, 1930. (N.S.2) 547-555.

Major (R. H.), *Classic Descriptions of Disease*, 2nd edition, 1930.

Mettler (Cecelia C.), *History of Medicine*, 1947.

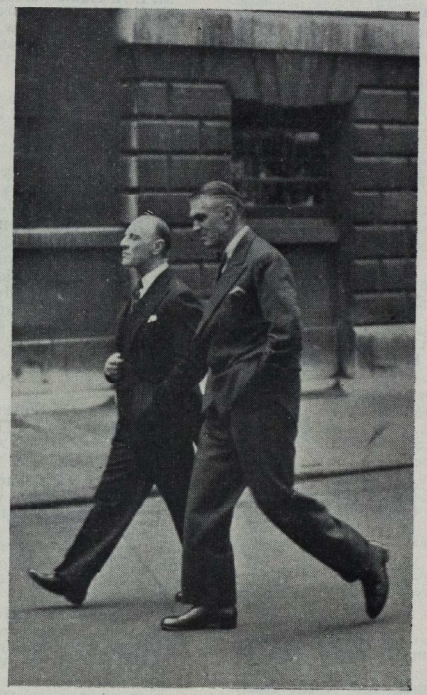
Rolleston (Sir Humphrey Davy, Bart.), *The Endocrine Organs in Health and Disease with an Historical Review*, 1936.

Seide (J.), Early History of Diabetes Mellitus. *Acta Med. Orientalia*, 1945. (4) 126-129.

Singer (Charles), *A Short History of Medicine*, 1928.

Stevenson (Lloyd), *Sir Frederick Banting*, 2nd edition, 1947.

An Address to the Cossham Medical Society, Bristol, on October 16, 1949.



I don't think that was funny, Hosford.

SPORT

CRICKET CLUB

v. MIDDLESEX HOSPITAL

Played at home, on Saturday, May 20. RESULT: Drawn.

St. Bartholomew's Hospital 150—8 dec. (J. A. Clappen 34).

Middlesex Hospital 67—7 (B. K. Arthur 4—20).

v. ROMANY C.C.

Played at Chislehurst on Sunday, May 21. RESULT: Won by 61 runs.

Bart.'s batted first on a wicket that gave very little help to the bowlers. In spite of this we only managed to gather 136 precious runs, to which Hodgson contributed 55. This total seemed hopelessly inadequate against the strong batting side of our opponents.

After a few very good introductory overs by Aubin and Hick, it became apparent that the wicket was showing signs of wear. Clappen and Haigh took over the attack and bowled unchanged for the remainder of the match.

From then on the batsmen were always in difficulty, and they were all out for 75. Clappen returned an analysis of 7—18, and Haigh's 2—37 did scant justice to his accuracy and spin.

St. Bartholomew's Hospital

D. C. Hodgson, c W. Gould, b. Watney	55
P. B. Biddell, st. Young, b. Ferris	7
J. D. W. Tomlinson, c. W. Gould, b. Ferris	5
M. Braimbridge, c. Plumbly, b. Ferris	13
H. B. Ross, st. Young, b. Gould	11
J. A. Clappen, b. Watney	1
D. F. A. Aubin, b. Gould	2
P. G. Haigh, c. Henwood, b. Murray	14
P. D. Moyes, c. Watney, b. Henwood	2
B. D. Hick, c. Ferris, b. Henwood	1
B. N. Foy, not out	16
Extras	9
TOTAL	136

Murray 1—11; Ferris 3—22; Henwood 2—27; Gould 2—47; Watney 2—20.

Romany C.C.

P. D. R. Smith, b. Aubin	2
W. F. Gould, c. Moyes, b. Haigh	9
L. C. Henwood, c. Ross, b. Clappen	20
A. S. Nunn, st. Moyes, b. Clappen	2
J. P. Wood, st. Moyes, b. Clappen	0
G. P. Plumbly, not out	27
I. S. Ferris, c. Braimbridge, b. Haigh	9
D. N. Watney, b. Clappen	2
A. C. Gould, c. Haigh, b. Clappen	4
A. Murray, c. Ross, b. Clappen	0
A. S. Young, c. Biddell, b. Clappen	0
Extras	0
TOTAL	75

Aubin 1—17; Hick 0—3; Haigh 2—37; Clappen 7—18.

v. INCOGNITI C.C.

Played at Chislehurst on Wednesday, May 24. RESULT: Drawn.

The Incogniti batted first, and scored freely before lunch, assisted by the chilled fingers of the fielders.

Lunch restored us to life, and the opposition were dismissed for 217, eight wickets being taken by catches. This total seemed extremely formidable, particularly when our opening pair were back in the pavilion with only seven runs on the board.

Tomlinson and Braimbridge then took the precaution of playing themselves in, and the next wicket did not fall until 150 runs had been made. After this, our chief enemy was the clock, and at one minute to seven, seven runs were still needed. At the crucial moment, the bowler—not Mr. Stephen Potter—inadvertently bowled a no-ball, which prolonged the over until 7 o'clock, thus preventing another.

The match was therefore drawn, the Hospital needing six runs to win with three wickets in hand.

Incogniti :

P. Wardle, c. Moyes, b. Ross	25
H. I. Jory, c. May, b. Foy	73
R. W. Fenn, c. Tomlinson, b. Arthur	23
D. G. T. Hicks, c. Ross, b. Aubin	6
M. J. Hardy, c. Clappen, b. Aubin	2
T. C. Fort, c. Moyes, b. Aubin	6
D. M. Attwood, b. Ross	47
J. L. Rampton, c. Hodgson, b. Foy	5
M. I. A. Hunter, c. Aubin, b. Arthur	26
O. G. Battcock, not out	1
G. C. Melluish, l.b.w., b. Ross	0
Extras	3
TOTAL	217

Aubin 3—29; Arthur 2—43; Clappen 0—22; Foy 2—47; Ross 3—45.

Bart.'s :

D. C. Hodgson, b. Fort	3
A. G. May, c. Fort, b. Battcock	0
J. D. W. Tomlinson, st. Jory, b. Hardy	74
M. Braimbridge, c. Hunter, b. Hicks	74
H. B. Ross, st. Jory, b. Hardy	15
J. A. Clappen, not out	31
D. F. A. Aubin, c. Hicks, b. Battcock	1
P. D. Moyes, c. Hardy, b. Hicks	2
B. N. Foy, B. K. Arthur, and J. S. Vazifdar did not bat.	
Extras	12
TOTAL (for 7 wkts.)	212

Battcock 2—35; Fort 1—11; Hardy 2—49; Hicks 2—44; Mellhuish 0—23; R. W. Fenn 0—20.

v. R.N.V.R. C.C.

Played at Chislehurst on Sunday, May 14. RESULT: Won by five wickets.

Our opponents won the toss and decided to bat. The wicket suited the opening batsmen well, and they passed 60 without loss. However, before reaching 100, five wickets had fallen, and they were finally dismissed for 146.

Bart.'s had plenty of time to make the runs, our best performer being Hodgson, who scored 44. He opened the innings, and was not dismissed until victory was well within sight.

R.N.V.R. C.C. 146 (W. S. Harris 66; H. B. Ross 4—30).

St. Bartholomew's Hospital 147—6 wkts. (D. C. Hodgson 44, H. B. Ross 37 n.o.).

v. CROFTON PARK

Played at Chislehurst on Saturday, May 27. RESULT: Drawn (rain stopped play).

Crofton Park 121—7 dec. (L. G. Bishop 85).

St. Bartholomew's Hospital 44—2.

v. STANMORE C.C.

Played at Stanmore on Sunday, May 28. RESULT: Won by 73 runs.

As usual, we were favoured by good weather for this match, and it was played on a "sporting" wicket. All the more credit is therefore due to an innings of 73 by Clappen, which dominated our batting. He went in at a time when our total lacked that touch of respectability, and he exercised all the fieldsmen without preference—including long-on.

Stanmore ultimately had to face a total of 189 on a crumbling wicket, and they never really looked like making the runs.

The wickets were shared more or less evenly between seven bowlers, and the last wicket fell with their total at 116.

St. Bartholomew's Hospital 189 (J. A. Clappen 73).

Stanmore C.C. 116.

v. BALLIOL COLLEGE, OXFORD

Played at Oxford on Saturday, June 3. RESULT: Won by six wickets.

Balliol College 115 (C. E. Elliott 37; B. K. Arthur 4—22, B. N. Foy 4—22).

St. Bartholomew's Hospital 116—4 (A. G. May 41 n.o., J. P. Waterhouse 31 n.o.).

v. OLD ALLEYNIANS

Played at Dulwich on Sunday, June 4. RESULT: Won by 114 runs.

St. Bartholomew's Hospital 181—8 wkts. dec. (H. B. Ross 53, P. G. Haigh 40).

Old Alleynians 67 (B. N. Foy 6—20).

RUGBY CLUB

Officials for 1950-51

President: Dr. E. F. Scowen.

Vice-Presidents: Mr. F. C. W. Capps, Prof. Sir J. Paterson Ross, Mr. D. B. Fraser, Dr. C. F. Harris, Dr N. C. Oswald, Prof. A. W. Wormall, Mr. W. D. Coltart, Prof. A. J. F. Cave.

Captain: C. W. H. Havard.

Vice-Captain: K. A. Clare.

Hon. Treasurer: G. W. Mears.

Hon. Secretary: M. J. A. Davies.

Pre-Clinical Representative: J. K. Murphy.

GOLF CLUB

May 10, v. City of London Police

In a four-ball foursome match at Old Fold Manor Golf Course, Barnet, the side defeated the City of London Police by 3 matches to 1

RESULTS

L. R. Gracey and D. H. Rushton beat Salmon and Branch 4 and 3; C. J. R. Elliott and J. S. Dodge beat Dollonay and Martin 2 and 1; J. Bowman and G. Greenhalgh beat Purchase and Latchford 2 up; R. Dreaper and J. P. Waterhouse lost to Wood and Miller 2 down.

Staff Match—Denham

On May 17th at Denham, once again the staff entertained the students to lunch, tea and a delightful day of golf. Battle, in the form of singles, was joined soon after lunch, the students producing a convincing victory of 8 points to 4. This was not the case in the evening, for a hurried tea, followed by its inevitable trail of dyspepsia, allowed our more seasoned elders to halve the foursomes with their rapidly tiring opponents.

Highlights of the day were L. R. Gracey's fine dash for victory at the 18th over Dr. McIlroy, and Dr. J. W. Platt, who astonished everyone and improved on his already outstanding record, by driving into the woods on the 17th for the fifth successive year.

RESULTS

Singles : L. R. Gracey beat Dr. M. B. McIlroy 1 up; R. V. Fiddian beat Prof. L. P. Garrod 4 and 3; D. H. Rushton beat Mr. G. T. Hankey 4 and 2; Dr. H. Giles halved with M. Braimbridge; J. Bowman beat Dr. G. Graham 1 up; C. Elliott beat Dr. J. W. Platt 9 and 8; Dr. R. A. Shooter beat M. Cassels 9 and 7; R. E. Dreaper beat Dr. H. F. Brewer 5 and 4; G. Greenhalgh beat Dr. G. W. Hayward 2 up; Dr. H. Morgan beat J. S. Dodge 8 and 7; Dr. F. Knott halved with A. B. Lodge; Dr. M. B. Terry beat D. L. Hodgson and J. Montagnon 2 and 1.

Foursomes : L. R. Gracey and R. V. Fiddian beat Dr. M. B. McIlroy and Prof. L. P. Garrod 3 and 1; Mr. G. T. Hankey and Dr. H. Giles beat D. H. Rushton and M. Braimbridge 2 and 1; J. Bowman and C. Elliott beat Dr. G. Graham and Dr. J. W. Platt 1 up; Dr. R. A. Shooter and Dr. H. V. Morgan beat I. S. Dodge and M. Cassels 4 and 3; R. E. Dreaper and G. Greenhalgh beat Dr. H. Brewer and Dr. G. Hayward 1 up; Dr. F. Knott and Dr. M. B. Terry beat D. L. Hodgson, J. Montagnon and A. B. Lodge 2 and 1.

ATHLETIC CLUB

The 1950 season opened fairly successfully, and to date we have had five fixtures, together with the University Championships.

We welcome all new members to the Club; response has been good, and prospects for the future, when our clinical men leave, are good. The Ladies' A.C. has made a very successful appearance, while the captain, Helen Merridith, and M. Bott, have already figured prominently for U.L.A.C.

Our first fixture was against Cambridge Harriers and Guy's Hospital. We were beaten by the former, but were ahead of Guy's.

On May 17 we entertained Shaftesbury Harriers at Chislehurst, and after a very thrilling match, in which J. A. Stainton-Ellis was kept busy running a 100 yds., 1 mile and 880 yds., we won by two points.

Results

100 yds.: 1st, B. D. Lascelles (Time 10.6 secs.); 3rd, J. A. Stainton-Ellis.

220 yds.: 2nd, B. D. Lascelles.

440 yds.: 1st, A. H. Macdonald (Time 53.0 secs.); 3rd, R. R. Wheeler.

880 yds.: 1st, A. E. Dormer (Time 2-6.0).

1 mile: 1st, J. A. Stainton-Ellis (Time 4-49.2).

Shot: 1st, D. Craggs (Distance 34ft. 9in.); 2nd, N. Khurshid.

Discus: 1st, N. Khurshid (Distance 90ft. 3in.); 2nd, D. Craggs.

Javelin: 1st, G. Middleton (Distance 110ft.).

High Jump: 3rd, D. M. Stainton-Ellis.

Long Jump: 2nd, H. Poirier.

Bart.'s won: 34—32.

Against King's and Battersea, we were somewhat weak and consequently were beaten rather badly. However, in our next match against Westminster Bank and Orion Harriers we were victors.

Results

220 relay: 1st, Bart.'s.
880 yds.: 1st, J. A. Stainton-Ellis (Time 2-3.0).
1 mile: 2nd, J. A. Stainton-Ellis.
High jump: 1st, H. Poirier (5ft. 2in.).
Long jump: 1st, B. D. Lascelles (18ft. 5in.).
Shot: 1st, D. Bee (36ft. 6in.); 2nd, D. Craggs.
Discus: 1st, D. Bee (95ft. 6in.).
Javelin: 1st, D. Bee (141ft. 1in.); 2nd, G. Middleton.
Bart.'s won: 27, 24, 13.

University Championships, Motspur Park. May 14

We entered a strong team in this championship, had quite a few finalists, and retained our position of third in the competition. Arthur Wint won both the half and quarter mile, breaking the latter record. The Ladies again figured prominently, and were fifth in their section.

Scoring positions in the finals were gained as follows:—

80 metres hurdles, women:
440 yds., women: 2nd, M. Bott.
880 yds., women: 2nd, M. Bott.
Throwing the hammer: 1st, R. T. Heylings.
1 mile walk: 5th, G. Wallace.
440 yds.: 1st, A. S. Wint (49.8 secs., record); 3rd, A. H. Macdonald.
880 yds.: 1st, A. S. Wint (1-57.4); 2nd, A. H. Macdonald.
1 mile: 2nd, A. E. Dormer.
120 yds. hurdles: 4th, E. M. Rosser.
440 yds. hurdles: 3rd, E. M. Rosser.
Weight: 1st, D. L. Bee.
Hop, step, and jump: 4th, A. H. John.

Six of Bart.'s athletes—Wint, Heylings, Dormer, Rosser, Bee and Macdonald, have represented London University, while the Hospital were very prominent in helping U.L.A.C. obtain second place in the U.A.U. British Universities' Championships at the White City on May 19th.

Bart.'s men were:
440 yds.: 1st, A. S. Wint (48.4, record).
880 yds.: 1st, A. H. Macdonald (1-57.8); 3rd, A. E. Dormer.
Hammer: 5th, R. T. Heylings.
440 yds., women: 2nd, M. Bott.
880 yds., women: 1st, M. Bott.
80 metres hurdles: 3rd, H. Meredith.

It is significant that at the start of the London v. Paris University match, a Bart.'s Shield was presented to Paris University by U.L.A.C. in exchange for a Paris flag.

We look forward to the United Hospitals' Championships, being held this year at Motspur Park on June 10, and are hoping for a good turn-out on Sports Day the following Saturday.

The Club offers its congratulations to its last years' skipper, Ian Burn, on having passed his Finals. We wish him luck, and shall find him a big loss.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LIV AUGUST No. 8

IN SEARCH OF SOMA

"Oh, Father, I should so like to be a Resurrection-Man when I'm quite growed up!" were the words of young Jerry Cruncher as he ventilated his youthful aspirations towards his father's "honest trade."

We do not, however, have to comb the realms of fiction to find evidence of the underhand steps that our predecessors were wont to take in order to obtain their anatomical material. The newspapers and periodicals of the eighteenth century, with their advertisements of impenetrable coffins, bear record of the body snatchers. Our ancient graveyards, too, with their bricked-up tombs, tell of the menace that Mr. Cruncher and his like were to the public. The monologue of *Mary's Ghost* addressed to her mourning lover in one of Thomas Hood's *Pathetic Ballads* cites the names of several distinguished gentlemen who were given to trading with the Resurrection-Men.

"... The arm that used to take your arm
Is took to Dr. Vyse,
And both my legs are gone to walk
the hospital at Guys. ...

As for my feet, the little feet
You used to call so pretty,
There's one I know, in Bedford Row,
The t'other's in the City. ...

The cock it crows—I must be gone.
My William, we must part!
But I'll be yours in death, altho'
Sir Astley has my heart. ..."

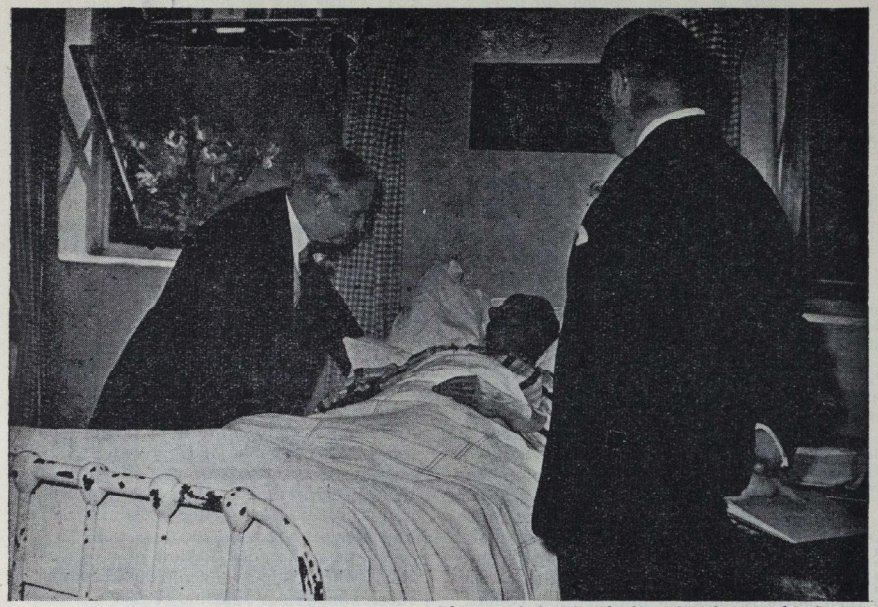
No. 14 Bedford Row was the home of no less a person than Abernethy.

Everyone is familiar with the story of the conviction of Burke and Hare in 1827 for their trade in the bodies of their murdered victims. This was but one of several cases. The anatomists continued to labour under the cloud of public disapproval until the passing of the Anatomy Act in 1832. By this the supply of corpses was regularised, and it became legal for the unclaimed bodies of paupers to be used for dissection.

We have the good fortune now to live in times when paupers are rapidly becoming a race extinct. An outcome of this is a shortage of cadavers for dissection. We have read in the *B.M.J.* of the manufacture of plastic bones for teaching purposes. Are the days coming when anatomy will be learned from bakelite bodies? Rather must the public be encouraged to supply our needs in the more traditional way. In another context we hear of the lack of eyes for use in corneal grafting. Are our ophthalmologists to follow the practice of some of their continental colleagues and help themselves from cadavers without obtaining permission? This savours a little too much of Mr. Cruncher.

It is now commonplace for the bones of amputated limbs to be used for homogenous grafting and for blood donors by the thousand to give of themselves without a grudge. A few people already make arrangements in their lifetime to subscribe to our requirements of post-mortem material and it is not unreasonable to suppose that more might be willing to follow suit. It would be advantageous for the medical profession to make its needs more widely known.

VIEW DAY



Photograph by H. Charles, The Photographic Society.

Sir George Aylwen with Prof. Sir James Paterson Ross in Percival Pott Ward.

When the patients were asked if they had anything to say to the Treasurer and Governors this man astonished everyone by replying in the affirmative. On being invited to speak he declared: "I could not have been treated better if I'd been a king." There were audible sighs of relief from the entourage.

ABERNETHIAN SOCIETY

The 154th session was brought to a close on June 22 when Mr. Victor Bonney addressed the Society on "A Retrospect over Sixty Years."

The Annual General Meeting was held on June 15, when the Secretaries reported that the year had been a successful one. They stated that the average attendance at meetings had been higher than in recent years, and that it had been particularly pleasing to note the large proportion of pre-clinical students amongst the audiences.

During the session, eleven ordinary meetings and one clinical evening have been held, and three films have been shown. Speakers during the year have been Sir James Paterson Ross, Dr. Charles Hill, Professor J. W. S. Blacklock, Mr. Reginald Vick, Dr. Geoffrey Bourne, Sir Godfrey Russell Vick, Lord Moran, Professor Alexander Kennedy, Sir Heneage Ogilvie, Lord Webb-Johnson, and Mr. Victor Bonney.

The Committee for 1950-1951 is:—

Presidents: K. E. J. Bowers, J. P. Waterhouse.
Vice-Presidents: R. V. Fiddian, P. D. Matthews.
Secretary: G. S. Banwell, C. W. Coole.
Pre-Clinical Representatives: Miss R. B. Hurst, E. J. Batterham.

THE LIFE AND WORKS OF SIR D'ARCY POWER

The Subject of the Wise Prize Essay for 1950

I. THE LIFE OF SIR D'ARCY POWER

By G. DAVIES

I.

SIR D'ARCY POWER might say, with Percival Pott, that he served St. Bartholomew's Hospital "man and boy for half a century." He was a man of wide interests who laboured for many institutions and societies. But to the past history and present welfare of this hospital he was particularly devoted. His life is thus of special interest to us.

He was born on November 11th, 1855, at 3, Grosvenor Terrace, Pimlico, S.W. He was the eldest of eleven children: the names of many of his brothers and sisters became well known in the professions, and in business life. In the previous year his father, Henry Power, had been elected Fellow of the Royal College of Surgeons: his name is one of the first eight on the Roll. His father had a brilliant career at the University of London, and, at the time of D'Arcy's birth, lectured in Anatomy and Physiology. Though he was later to be first ophthalmic surgeon to St. Bartholomew's Hospital for nearly a quarter of a century, and later a Governor of the Hospital, he was at this time, like William Savory, living from hand to mouth. A friend wrote of him that "he was descended from an Irish family of soldiers, and was gifted with a handsome and distinguished face, and a splendid physique. The chivalry inherited from his paternal ancestry, in combination with the culture of his deeply religious mother, accounted for his single-heartedness and natural happiness of disposition." He was generous and kind, sympathetic and frank. His quick wit, keen perception and versatility derived from his Irish progenitors rendered him a delightful companion. His love for books and his devotion to his scientific work are qualities which appear markedly in the character of his eldest son. Henry Power was an excellent lecturer and examiner, and wrote on many subjects. A distinguished member of his profession, he was a Member of the Council, and a Vice-President of the Royal College of Surgeons.

Henry Power's grandfather, Lieut.-Col. Francis Power, was an ensign in the King's German Legion. The chief officer of the engineers in the Legion was a Colonel D'Arcy, and it is from him that the name seems to have entered the family of Power; it was given to a child of Lieut.-Col. Power's first marriage.

Henry Power and Miss Ann Simpson were married at Whitby in 1854; it was here that the Simpson family had lived for hundreds of years. They were a family of businessmen, many of whom were Quakers; her father, Thomas Simpson, was a shipowner and banker. Henry Power and his wife started life in London on a preposterously small sum, and "were generally considered a couple of little fools." Her dogged Yorkshire perseverance was to serve them both in good stead.

The boys and girls were brought up in a happy domestic atmosphere. With D'Arcy, especially, much care was needed, and his health caused his parents considerable anxiety. One illness, in which his right tibia was affected, is worthy of note: it probably accounted for his limp. The young child early showed that he had an excellent memory, and an aptitude for observation, which was equally pleasing to his father. From his teacher he learnt not so much reading, writing and arithmetic, as a habit of neatness for which he was ever thankful. He played either in the Green Park or on Clapham Common; while on Sunday mornings he would go, with the rest of the family, to Westminster Abbey.

When the family moved, in 1866, to 45, Seymour Street, it was decided that D'Arcy should be sent to the St. Marylebone and All Souls' Grammar School at No. 1, Cornwall Terrace, Regent's Park. The school, founded by the Rev. Henry North, father-in-law to Sir James Paget, drew its pupils from the sons of doctors who lived in the neighbourhood. In his first year, D'Arcy won a prize for reciting "The Lay of Horatius"; he went on winning prizes during his four years there. At the same time his father taught him the elements of Greek. Much of his holiday time was spent at Whitby; D'Arcy looked upon it as a

second home, for many of his relations lived there.

At the age of fourteen he entered the Merchant Taylors' School, which was then in Suffolk Lane under Cannon Street Station. On entering he was placed in the upper third form. The education was mainly classical, and D'Arcy won several prizes while he was there. He showed his interest and ability in the subject by winning the Tyler Prize for History. At the same time he was awarded—in spite of his "vile handwriting"—the Pigeon and Pugh Prize for the boy best fitted for the merchant's office. This was the only occasion on which one boy won both prizes. In consequence of his winning the Tyler Prize, his last term at school was devoted to a special study of history. Though he later took up Natural Science at Oxford, and became a surgeon, he often "played truant" from his surgical practice, and it was his first love for History that was most often responsible for this.

In 1874 he went to Oxford. The group which entered New College that Michaelmas Term spent most of its time on the Upper River: here Power excelled. At the Regatta he was awarded a cup for winning, in one afternoon, sculls, punts, fours and eights. He read History for two years, intending to go in for honours in the History School. But, abruptly, he "deserted History and took to Biology." No doubt the primary reason for his doing this was that he knew he had to earn his own living. The transition was not as abrupt as would at first appear, for many of his friends—Professor Rolleston and Sir Henry Acland among them—were scientific men. The interest in Biology which had been aroused at Oxford was fostered by T. H. Huxley, whose lectures on Biology D'Arcy Power had been attending during his vacations in London.

Having won an exhibition at Exeter College, Power obtained a transfer there in 1877. He was appointed demonstrator of Physiology to C. J. Yule, who was University lecturer and a Fellow of Magdalen. With Yule he worked on the standardisation of curare. He also assisted Sir Joseph Fayrer and Sir Lauder Brunton in their experimental work. At Exeter College, Power was a pupil of Ray Lankester, who insisted that every student of his should undertake some original work before his final examination. In his study of the vascular system of the earthworm, he looked for a word to use in describing the glomerular bodies. The term which he finally decided upon—"Nephridion"—is now in general use as "Nephridium." After this he went on working for the Final Schools in Natural Science: Power was one of the three whose names were in the first class. Dr. Pye Smith, the examiner in Biology at Oxford, was impressed by D'Arcy Power's ability and retained an interest in him; it was to Smith that Power was later to dedicate his book on William Harvey.

II.

When D'Arcy Power came to this Hospital in October, 1878, he came to a place where the name of Power was already honoured and loved. He entered as a perpetual student, and his father duly sent a cheque for a hundred and twenty guineas to the treasurer. The treasurer sent back the cheque by return, saying that "Dog did not eat dog."

Speaking of this period forty years afterwards, he said that at twenty-three he "found himself amongst a most indulgent body who at once appointed him a teacher, invited him to Christmas dinner, and told him they had given him the opportunity of winning his spurs, should he be so inclined." The staff at that time numbered twenty-eight; everyone proved to be a good friend. One of the amusing incidents which occurred in his first few months at the Hospital was in connection with his appointment as assistant demonstrator of Physiology. On entering the lecture room to meet his class for the first time, he was greeted with: "This is for second-year men only, so get out!" The reaction was quite a natural one, for he appeared young, and was quite unknown at the time. There was a slight shock when he sat down and began to question them.

During the next two summers he worked strenuously for his Membership examination. He learnt his anatomy not only while teaching physiology at the Hospital, but also Biology at University College (as demonstrator to Ray Lankester). In 1882, having become a Member of the Royal College of Surgeons, he was nominated as ophthalmic house-surgeon to his father and Mr. Bowater Vernon. While filling this post, he did a good deal of other medical work. The casualty physician disliked coming into hospital by nine in the morning, and would ask D'Arcy Power to take his place. Junior house officers seem to have had an unusual disinclination for work. While junior house surgeon to Sir William Savory (which was his next appointment), he was virtually full house-surgeon; his senior was more interested in the stage than in surgery. Much more responsibility rested upon the house-surgeon in those days. When Power wanted advice, he would go to his master, Sir William Savory; or he went to Sir James Paget—at breakfast time, the only time he could catch him.

When, in December of the next year, he was taking the final F.R.C.S., one of the examiners said prophetically of his group: "Here come the future giants of the profession." Three days later, certain in his own mind that he had passed, he married Eleanor Fosbroke. It is related that young D'Arcy Power arrived rather late for eight o'clock surgery that morning, apologising and explaining that he had been a little delayed as he had been getting married on the way down to the hospital. This story is almost certainly true, and is as typical of his dry humour as of his devotion to hospital duty. His first contact with the Fosbroke family was when George Henry Fosbroke, Eleanor's father, was sent to Henry Power to be taught. It is interesting to reflect that he was sent there by mistake originally; but teaching must have been satisfactory, for Fosbroke stayed at the home of the Powers. The two families became very friendly, and exchange visits were frequent. The marriage proved a very happy one.

They were preparing to go to Vienna in November, 1883, when James Shuter died after drinking laudanum in mistake for a cough mixture. On his death Anthony Bowlby was elected Surgical Registrar, and thus the post of curator of the Museum became vacant. Power was chosen, and held the post for the next five years. The classes that he and Bowlby gave in surgery were very successful: they had a monopoly of F.R.C.S. students for some years. He and his colleague, James Berry, got into trouble for tying the lingual artery in a number of bodies while teaching operative surgery. When they determined to provide the museum with a horse skeleton, they were again censured by the Anatomical committee. The horse was brought into the dissecting room at ten o'clock in the evening, but large doses of prussic acid had no effect upon it. At five the next morning, the skeleton had been secured after much labour, and the room had become a perfect shambles. The dealers refused to pay anything for the skin and flesh, which were only removed "to oblige." The articulated skeleton is now in the museum.

Though he was soon to hold a number of clinical appointments at other hospitals, it was not until 1898 that Power became Assistant Surgeon to the Hospital. The election of a new member of the staff became necessary on the resignation of Sir Thomas Smith, and the promotion of Mr. W. J. Walsham. The contest between Power and his friend James Berry was vigorous: both were highly thought of, and well recommended. The election—which was in the hands of the whole body of governors—took place in the Great Hall. Students crowded in the Square to hear the result: Power was elected by ninety votes to sixty-eight.

It was customary for the assistant surgeon to act as specialist, and for two years Power was in charge of the Throat and Nose Department. In 1904, Mr. John Langton resigned and he was elected full surgeon. On his resignation in 1920 Power was elected Consulting Surgeon and Governor to the Hospital.

III.

Sir D'Arcy Power's reputation as a humanistic historian may have tended to overshadow his eminent position as surgeon. When he became an assistant surgeon at this Hospital, Lister's doctrine and his aseptic technique were only beginning to be established. Not many years before, a single pair of forceps was used for obtaining haemostasis in a thigh amputation. The pre-antiseptic era, represented by his first master, Sir William Savory, was only gradually being superseded. Attempts had been made to introduce new techniques, but what zeal there was, was without any real knowledge. Bacteriology was not taught in the Medical School till 1891. His generation, with their biological training, understood and endeavoured to carry out the teaching of Lister.

He brought with him a scientific training in physiology and pathology. During the years of preparation, he had been enabled to obtain a thorough and general knowledge of surgery. It was not surprising that he

should remain essentially a General Surgeon while devoting his attention to a number of special problems in Surgery. There was nothing he disliked doing, and he was quick to adopt something new. This was shown by his enterprising adoption of Colt's apparatus for wiring an aneurysm. A palliative procedure, which was a great advance at the time, it has not survived.

Though receptive of new ideas, he belonged, in some ways, to the old school. He did not emphasise, to the extent that some did at the time, good technique as the most important thing for which to strive. Like Lister, Sir D'Arcy did not excel in operative technique. He did not agree with Lord Moynihan's dictum: "Double the incision and halve the mortality"; he always used a very small incision. His motto was: "Quick in and quicker out." He once performed a gastro-jejunostomy, from the first scratch to the last suture, in sixteen minutes. Students used to come from all over London to see him perform this operation: gastro-jejunostomy was a field in which he was a pioneer.

It was at an emergency operation that he excelled. He insisted on doing his own, even at night, and would often go down from his home in Chandos Street on his bicycle, which he would leave in the Square while he hurried to the theatre. Here, the value of his fast technique was evident. He maintained that it was always better to do an operation in the minimum of time; his business was to leave the patient in as slight a state of shock as possible. He made a habit of having a race with himself while operating, and he never felt that it had been done sufficiently quickly.

He was an old-style diagnostician, jumping to a diagnosis, and not making many mistakes. On his rounds in Henry and Lucas Wards, the care and consideration with which he treated his patients were always evident. Unlike some of his colleagues, he did not terrify his students or patients; and he had a fatherly manner which endeared him to children. His teaching was always good, and his lectures full of substance.

Power was closely associated with the Royal College of Surgeons. He was twice elected Vice-President, in 1921 and 1922. Characteristically, he esteemed others better than himself, and this alone prevented him from being President of the College. The post of Honorary Librarian was created for him in 1929 at the death of Victor Plarr, the Librarian. We may feel proud that the suggestion came from St. Bartholomew's Hospital.

Ten other hospitals were served by him during his lifetime. During the 1914-18 War he served as Lieut-Col. at the 1st London General Hospital—at first in charge of its surgical division, and later (1917-20) in charge of the whole hospital. He also served two other hospitals during this time, and represented the Royal College on the Appeals Boards. He was knighted in June, 1919, being created a Knight Commander of the Military Division of the Most Eminent Order of the British Empire.

Few men can have served as many committees as did Sir D'Arcy. As President (or in some other capacity) he served most British Medical Societies, and was honoured by many Societies outside his own land. Thousands of students had cause to be grateful to him as an examiner: he felt most strongly that it was not his business to find out what the student did not know.

Sir D'Arcy twice visited America. The first occasion, in 1924, was his visit to Boston to act as Surgeon-in-Chief at the Peter Brigham Bent Hospital. Mr. John Fulton, recalling his enthusiasm, clinical acumen, and rich fund of anecdote, says: "He was not entirely familiar with the somewhat involved ritual and paraphernalia of an American Surgical Amphitheatre, but he adapted himself to this with the spiritual calm of a much younger man." When he visited the United States in 1930, he renewed many friendships with the scholars and surgeons of that land. In 1928, with Henry Cushing, Dr. Francis and Geoffrey Keynes, he was elected a "Friend of the Osler Club."

His last long journey was made in 1935. At the invitation of the Royal Australasian College of Surgeons, he went to deliver the inaugural address at the opening of the College.

A large part of his time was devoted to the study of History and Bibliography. Perhaps the most productive and certainly the more lasting part of his labours were in these fields, as will appear in the second article, dealing with Sir D'Arcy Power's "Works."

IV.

Sir D'Arcy was never able to understand how he found a place so easily in the hearts

of those with whom he came in contact. The students, perhaps, went to the heart of the matter when they nicknamed him "Sunny Jim." It was his Heraclean cheerfulness more than any other characteristic, which made him a welcome companion. Some of the portraits of Sir D'Arcy have caught the merry look in his eyes. He had a nature "sloping towards the southern side," as Lowell has so happily phrased it. His merry wit often found expression in a joke, or in teasing, which was invariably kindhearted. A conversation with someone he knew well would be full of laughter. Indeed, he was censured by some for his light-heartedness: he would chaff his son about the possibility of leaving his father's ashes on the rack when they were being taken to Bidford-on-Avon.

He was always simple and approachable, yet he had that air of authority which was most evident when someone might take advantage of his kind nature. It was a sorry thing for a student who would thus become a subject of his crushing wit. He believed in "telling the patient," and his candour was evident in all his dealings. The golden rule was followed as much in his biographical writings as in his life. His charity would extend to anyone whose need became known to him.

He had a great capacity for work. His habit of going to bed at ten o'clock must have contributed to maintaining his boundless energy. But there was another reason why he was able to labour so hard in many fields. His wife, a first-rate manager, relieved him of all domestic worries. She gave him every encouragement in his work, and was an excellent hostess. They were like each other in many ways. Her kindly nature found endless opportunities to express itself. She, too, was witty, and of a happy disposition. Like her husband, she had a clear knowledge of good and evil and their limitations.

Together Sir D'Arcy and Lady Power faced distressing times. Their first child, Eleanor Haynes Primrose, died at the age of two. She caught whooping cough from her father, and was unable to withstand it. There were two other children. Only one son, Air Vice-Marshall D'Arcy Power, survives; with a son George D'Arcy now a student at St. Bartholomew's Hospital, and a daughter Angela. Their younger son, George Henry Fosbroke, was a lieutenant during the 1914-18 War. It was when he was reported missing during the second battle of Ypres, that their happiness was over-shadowed for a second time. Four days earlier, "Foss," who was dearly loved, had left home "to undertake a duty he hated." The great grief was shared by others who knew him as a brilliant and promising science student, who had already made his mark at Merchant Taylors' and Oxford. With untiring efforts Lady Power tried to ascertain his fate: she could never bring herself to believe that he was killed. Though she retained her good looks and indomitable spirit to the end, her death was hastened by the tragedy thus brought into her life. It came suddenly. Her death occurred on the morning of June 26, 1923, while she was lying in bed after drinking a cup of tea. She was discussing a proposed "At Home" with Sir D'Arcy, when she stopped in the middle of a word and died. She died literally of a broken heart, for on post-mortem examination a ruptured cardiac aneurysm was found.

Sir D'Arcy had to bear his third great sorrow alone. As he did so his equanimity was a source of wonder to his friends. He told one of them that the secret was that he was able to keep his mind in separate compartments. Never did he allow a personal sorrow to touch those around him.

The same dogged determination to overcome the bitterness of bereavement enabled him to overcome his physical disabilities. He was small and lame, but these things never affected his life or outlook. He rode his bicycle not only to operations but also as a recreation. He was a man of few eccentricities. A very shrewd judge of men, he was tolerant of weaknesses and foibles in others.

His way of life was simple, but he was fond of good food. He was frequently at dinners of various kinds, and was often in demand as a speaker. He was proud to be one of the twenty-four members of the Confrères Club, which met regularly for dinner and debate. Dining clubs, he believed, were the best dissipators of professional jealousies. He was an excellent judge of wine, and a connoisseur particularly of champagne. While by no means a wine-bibber, he echoed the sentiment expressed by Sir James Paget: "Thank God for good wine!" He was for fifteen years Chairman of the Wine Society, and during this time its

membership vastly increased. According to one writer Sir D'Arcy's very bearing spoke of the health-giving properties of good wine.

On his seventy-fifth birthday, his old housemen gave him a silver replica of the wounded soldier who used to stand outside the Hospital gate. They knew how well Sir D'Arcy would appreciate it. He was a great friend of Omar Ramsden, the silversmith. He regarded Ramsden as a modern Benvenuto Cellini. Together they worked out many designs, for Sir D'Arcy would often be approached for the design of medals or the format of books. Memorial plaques of an original form were favourite designs. In his favourite form the life history would be symbolically represented round the periphery, while the simple name stood in the centre of the plaque. Sir D'Arcy was also very interested in Heraldry, and had a wide knowledge of the subject.

The names of Power and Simpson had long been famous in Freemasonry, when D'Arcy Power was initiated in 1890. He was great among them, and achieved high rank in the Grand Lodge of England; he was a founder of a number of Lodges and Chapters, including the Rahere Lodge at St. Bartholomew's Hospital. In 1933 he wrote in the "Architect" an article on "The Idea of the New Freemason Hospital in Ravenscourt Park"; he was very proud of the hospital when it was built, and served the new as he had served the old.

He lived alone for the second half of his life at his home in Cavendish Square. He was sorely tried by different housekeepers and their associates. In spite of his trials, he worked happily at his home and elsewhere for the innumerable committees and institutions which he continued to serve. At lunch time, eminent medical personages would often be seen entering his house. The house, next door to the Medical Society of London, became quite a museum. He knew the associations of every article of furniture. His vast library of valuable books had been chosen with taste and discernment along the years. When, in 1940, his house was bombed, he felt it was not safe to keep the library under one roof. So with regret the news was received that Messrs. Sotheby were to dispose of the large collection. The sale realised £2,415. Many and various were the books sold; some of them deserve special attention, for they illustrate aspects of Sir D'Arcy's literary activity which may easily be overlooked.

Sir D'Arcy worked (from 1929) in the Librarian's Room at the Royal College of Surgeons. Here a portrait of him now hangs, painted when Sir D'Arcy was seventy-five by Sir Matthew Williams-Thompson. In this room, for those who knew the man, or have come to know him through his works, his spirit lingers.

After the air raids of the autumn of 1940, Sir D'Arcy moved to his son's home at Northwood, Middlesex. Soon after his eighty-fifth birthday, his heart began to fail: during this illness the news of the bombing of the College was kept from him. He died on May 18, 1941. "He was getting very tired," a friend said, "and was glad to lay down the burden." He was cremated at Marylebone Cemetery on May 21, and buried at Bidford-on-Avon. A Memorial Service was held at St. Bartholomew-the-Less on May 28, at which Professor Gask gave the funeral oration.

With Sir D'Arcy Power, as with many others, his life cannot be truly interpreted apart from his work. Yet, unlike many famous men, Sir D'Arcy's lasting memory is to a great measure independent of his work. While there are men in the Profession who, like him, "combine intellectual pre-eminence with nobility of character," Sir D'Arcy will be remembered—a man greatly beloved.

THE WIX PRIZE

The Wix Prize for 1950 was awarded equally to G. Davies and M. B. McKerrow. The subject of the essay was "The Life and Works of Sir D'Arcy Power."

OF SUMMER, SURGERY AND SCOTLAND

By TROCAR

ON Saturday, December the 17th, 1825, the Annual Dinner was given to J. Brookes, Esq., a teacher of Anatomy, by his pupils. And from the published account of this function the following extract is derived:—

> "The Court of Examiners at the College of Surgeons . . . have declared . . . that the science of Anatomy can only be taught under certain states of temperature, of course, therefore, only in certain latitudes; that in this country, when the thermometer stands at or about summer heat, no Englishman can learn Anatomy; and that, therefore, all certificates of attendance at lectures, delivered during the summer, shall be rejected."

But what, you may well ask, has the learning of Anatomy got to do with the season (as though you didn't know!)?

Let us, therefore, probe a little further into this mystery. Saturday, the 14th day of January, 1826. A Notice in a Medical Publication is headed ROYAL COLLEGE OF SURGEONS IN LONDON, and proceeds to state that—

"This sink of infamy and corruption—this receptacle of all that is avaricious, base, worthless, and detestable in the surgical profession, like some other Aegean Stables, is near the hour of its purification," and goes on to say that certain public-spirited members of the College are set on its purification, and that Mr. Lawrence of St. Bartholomew's would be delighted to act as chairman. Arrangements are therefore made for the presentation of a petition to the Legislature, the Resolutions on which the Petition is to be founded to be discussed and agreed on at a General Meeting of the College Members, appointed for Saturday the 11th of February, 1826.

January the 21st. An article in a Medical Publication gives us the cause of all the bother in the shape of the peculiar demands of the College Hierarchy. The writer obviously feels a little strongly on the subject:—

"The compulsatory production of certificates of attendance on WINTER COURSES OF LECTURES.

"The refusal to receive certificates of attendance on lectures, unless such lectures have been delivered by the SURGEONS OF THE LONDON HOSPITALS, OR THEIR FRIENDS.

"The refusal to receive certificates of attendance on lectures on the SURGICAL PRACTICE OF THE PROVINCIAL HOSPITALS AND INFIRMARIES, as those of Bristol, Manchester, Leeds, Birmingham, Exeter, etc., etc.

"The exclusion of the members from the Museum (John Hunter's) except at certain brief periods.

"The shameful neglect in not printing a descriptive catalogue of the contents of the museum.

"The refusal to allow Members to make casts, or take drawings of the various preparations in the Museum.

"The insult which they invariably offer to the Members who have so liberally contributed to their support in compelling them to enter the MENIALS' entrance of the College in Portugal Street, whilst themselves and their hospital COLLEAGUES are as uniformly permitted to ORNAMENT the aristocratic portals in Lincoln's Inn Fields.

"The highly objectionable practice in electing each other, by which corrupt mode of procedure partiality of the most profligate description has been exercised, by which individuals have been elected to the Council and Court of Examiners of the College, who are entitled to no other name than that of surgical idiots."

And so on, in a similar vein for some considerable length.

Saturday, the 4th of February—the Meeting arranged for the 11th inst. is postponed to the 18th instant, to allow the Barrister entrusted to draw up the Petition, sufficient time to examine the "Immense Mass of Royal and Parliamentary Rubbish, consisting of Charters and Acts of Parliament which have reference to the Surgical Profession."

February the 18th. Upwards of twelve hundred Gentlemen met at the Freemasons' Tavern, Mr. Lawrence being in the chair. The proceedings started sharp at 7 o'clock, and as is usual with meetings of this sort, was somewhat lengthy; a few extracts, however, may be given. From the opening speech of the chairman:—

"In the year 1824, certain regulations were framed by the ruling body of the College of Surgeons, which I considered as having been directed against the whole body of the members of the profession. The substantial enactment is short but effective for its purpose. I will read the byelaw, if you please, before I enter upon any commentary:—

'The Court of Examiners of the Royal College of Surgeons, in pursuance of their duty to promote the cultivation of sound chirurgical knowledge and to discountenance practices which have a contrary tendency, have resolved—That from and after the date hereof, the only schools of Surgery recognized by the Court, be those of London, Dublin, Edinburgh, Glasgow, and Aberdeen. That Certificates of Attendance upon the Chirurgical Practice of a Hospital be not received by the Courts unless such Hospital be in one of the above recognized schools, and shall obtain, on an average, one hundred patients.

'And that all Certificates of Attendance at lectures on Anatomy, Physiology, and the theory and practice of Surgery, and the performance of dissection, be not received by the Court, except from the appointed Professors of Anatomy and Surgery in the Universities of Dublin, Edinburgh, Glasgow and Aberdeen, or from persons teaching in a school acknowledged by the Medical establishment of one of the recognized hospitals, or from persons being Physicians or Surgeons to any of those Hospitals.'

"Such, Gentlemen, are the principal points in the regulation agreed to by the Court of Examiners.

"But, Gentlemen, I have a more material objection to state, and it is to the catalogue of the schools of instruction to which the privilege of recognition has been conceded—Aberdeen, Glasgow! We know, Gentlemen, that at least Anatomy cannot be studied in those places with any hope of success. (Ancient Universities, please note.)

"Gentlemen, the teaching of Anatomy is not so simple a thing as some persons may suppose."

From a Mr. MacIlwain—The *Honourable* and *Lucrative* employment of teaching Anatomy is confined to a few individuals, who are eligible only by an accidental distinction, acquired by means often independent of personal merit; all other surgeons, however great their ability and acquirements, are excluded; talent and industry are deprived of their just reward, and emulation and competition, the surest sources of excellence, are extinguished. Of the ten examiners whose names are signed to this attempt at erecting the teaching of Anatomy and Surgery into a monopoly for the benefit of a few individuals, eight were at that time London Hospital Surgeons.

The following is a list of the Gentlemen who enacted this Law:—

Sir Astley Cooper, Mr. Abernethy, Mr. Cline, Mr. Lynn, Sir Ludford Harvey, Mr. Foster, Sir David Dundas (who at the time was dead, having died at the age of 77, on the 10th of January, 1826), Sir E. Home, Mr. Norris, Sir William Blizzard.

From a Mr. Wakefield, a resolution—"That the members in General may justly complain, that on every occasion of a public lecture delivered in the theatre of the College, they are compelled to enter at a separate and inconvenient door at the back of the building, whilst for the Council and their personal friends is reserved the entrance in Lincoln's Inn Fields, with many other accommodations and CONVENIENCES."

The next meeting on the 4th of March was a great success, from the critical Resolutions proposed to the re-opening of the subscription list. It contains, also, the explanation of the boycott of Summer Lectures—which were largely given during the summer months by the external teachers — Mr. J. Brookes, met with in the first paragraph, is typical of his fellows. Mr. Wakley speaks: "There is a reason, Gentlemen, why Mr. Brookes has been excluded; the reason for this exclusion is that he has sold his information at HALF the College price; he has sold his knowledge at too low a rate, and therefore he is not a member of the Hunterian Society."

And there we will leave the College of Surgeons formulating their petition to be presented to the King or to the House—they weren't quite certain which would be correct—and trust that all readers will now be sufficiently "In the picture" to appreciate the following verses which I offer without further comment:—

SOUND CHIRURGICAL KNOWLEDGE

Away with all your stethoscopes, your stomach-pumps and tractors;
Away, ye little mountebanks, make room for greater actors;

Here comes Sir Astley Cooper, Bart., Bill Buzzard and Old Luddy,
With bellies big, and purses deep, and brains cold, soft and muddy,

With seven other learned pigs from London's Royal College—
Who come to tell us when and where to purchase "Good sound Knowledge,"

To show how learning, like the itch, prefers a northern station;
And how thermometers become fit tests of education.

"Sound Knowledge," say these cunning quacks, dwells only, on permission,
With those to whom we grant a right to sell it by commission.

Like sprat or herring, learning comes in season in November,
And knowledge gained at other times won't serve to make a member.

But here they are, these ten "wise men," let's listen to their gammon,
Perhaps they'll tell us why sound sense may not be had with salmon.

Who is that red-gill'd big-paunch'd man, and who that little fellow?
What! "Don't you know the lecturer on fæces black and yellow?

That is John Ab-rn-thy, mon, frae Scotland cum to London,
To tell how certain things should look, at times when breech is undone;

"Like wetted rhubarb should they be"—but hark, he growls, pray listen,
And, if he's contradicted aught, mark how his eyes will glisten!

John Ab'rn'thy, loquitur.

"Ye stupid fools and blundering churls, who want our leave to practise,
Behold, I take the pains to tell what our new-fangled act is.

We have decreed that there shall be IN ENGLAND BUT ONE station
At which young men shall "grind to pass" with OUR approbation.

With SCOTLAND 'tis a different thing, you all know I am Scotch, sirs,
And for my clan I do not mind—to shuffle, cheat and botch, sirs.

In SCOTLAND, then, raw lads may find THREE SCHOOLS TO ONE ELSEWHERE, sirs,
And those who deem this law unjust may scout it if they dare, sirs,

Though England have a right, no doubt, from size and population,
And wealth and rank and consequence, to claim a treble ration,

There must and shall be three to one in favour of the Scots, sirs,
Or else, I vow, I'll write no more coarse chapters on . . . pots, sirs.

Moreover, 'tis our royal will—our most imperial pleasure,
As well to fill our classes out, as swell our bags with treasure,

That knowledge henceforth be unsound, to reason quite contrary,
Unless obtained sometime about the month of January;

No one shall dare to think or say that any man can truly
Acquire the art of lopping limbs within three months of July.

It shall be monstrous and absurd for brats to learn their letters
In summer time, as if to mock AT US, their Royal betters;

We will solicit Parliament this session, if it pleases,
To pass an act to shut up books, excepting when it freezes,

To make it felony to teach or learn in summer season,
DISSECTING shall be sacrilege, and "GRINDING" shall be treason.

So fare ye well, confound ye all—may every ill infest ye,
If ye shall dare to make a stir, and say we have oppress'd ye.
March 2, 1826.

CORRESPONDENCE

LECTURE ACCOMMODATION

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

Dear Sir,

This plea is really addressed to the designers of our future clinical lecture theatre. In the recently rehabilitated practical surgery room, the seating has obviously been designed by someone who has long forgotten what it feels like to sit on a lecture bench. The writing ledges are presumably meant to be used, though at a well-attended lecture yesterday, there were only four people using them for their intended purpose: the reason being obvious—they are much too high and narrow, and also are placed too far away from the bench for convenience.

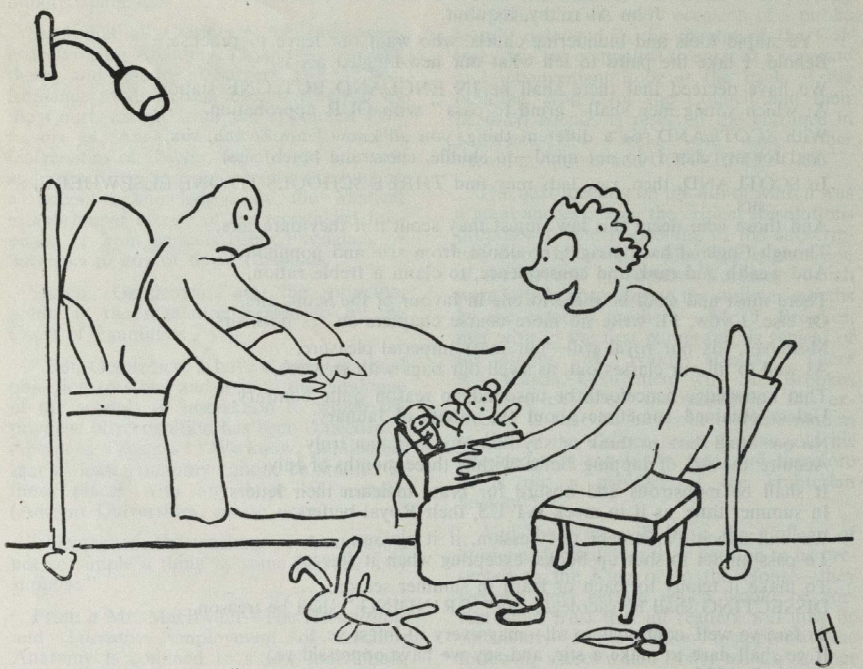
When the note-taker is forced to lean back to find enough support to write on his knee, the overlapping ledge behind protrudes neatly and most uncomfortably into the spines of his scapulæ. This may be an excellent prophylaxis against sleep, but the discomfort entailed is apt to distract attention from the lecture.

Is it too much to expect that the architect, already probably drawing up plans for the new Theatre, will try to recall his own student days, or that he will consult some of his successors who will have to use the place; or still better, that he may sit on a bench in the front row during a lecture?

We think that he would soon realize the truth of our complaints if he did so.

Yours, etc.,
P. G. CRONK,
B. W. M. MACARTNEY.

Abernethian Room.
May 18, 1950.



" . . . It's called Occupational Therapy."

PROLONGATION OF THE INITIAL STARVATION PERIOD IN INFANTS

(*With apologies to the B.M.J. of* 17-6-50)

Both Pædiatricians and Geriatricians are united in assuring us that birth precedes death, the Obstetricians adding a rider to the effect that birth is really only an incident between conception and the grave. Thus this correspondent was thrilled to read in the *B.M.J.* a profound solution to these great problems so succinctly stated as to confound one by its simplicity. Perhaps this correspondent is being too kind if he makes the assumption that the authors of the paper had really grasped the full implications of what they wrote. In the summary of this paper they seem to have glossed over the really significant concept contained in their work.

At the moment of writing this correspondent is vitally concerned with practical pædiatrics, really down-to-earth stuff. Rhesus incompatability, Diabetes, Nocturnal Enuresis, the Fate of the Foreskin: all these fascinating facets of pædiatrics fade into insignificance beside the real problem, the crisis of this particular position in space.

What, you will by now be asking, is worrying this correspondent; what is this gripping vital problem that is lashing him into such a frenzy of hieroglyphic activity? Gentle reader—the infant is crying.

Even now I can visualise the ill-concealed smile of amusement that is crossing your handsome (or beautiful) face, the " risus sardonicus " or perhaps an esoteric elevation of the eyebrow. " Is that all, you will say." But believe me, dear reader, the problem is not an academic one. This infant does not just " cry," it yells, it shrieks, it makes a series of noises of a diabolical character, there is never any " let-up." One has only to listen to a baby crying in the night to become convinced of the validity of the Doctrine of Original Sin. The noise dominates me in the present, colours the past, and prejudices with grim foreboding the immediate future. This correspondent is, however, a practical pædiatrician, and is aware that not only he alone is affected. He has applied to the problem a mind trained by erudite teachers. The Actiology of the condition is obscure, the factors multiple and diverse, generally controversial; Psychic, the names of Freud and Jung rush forward; Somatic, and thoughts of bowels and food occur *ad nauseam*. The symptoms in the form of variable wave lengths of the auditory spectrum cause even the deaf ear to turn. The Diagnosis shrieks! The Prognosis seems eternal. (Whoever coined the phrase " pregnant silence " must have known little of what the " facts of life " had in store for him.) Palliative treatment is laborious, time-consuming, and ultimately always proves to be a failure. Yet, thanks to the *B.M.J.* this correspondent has at least appreciated that the cure is so devastatingly simple —Prolongation of the Initial Starvation Period in Infants " ad finitum."

" TALIPES."

STUDENTS' UNION

At the meeting of the Students' Union Council on June 7th P. D. Matthews retired from his post as Senior Secretary. L. C. Dean was appointed in his place, and M. C. Hall was appointed Junior Secretary.

KING'S BIRTHDAY HONOUR

O.B.E. (Military Division).

George Desmond Wedd, M.B., B.Chir., D.O.M.S., Surgeon Commander R.N.

THOUGHTS ON CARCINOGENESIS

By WILFRED SHAW

THERE is little evidence of the existence of any body resistance to the growth of malignant tissue when once a neoplasm has developed. The tumour seems capable of assimilating from the blood stream all the substances necessary for its development and the body metabolism is squandered by the growth rather than utilised by such processes as inflammation. Histologically, the reaction of the tissues around malignant cells is slight, and it is reasonable to conclude that the body resistance to malignant disease is negligible. Few medical men have known spontaneous absolute cure of malignant disease, although it may occur when the primary growth is in its early stages. In gynaecology it is known that certain forms of chorion epithelioma undergo spontaneous retrogession though usually only temporarily. Krukenberg tumours of the ovaries, unassociated with a primary growth elsewhere, have been explained on the assumption that the primary growth has undergone spontaneous cure. If a malignant growth has become established, the prospect of cure depends either upon the excision of all malignant cells—basically a mechanical procedure—only possible in early cases, or upon the destruction of the malignant cells by means of radiology. Anti-carcinogenic substances are receiving consideration, but as yet little progress has been made.

Little is known of the local method of development of carcinoma, but some work has been done by Hinselmann and Te Linde upon the non-invasive intra-epithelial carcinoma of the cervix. Presumably, if a single cell in the body becomes malignant and survives, it may grow and ultimately form an inoperable growth, but it is not known whether the malignant change is primarily unicellular. If multicellular, it must be supposed that several cells take it upon themselves to become malignant simultaneously. Nor is it known whether attacks of malignant disease can occur in the same way as attacks of infectious disease. There is some evidence that recurrence of malignant disease at the primary sites after radiotherapy may be caused by the development of a new tumour.

Experimental carcinogenesis shows that malignant disease may be produced by certain hydrocarbons, viruses, parasites and radiant energy and more and more carcinogenic substances and factors are being discovered. All carcinogens seem to possess the fundamental property of modifying normal mitosis, so that after division the daughter cells are malignant in type and like a mutant transmit the malignant properties to succeeding generations. It is perhaps inaccurate to talk of the mutation theory of malignant disease, for the cells which result from the hypothetical original atypical division are not necessarily of the same type. Almost nothing is known of the mechanism whereby carcinogens convert normal mitosis to atypical malignant mitosis. Indeed very little is known of the chemical and physical changes which develop in the healthy cell at normal mitosis. For many years students have been irritated when I have postulated that the facts of cell division and reproduction are inexplicable in terms of physics and chemistry and often have been even more irritated when I have expressed my belief in the existence of a third force.

Carcinogens and carcinogenic factors are so wide-spread that it is difficult to explain why malignant disease is not more common than it is. It may be that all animal and vegetable life has a natural means of protection against the development of malignant disease. There are, perhaps, two problems. The first is to determine whether the body has any natural protective mechanism against the development of what might be termed atypical malignant mitosis. The second is to explain why the body resistance to malignant disease when once the growth is established is so small and, as a corollary, why the metabolism of the malignant growth has such high priority.

Heredity plays some part in the incidence of cancer and some patients seem predisposed to develop different types of cancer at different times. Carcinoma of the breast and carcinoma of the uterus arise in the same patient so frequently that the association cannot be regarded as fortuitous. Recently Truelsen has recorded the case of a patient who succumbed to carcinoma of the cervix, having previously suffered from carcinoma of the breast, carcinoma of the eyelids and bilateral carcinoma of the ovaries. Certain parts of the body are particularly prone to malignant disease and many of the affected organs are exposed to infection. On the other hand, malignant disease develops so rarely in wounds of the skin, muscle and bone, that these tissues seem to have some local resistance. Areas of chronic ulceration are often the sites of malignant growths but in these areas healthy cells are replacing cells which have been damaged and there is an active process of cell division, metaplasia and even dedifferentiation. It it probably true to say that wherever diseased cells are in a state of metaplasia or division the incidence of malignant change is relatively high. It may be, of course, that carcinogens are more effective upon cells in a state of instability and it may be that the milk factor is the carcinogen which affects breast cells in a state of metaplasia. These suggestions explain the more frequent incidence of carcinoma of the cervix in multigravidae than in nulliparae.

On the other hand healthy tissues in a state of active division and growth rarely become malignant. The corpus luteum becomes fully developed in eight days yet a malignant tumour of the corpus luteum has never been described. Carcinoma of the endometrium is almost unknown during the child-bearing period of life yet frequently arises after the menopause, when endometrial activity is at a minimum. The fœtus in utero is not protected from virus infection and is susceptible to radiant energy, yet with all the multitude of cell divisions in the growing fœtus, malignant disease is almost unknown. It is possible that some natural protection exists against the development of malignant disease in healthy tissues in a state of active cell division. I have often wondered whether the theca interna cells take on this function in the case of the corpus luteum. The cytotrophoblast of the early ovum has many of the properties of malignant tissue yet chorion epithelioma is a rare tumour. It is possible that the mysterious large cells found in the myometrium around the growing ovum are anti-carcinogenic in function. The peculiar cells found in the ovaries in cases of carcinoma of the uterus were originally thought to be carcinogenic. This view may be wrong and the cells may be protective against the development of malignant disease for it was realised immediately that the cells were more plentiful in cases of early carcinoma yet were found with difficulty with advanced growths. Similar cells are found in the parathyroids and the suprarenal and primary tumours of the suprarenal body are extremely rare. It is therefore possible that protective factors against the development of atypical malignant mitosis are present in the fœtus in utero. They may also be distributed through the body of the adult. Some patients may have a congenital deficiency so that an adolescent may develop a sarcoma of the tibia after being hit by a cricket ball. It may be that the endocrine changes at the menopause reduce anticarcinogenic activity so that malignant disease is relatively common at that age in the genital organs of the human female. With age and atrophy, the anti-carcinogenic cells reduce their activity and malignant change becomes more common as the years advance.

Some years ago I expressed these views to a surgical colleague and he produced two cases of carcinoma of the breast in the last stages of the disease. Fœtal extracts were made aseptically from material removed at hysterotomy and were injected around the malignant tumours. Nothing happened. The investigation was regarded as a forlorn hope, because the theory stipulates that fœtal tissues contain substances which prevent atypical mitosis and do not destroy malignant cells when once such cells have developed.

These views have been put forward to stimulate criticism and to interest the younger generation of medical men in the problems of carcinogenesis. Medical opinion is perhaps the most critical of all and there has been some hesitation about publishing views which time may show to be quite unsound and even ridiculous.

DEATHS

Dr. Alan William Holthusen, of Crowstone Road, Westcliff, on April 20, 1950, at St. Bartholomew's Hospital.

Dr. Harold Keith Tucker on March 10, 1950, aged 50, at Leyland, Lancs.

THE DEAN OF AMERICAN MEDICINE

By J. E. COTES.

THE centenary of the birth of William Welch is an opportunity to recall one who did much to fashion contemporary American medicine and to convert a land of G.P.s into the power-house of scientific medicine that it is today.

Welch was born in Norfolk, Connecticut, on April 8, 1850, the son of a general practitioner. He was a quiet boy and grew up with a strong distaste for the empiricism of the general medicine of his day. He did well at Yale and only reluctantly took up medicine when he failed to get the tutorship in Greek which was his immediate aim. But the logical outlook that he acquired was of great value to him and he had no difficulty in getting through his course at the College of Physicians and Surgeons at New York; the exactness of anatomy particularly appealed to him and he was very conscious of the value of pathology when so much was in doubt. But the subject was badly taught and when he won a miscroscope as a prize for some clinical notes there was no one available to teach him how to use it.

In 1876, soon after qualifying, Welch made his pilgrimage to Europe. He studied at the leading German universities and learnt pathology from the great teachers of his day. In addition, he was struck by the excellent laboratories, the ample staff and the high standard set for the students; all so different from the American schools where teachers existed on the fees of their pupils and lowered examination standards to attract them. Thus when Welch returned to New York two years later he brought back both pathological knowledge and the vision of a better educational system which he was later to substantiate. But, at first, there was no indication of what was ahead.

For six years Welch worked in New York as the Bellevue Hospital pathologist and started the first morbid histology class in America. At first in a small room with no assistant, it expanded rapidly as his fame spread. He worked hard, lived simply and had few recreations, but became immensely popular with his pupils. In 1884 he was appointed Professor of Pathology at Johns Hopkins University Medical School which was in the process of formation as a new centre of medical teaching. Dean of the Medical School, he supervised its birth and developed its characteristic features: the subdivision into departments each under a professor, of whom Osler, Professor of Medicine was the most illustrious; the emphasis on pathology and the high entrance qualifications for students of both sexes—the last a topic on which he had fewer doubts than might have been expected of a bachelor. The medical school prospered and with it the "Pathological" where he presided under the genial guise of Popsy. The teaching seems to have been first rate, though Welch was invariably late for his lectures. Research flourished and his assistants, men such as MacCallum, Whipple, Opie and Flexner—the Welch rabbits as they were called—did great things.

Welch himself will be remembered for his discovery of bacillus aerogenes capsulatus, later called Clostridium welchii, in the blood of a negro who died with an aortic aneurism. He produced papers on innumerable topics and founded the Journal of Experimental Medicine of which he was editor. It was the first journal in America to be devoted to medical research and it brought him into touch with research workers all over the country: but it was only one of many activities. In the same period he delivered countless addresses, was chairman of a multitude of committees, president of many organisations.

In 1901 Welch became president of the Board of Scientific Directors of the Rockefeller Institute and played a big part in its development as a centre for medical research. Under his guidance Rockefeller Institutes grew up the world over, among them the London School of Hygiene. In addition there are today Welch Endowment Funds and Welch Fellowships in Medicine which "commemorate one of the Foundation's wisest advisers." He established a chain of Public Health laboratories throughout America and was first professor of Public Health and editor of the American Journal of Hygiene. Later, in his declining years, he occupied the chair of the history of medicine at Johns Hopkins.

Throughout his life, Welch had few relaxations. He enjoyed his food and his cigar; was fond of sunbathing and visiting amusement parks, of music and of watching college baseball. He had an excellent memory, wide knowledge and a tolerant outlook. In committee he was able to see and explain the other point of view and then to bring it round to his own, so that he was able to persuade without offending. He was content to hurry slowly. There is little he did that might not have been done by a host of others and he owed his achievements to his ability first to appreciate new ideas and then to create the environment in which they might be developed. To quote Osler:

"No man of his generation in the United States has so deeply influenced the profession not only by his administrative ability and his stimulating work in pathology, but much more by a personal unselfish devotion to its highest interests."

Ref. William Henry Welch, by Flexner and Flexner, 1941.

I would like to thank Mr. J. L. Thornton for his assistance.

Based on a talk to the Osler Club, 21.4.50.

THE H.S.

A Tribute to the Late Dr. V. J. Duigan.

By HELEN A. LATHAM, S.R.N.

In 1901 I entered the Herefordshire General Hospital as a probationer. It was a Bart.'s preserve, and V. J. Duigan was its house surgeon. We were a happy family, due chiefly to his guidance and influence. If it "wasn't cricket" the H.S. didn't do it and nobody else dared either. (True, we were told daily at Bart.'s we should have our necks wrung.) He nearly always came to evening prayers in Oxford, the men's surgical ward; and he used to tell us, "If I am ever ill send for Anthony Bowlby." He did no end of kind things which he could never afford, and he had no thought of repayment.

He never dropped a brick in diagnosis (you can always tell a Bart.'s man, but you cannot tell him much!), and he was a wizard at the head of the operating table—no green-for-danger then! The surgeon used to ask, "Can I go on Duigan?" Sometimes dear Mr. T. Turner, consulting surgeon to all Herefordshire, and aged about seventy, would barge into the theatre by the wrong door, clad in winter overcoat trimmed with lovely sable collar and cuffs. He would peer into the open abdomen and say, "What have we here?"—the surgeon nearly in fits at the sable cuffs so very nearly in the open carpet bag. One day the H.S. whispered to me, "Get a pair of white sleeves and make him wear them." The theatre sister had already tried; I was very small, and I gazed imploringly up at the tall and very handsome old gentleman, "Will you have these sleeves, sir?" "Yes, my dear, I think I will. My wife will be so angry if I get these cuffs spotted"—he knew quite well why he was asked to wear them!

When the H.S. departed after being captain of his happy ship for three years, he left on his sitting-room mantelpiece the following "Rules for my successor" (another Bart.'s man):

1. Respect Mr. Morris.
2. Walk warily with Chapman.
3. Put up with Dubbs, who means well.
4. Do Lilley's out-patients—he gives damn good dinners.
5. Leave the kids to Dorothy Shaw. She knows more about them than you ever will.
6. Swear at the spratt (me)—she thrives on it.

I have worked for many Bart.'s men since my training. They are gentlemen, and they always know their job. I have been told I know mine; and I owe that to V. J. Duigan. He was a great gentleman and he loved Bart's.

CHANGE OF ADDRESS

A. B. Pavey-Smith, F.R.C.S., to North Wood, Nailsworth, Glos.
Cortlandt MacMahon, M.A., to The Croft, Trebor Avenue, Farnham, Surrey.
Dr. C. J. Martin to 49, Belmore Road, Randwick, Sydney, N.S.W., Australia.

SPORT

GOLF CLUB

v. St. Thomas'

On May 31, at Porter's Park Golf Club, an enjoyable afternoon's golf resulted in a draw of 3 matches all, Dr. McIlroy, R. E. Dreaper and J. S. Dodge winning their matches by convincing margins.

v. Imperial College

On June 21, at Purley Downs Golf Course, an afternoon's golf played in pouring rain resulted in another draw of 2 matches all.

Results

L. R. Gracey lost to Glover 1 down; D. H. Rushton beat Gibson 6 and 5; C. J. R. Elliott and R. E. Dreaper lost to Wallace 1 down; A. B. Lodge and J. P. Waterhouse beat Poynder 5 and 4.

Ilford

Besides being able to play at Sundridge Park Golf Club at 2/6 a time, it is now possible for members of the Golf Club to play at Ilford Golf Course from Mondays to Fridays at the reduced green fee rate of 2/-.

At an inaugural meeting held there on June 14 a prize for the best gross score was won by L. R. Gracey, who returned a fine 74, the best handicap score being returned by C. J. R. Elliott with a net 69.

CHESS CLUB

The Chess Club has played six matches during the past season, winning five and drawing one.

In the London University League, Division II, we won three matches and drew one. This gave us an equal match score of 3½ points with Sir John Cass College, but they were awarded first place, having won more individual games.

We have also played and won two friendly matches; one, a most enjoyable match, against Bromley, and the other against the London Hospital.

An entertaining lightning tournament, won by G. E. Thomas, ended an enjoyable and successful season.

The next season begins in October, and we would welcome any new members whatever their standard of play. We would be especially pleased to see a larger representation from Charterhouse Square at our meetings.

HOUSE APPOINTMENTS

JULY 1 to DECEMBER 31, 1950

At St. Bartholomew's Hospital

	Senior	Junior
Dr. Bourne	M. W. Partington	G. C. R. Morris
Dr. Cullinan	P. I. Roffey	G. W. Marsh
Dr. Scowen	A. M. Baker	J. F. Hale
Prof. Christie	J. B. Dossetor	P. J. Lawther
Mr. Hume	K. R. Mason-Walshaw	R. P. Holmes
Mr. Corbett	J. D. W. Tomlinson	J. L. Milligan
Mr. Hosford	G. Kazantzis	N. A. Green
Prof. Sir J. Paterson Ross	J. D. Griffiths	N. G. Rothnie
Casualty Physician	N. P. Bhandari	
Children's Dept.	A. D. Munro-Faure	J. Bouton
E.N.T. Dept.		D. C. James
Skin & Gynæ Dept.	J. R. Harris	
Eye Dept.	M. Reckless	
Intern		
(Midwifery)	D. C. H. Garrod	J. D. Cairns
(Gynæcology)	Miss H. Bambridge	
Anæsthetists	C. Todd (S.R.A.) F. A. Cooper	
Dental Dept.	D. Weinstock	
Orthopædic Dept. (Accident Service)		J. L. Godden

At Hill End Hospital

Dr. Spence		J. M. L. Gilks
Mr. Nauton Morgan	M. B. S. Cooper	
E.N.T. Dept.	R. E. G. Gosling	
Orthopædic Dept.	B. I. Brest	J. I. Burn
Thoracic Dept.	I. R. McWhinney	
Neuro-Surg. Dept.	G. A. Court	
Anæsthetists	I. Jackson (S.R.A.) J. W. Latham J. C. S. Ainley-Walker	

Alexandra Hospital

R.M.O. A. J. Wainwright

APPOINTMENTS

The following new appointments to the medical staff have been made:—

Senior Registrar to Dr. Cullinan's firm from September 1, 1950 ... Dr. C. F. Cooper

Senior Registrar to Mr. Naunton Morgan's firm from October 1, 1950 ... Mr. I. P. Todd

Registrar Anæsthetist from July 1, 1950 ... Mr. I. Jackson

From June 1, 1950

Part-time Junior Registrar in S.T.C. ... Mr. G. A. Coombs

Junior Registrar in the Children's Department Dr. R. C. Roxburgh

Resident Junior Registrar, Department of Anæsthetics ... Mr. C. Todd

From July 1, 1950

Junior Registrar in the Gynæcological and Obstetrical Department ... Mr. M. P. Durham

EXAMINATION RESULTS

UNIVERSITY OF LONDON

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

April, 1950

Pass

Benett, G. R.
Bouton, M. J.
Brest, B. I.
Burn, J. I.
Capstick, N. S.
Chorley, G. E.
Cox, J. S.
Drown, G. K. M.
Eve, J. R.
Eyfe, A. E.
Green, N. A.
Hibbard, B. M.
Holland, W. G.
Hurter, D. G.
Jenkins, A. V.
Kaye, M.
Lawther, P. J.
Moore, G. J. M.
Rees, J. H.
Rothnie, N. G.
Simmons, P. H.
Smith, R. V.
Stebbings, N. E.
Studdy, J. D.
Tannen, G. P.
Vercoe, M. G. S.
Wainwright, A. J.
Warlow, P. F. M.
Woolf, J. C.
Zakon, R.

Supplementary Pass List

Part I

Bexon, W. H.
Brooks, W. V.
Cassells, M. J.
Coldrey, J. B.
Cooray, M. P. M.
Gould, G. T.
Griffiths, E. J.
Hale, B. C.
Hambling, M. H.
Horwitz, H.
Hovenden, B. J.
Ibbotson, R. N.
Jenkins, G. C.
Jones, J. N. W.
Kinsman, F. M.
Molloy, C.
Montgomery, B. K.
Moynahan, A. R.
Norman, M. H.
Pedersen, D. L.
Phillips, G. D.
Sacks, R. H. B.
Scott, W. C.
Smith, I. G.
Steinberg, V. L.

Part II

Bendas, J.
Cassells, M. J.
Davies, W. H. G.
Hale, B. C.
Jenkins, G. C.
Reading, J. H.
Wendell-Smith, C. P.
Wright, R. F.

Part III

Bexon, W. H.
James, D. C.
Liu, S.
Marsh, G. W.
Molloy, C.
Moynahan, A. R.
Pedersen, D. L.
Phillips, G. D.
Smyly, D. P.

RECENT PAPERS BY BART'S MEN

ATKINSON, MILES. Ménière's Syndrome: observations on vitamin deficiency as a causative factor; III. The general disturbance. *Arch. Otolaryngology*, 51, Feb., 1950, pp. 149-164.

———. Ménière's Syndrome: a new drug for control of acute attack. *Arch. Otolaryngology*, 51, April, 1950, pp. 312-315.

BANKS, T. E., FRANCIS, G. E. C., MULLIGAN, W., and WORMALL, A. Some antigen-antibody reactions studied with the aid of radio-active isotopes. *J. Physiol.*, 111, April 15, 1950. pp. 13*P*-14*P*. 4

*BLACKBURN, G. Acute cholecystitis. *Practitioner*, 164, March, 1950, pp. 254-257.

BOURNE, GEOFFREY. Riddle of arteriosclerosis. *Practitioner*, 164, June, 1950, pp. 481-7.

BOYD, A. M. A classification of occlusive vascular disease. *Practitioner*, 164, June, 1950, pp. 488-96.

*——— and JEPSON, R. P. External iliac artery thrombosis. *Brit. Med. J.*, June 24, 1950, pp. 1457-1460.

BURROWS, H. JACKSON. Variable scale for measuring from radiographs in Smith-Petersen nailing. *J. Bone and Jt. Surg.*, 32-B, May, 1950, p. 273.

*CATES, J. E. Oedema and potassium loss in combined sodium p- aminohippurate and penicillin therapy: a metabolic study. *Clin. Sci.*, 8, July, 1949, pp. 53-63.

DALE, SIR HENRY. The action and uses of the antihistamine drugs as applied to dermatology. *Brit. J. Derm. and Syphilis,* 62, April, 1950, pp. 151-158.

*DISCOMBE, G. Phase-contract microscopy in The clinical laboratory. *Acta Haematol.,* 3, April, 1950, pp. 152-162.

DOBREE, J. H. The diagnosis of acute conditions of the eye. *Clinical J.,* 5, May, 1950, pp. 128-131.

D'SILVA, J. L. and COMFORT, A. Partition chromatography of adrenaline and naradrenaline, *J. Physiol.,* 111, April 15, 1950, p. 20P.

*DUNHILL, SIR THOMAS. Pharyngeal diverticulum. *Brit. J. Surg.,* 148, April, 1950, pp. 404-415.

EVANS, C. A. LOVATT. New National Institute for Medical Research at Mill Hill. *Brit. Med. J.,* May 6, 1950, pp. 1063-1067.

FRANCIS, G. E. C. See Banks, T. E. (and others).

*GARROD, L. P. and SHOOTER, R. A. The rate of excretion of a large dose of penicillin. *Brit. Med. J.,* May 20, 1950, pp. 1169-1170.

*GRIFFITHS, E. Carcinoma of the adrenal cortex: Report of a case without endocrine changes. *Brit. J. Surg.,* 37, Jan., 1950, pp. 311-314.

*——— (and FALCONER, C. W. A.). The anatomy of the blood vessels in the region of the pancreas. *Brit. J. Surg.,* 37, Jan., 1950, pp. 334-344.

——— and others. A trial of procaine penicillin preparations. *Brit. Med. J.,* April 1, 1950, pp. 761-763.

HADFIELD, GEOFFREY. Thrombosis. *Ann. Roy. Coll. Surg. Eng.,* 6, April, 1950, pp. 219-234.

HARRISON, NORMAN K. The selection of sensitive materials for medical photography. *Brit. J. Photography,* 97, May 12, 1950, pp. 235-239.

———. Medical photography and the patient. *Nursing Mirror,* 91, June 9, 1950.

———. Photography of skin conditions. *Functional Photography,* 1, June, 1950, pp. 28-29.

HARTRIDGE, H. Recent advances in the physiology of vision, Part 3. *Brit. Med. J.,* June 10, 1950, pp. 1331-1340.

*HEADY, J. A. *See* Griffiths, E., and others.

*HEWER, C. LANGTON. Trichlorethylene as an inhalation anaesthetic and analgesic. *Canad. Med. Assoc. J.,* 62, 1950, pp. 324-327.

HOWELL, TREVOR H. The simple treatment for fibrositis. *Med. Press,* May 31, 1950, p. 514.

*IVES, L .A. Neurinoma of the stomach. *Brit. J. Surg.,* 148, April, 1950, pp. 477-8.

JEPSON, R. P. *See* Boyd, A. M., and ———.

*JONES, P. F. *See* Griffiths, E., and others.

KERSLEY, G. D. The rationale, difficulties and possibilities of endocrine therapy in rheumatic diseases. *Med. Press,* May 17, 1950, pp. 461-462.

——— and MANDEL, L. Steriod therapy in rheumatoid arthritis. *Lancet,* June 24, 1950, p. 1153.

MULLIGAN, W. *See* Banks, T. E. (and others).

*MURLEY, R. S. Post-operative venous thrombosis and pulmonary embolism with particular reference to current methods of treatment. *Ann. Roy. Coll. Surg. Eng.,* 5, May, 1950, pp. 283-322.

O'CONNELL, J. E. A. The indication for, and the results of the excision of lumbar intervertebral disc protrusions: a review of 500 cases. Hunterian lecture . . . 16th February, 1950. *Ann. Roy. Coll. Surg. Eng.,* 6, June, 1950, pp. 403-412.

OSWALD, NEVILLE. Pulmonary changes in the reticuloses. *Proc. Roy. Soc. Med.,* 43, March, 1950, pp. 208-213.

RAVEN, RONALD W. Extended radical excision of the rectum for cancer. *Med. Press,* May 3, 1950, pp. 416-419.

*———. Cancer of the breast treated by oophorectomy. *Brit. Med. J.,* June 10, 1950, pp. 1343-1345.

———. A surgeon in Columbia. *The Broadway,* June, 1950, pp. 243-45.

ROSS, SIR JAMES PATERSON. Value of arteriography in diagnosis of peripheral vascular disease. *Practitioner,* 164, June, 1950, pp. 518-528.

SHOOTER, R. A. *See* Garrod, L. P., and ———.

*———. *See* Griffiths, E., and others.

*SIMON, GEORGE. X-ray appearances of acquired atelectasis of the upper lobes. *J. Faculty Radiologists,* 4, April, 1950, pp. 223-230.

*STORY, P. Histological reactions to injections of procaine penicillin in oil. *Brit. Med. J.,* June 24, 1950, pp. 1467-8.

WEBER, F. PARKES. Hamartomata and organoid tumours. *Med. Press,* May 31, 1950, pp. 512-3.

WORMALL, A. *See* Banks, T. E. (and others).

* Reprints received and herewith gratefully acknowledged. Please address this material to the Librarian.

BOOK REVIEWS

THE RHEUMATIC DISEASES, by G. D. Kersley, William Heinemann. 3rd Edition, 1950, pp. xiii + 143, plates 26. Price 15s.

This book contains a great deal of information that is not to be found in the text-books of general medicine. Although the author does not set out to give a detailed survey of all the literature on rheumatology, he nevertheless reviews most of the important milestones in the development of the subject. There is in this edition a new chapter on the endocrinological and biochemical aspects of rheumatic disease which makes easy and interesting reading of a complicated field of research. The chapter on special treatments gives a brief summary of the value of physiotherapy and the spa. The format is good and the plates are clearly reproduced.

INTRODUCTION TO PHYSICAL BIOCHEMISTRY, by J. M. Johlin. 2nd Edition, Cassell & Co., 1949, pp. xii + 246. Price 27s. 6d.

The theme of this book is good, it deals with the physico-chemical background of biochemistry and physiology, and this is a topic which is of fundamental importance in medicine. Only recently, however, have text-books suitable for students' use been available and for this reason it is to be welcomed. However, the author's manner of expression lacks that subtle yet felicitous turn of phrase which makes the reading of a book a joyous adventure, and would turn a good book into a great book. The average student will find it hard reading, simply because the style is ponderous.

There are, however, interesting chapters on the respiratory functions of the blood; the acid base balance of the blood; oxidation reduction potentials, and on biological oxidation—reduction systems. This last chapter would be much improved if the cyclical method of presentation of O/R systems was used.

One error in the chapter on the physical and chemical properties of water is that there are used two diagrams to explain the association of water molecules which do not agree between themselves, and both are at variance with the accepted theory of association due to "resonance" or hydrogen bonding. The author takes for granted—intentionally as stated in the preface—many basic facts of physical chemistry, but this makes an ordered presentation of the materials more difficult and is to be deprecated.

A BIOGRAPHY OF SIR BENJAMIN WARD RICHARDSON, by Sir Arthur Salusbury MacNalty. Harvey & Blythe Ltd., 1950, pp. vii+92, frontispiece. Price 7s. 6d.

We welcome the revival of the Masters of Medicine series, and are gratified by its initiation at the hands of a distinguished medical historian writing on such an imposing character. Richardson completed his autobiographical *Vita medica* a few days before his death, and it was published in 1897. It provides most interesting reading, and relates the development of its author from the occasion at his mother's death-bed in 1838, when she told him of the plans she had made for his education as a doctor, to the closing days of his life. A life crammed with hard work, successes, and association with some of the most distinguished medical men of the nineteenth century. Richardson did not specialise, but he dabbled successfully in most branches of medicine, including pharmacology, tuberculosis, anæsthetics, public health, medical psychology, and medical history, contributing usefully to all. The story of his very full life is well worth retelling, and this biography, which includes a Bibliography of Richardson's extensive writings, presents a fascinating outline. The book is inexpensive compared with similar medical biographies, but is worthy of a photograph in place of the frightful woodcut on dust-cover and frontispiece.

J. L. T.

BRITISH MEDICAL ASSOCIATION PROCEEDINGS OF THE ANNUAL MEETING, 1949. London, Butterworth & Co. (Publishers) Ltd., 1950, pp. xxvi+468, 56 figures. Price 25s.

This volume constitutes a record of the proceedings of the B.M.A.'s 1949 Annual Meeting, and the main advantage of such a record is that it contains something for everybody. Commencing with the Presidential Address on Man and the Machine, by C. W. Curtis Bain, it includes discussions on Diabetes mellitus; Prostatic obstruction; Breech presentation and its management; Radiography and disproportion; Pruritus vulvæ; Cephalometry; Functional uterine hæmorrhage; Post-operative pulmonary complications; Control of obstetric pain; Scope and limitations of radiotherapy; Angiocardiography; Radiology of joints; Simulation of heart disease; Treatment of osteoarthritis; The Sprue syndrome; Common difficulties in infant feeding; Ophthalmology in relation to diseases of the skin; Nasal allergy; and Structure and function of muscle, among other subjects. Contributions from Bart.'s men include E. B. Strauss on Intractable pain, Brain F. Russell on Psoriasis, C. H. Andrewes on Recent advances in knowledge of influenza, and G. D. Kersley on The Seventh International Congress on Rheumatic Diseases, the volume ending with a summary of Charles Hill's popular lecture on Health and happiness. The book is handsomely produced in accordance with the high standards set by the publishers, and at twenty-five shillings is remarkable value.

J. L. T

THE ORDINARY DEVOTED MOTHER AND HER BABY, by D. W. Winnicott. Privately published, pp. 47. Price 1s.

This booklet presents in print nine talks recently given over the B.B.C. system by Dr. Winnicott. In the course of them he explains in simple terms the physiological and emotional development of a baby in his earliest months. The book suffers by being in exactly the form in which the talks were delivered. The colloquial style and oversimplification may irritate a medical reader. Nevertheless, his booklet, which embodies many of Dr. Winnicott's own ideas, gives a very clear and honest account of the way in which a physician attempts to explain the subject to his patients, and for this reason there is much to be learned from it.

PSYCHOLOGICAL ASPECTS OF CLINICAL MEDICINE, by Stephen Barton Hall. H. K. Lewis, 1949, pp. xii+416. Price 21s.

It is pleasant to be able without reserve to praise the work of a psychiatric colleague. The title of the book is itself praiseworthy: the author might have called it "Psychosomatic Medicine," which would have missed the whole point. Physicians are coming to realise more and more that the whole of medicine is psychosomatic, seeing that man is a psychosomatic unity. It is time, then, that more psychiatrists recognized the fact that psychiatry, too, is psychosomatic. It is for that reason that any move to separate psychiatry from the main body of general medicine—such as by the formation of a separate Royal College—would be deplorably retrogressive. From Barton Hall's book one learns when and where it is more profitable to stress the psychic or the somatic ætiology of this or that disorder, and when and where the therapeutic emphasis should be psychic or somatic. Dr. Barton Hall reminds us that the B.M.A. Committee on Mental Health (1941) came to the conclusion that in any group of sick people "something like 30 per cent. will be found to be suffering from conditions about which it is helpful to have psychiatric advice." A psychiatrist has time to study and reach only the more highly specialised aspects of his subject. The psychological aspects of ordinary clinical conditions are the province of the general physician, the gynæcologist, the neurologist—in fact, of every clinician; and the medical student has a right to expect to receive psychiatric instruction in every clinical department of his teaching hospital. Until this desideratum is attained, Dr. Barton Hall's book will provide a valuable storehouse of that kind of knowledge.

E. B. STRAUSS.

This review also appeared in "Linacre."

AIDS TO HISTOLOGY, by Geoffrey H. Bourne. 5th Edition. Baillière, Tindall & Co., pp. viii+158. Figs. 59. Price 5s.

Considering the price of the individual members of the Student's Aid's series, and of the erudition of the separate authors, most of these books are of remarkable value for the money. For the average student, who has worked intelligently with a standard text-book, the complementary "Aids" is extremely useful for formulating a skeleton revision. Although the *homo multarum literarum* tends to regard the series with something approaching derision, one suspects that, in some instances, he may be guilty of "scorning the base degrees by which he did ascend."

The book under consideration, however, is not quite up to the standard of some of its fellows. Some of the diagrams are quite good: most are inadequate. Had there been five times the number of good diagrams and a fifth of the explanatory text, the book would have been of real revisional value. As it stands, it cannot be fairly recommended to students preparing for a 2nd M.B. examination.

INDUSTRIAL HEALTH, AN INTRODUCTION FOR STUDENTS, by R. Passmore and Catherine N. Swanston. Livingstone, 1950, pp. vii+110. Price 4s. 6d.

This excellent little book covers the whole field of industrial medicine in just over 100 pages. It is clear, concise and readable. If the object is to interest the student in the problems of industrial health, then this book will achieve it.

The structure of industry, the social background, environmental hygiene and industrial legislation are very adequately dealt with, sometimes perhaps in too much detail for the student.

The space given to occupational diseases is a reasonable proportion as a measure of relative importance to the subject as a whole. Yet the student will need to learn more about occupational diseases than what he finds in this book. As occupational disease is the main link for the student between medicine and industry it might have been dealt with rather more fully.

In spite of this criticism, the book is worth a place in the library not only of the student, but of any member of the profession whose knowledge of the medical problems of industry is in need of improvement.

G. O. HUGHES.

MODERN PRACTICE IN DERMATOLOGY, edited by G. B. Mitchell-Heggs. Butterworth, 1950, pp. xxv+836. 7 colour plates and 319 figs. Price 63s.

Unless your reviewer is much mistaken, this is the first composite text-book of dermatology from the British School, and despite the faults of overlapping, differences of approach and other inequalities that are inevitable in a work in which most chapters are contributed by different authors, it is decidedly a book which can be recommended to those senior medical students and general practitioners who require a large volume on dermatology and not a manual. As a matter of course, the dermatologist will have it on his shelves.

The editor, Dr. G. B. Mitchell-Heggs, has introduced several innovations in the planning of his work, for he has included chapters on the cutaneous manifestations of systemic diseases, the social aspects of dermatology, psychosomatic disorders, pharmacy, and diseases of the skin affecting the mucous membranes—subjects which receive but scant attention in the average text-book. Further, he has included three chapters on the skin diseases of hot countries, which will ensure that the work has a bigger appeal abroad than most British text-books.

It would be invidious to select various contributors for commendation, but it is pleasant to note that Bart.'s is most competently represented.

The publishers are to be congratulated on the format. They have used an expensive paper on which the many well-chosen illustrations have been excellently reproduced; the layout follows the accepted Butterworth style; the index is satisfactory.

In conclusion, one may say that this is a book which will serve its readers well in whatever part of the world they may happen to be.

A SHORT TEXTBOOK OF RADIOTHERAPY, by J. Walter and H. Miller. J. & A. Churchill, 1950, pp. xii+444. Illus. 199. Price 28s.

This book is based on lectures given to student radiographers studying for the M.S.R. or C.T. It will supply for this class of technicians a long-felt want.

The physics is described simply and clearly so that anyone with a basis of physical knowledge can clearly follow the text. Biology and pathology are followed by clear descriptions of the methods of radiation, radium and X-rays, principles of treatment and technique in malignant cases and benign conditions. The book ends with protection recommendations. For the post-graduate or medical student the book is, of course, elementary, but even they may derive benefit from the bird's eye view which is given of the intricacies of a speciality where there are so many differences, between centres as well as countries.

There has been a great need for such a book. Dr. Miller, the physicist to the Sheffield Radiotherapy Centre, and Dr. Walter, the Deputy Medical Director are to be congratulated for taking the initiative. It is an expensive book, but it will provide, supplemented by lectures and practical instruction, everything that trainee technicians require for their examinations.

I. G. WILLIAMS.

AIDS TO SANITARY SCIENCE AND LAW, by J. A. Struthers. Baillière, Tyndall & Cox. 4th Edition, pp. vi + 380. Price 6s.

An excellent aid to the study of Public Health with the accent on the environmental rather than the personal services. Because of this, it is more useful to D.P.H. students and students of Sanitary Science *per se.*, than for undergraduate medical students, for whom is recommended the following book.

AIDS TO PUBLIC HEALTH, by Llywelyn Roberts. 6th Edition, Baillière, Tindall & Cox, 1950, pp. viii + 304. Price 6s. 6d.

This useful little handbook has been necessarily widely revised on account of the passage of the National Health Act since its last edition. Public Health is approached by the student with some misgiving, but this brief and clear book goes some way towards dispelling this illusion—it is not a bizarre branch of medicine run by sanitary inspectors but necessary to all doctors, particularly general practitioners, in their daily work. The recent public health legislation is covered simply but adequately.

REGIONAL ILEITIS, by Burrill B. Crohn. Staples Press, 1949, pp. viii+225. Price 30s.

It is of very great interest to read a monograph on Regional Ileitis by Dr. Crohn, as it is to his name that the disease is so commonly referred.

The condition was first described by him in 1932 and during the intervening period, he has drawn on the many published observations by others in addition to those of his own. In this way he hopes to have gained a more comprehensive picture of the disease. In addition, he gives a description of the extension of the disease to the jejunum, and the colon. Newer methods of medical and surgical treatment are discussed.

The work mainly deals with Dr. Crohn's private patients and the careful observations carried out on them during the last fifteen years. In the chapter on Gross Pathology, more than one reference is made to the observations of Blackburn, Hadfield and Hunt, on specimens collected at St. Bartholomew's Hospital. Reference is also made to the little known "skip areas" as he calls them, which emphasises the character of the disease to miss segments of the small intestine on its proximal spread.

In the chapter on Clinical Features, reference is made to the perirectal abscesses and fistulæ which are often prodromal manifestations occurring before the typical mild diarrhœa.

There is a chapter on X-ray studies, emphasising the characteristic "string-sign" with numerous illustrations.

In the chapter concerning treatment, he doubts the value of conservative forms of medical treatment. He points out how surgical treatment has differed and he outlines the trend over the last fifteen years. He leaves the reader to decide for himself which method to adopt but he lays stress on two points:—

(1) That the division of the ileum proximal to the diseased area is a *sine qua non* to the success of any operation.

(2) That there is a very high percentage of post-operative recurrences following short circuit procedures alone.

The remaining chapters deal with ileo-jejunitis and ileo-colitis. In the latter, he refers to Chronic Ulcerative Colitis and points out how closely allied this disease is to Regional Ileitis—especially with regard to ætiological factors. He looks upon Ulcerative Colitis as a subsidiary disease, pointing out that there were 22 cases of combined Ileitis and Colitis in the series of 306 cases of Ileitis.

There are over 250 references in the book, and it will be of the greatest interest to the abdominal surgeon and to those working for higher degrees.

A HISTOLOGY OF THE BODY TISSUES, by Margaret Gillison. 1st Edition, Livingstone, 1950, pp. xiv + 220, illus. 103. Price 15s.

This small book gives briefly and clearly such histology as is required by the Student of Physiotherapy, or Physical Training, for whom the detail in the standard text-books is not necessary.

The subject-matter is pleasantly set out, easy to read, and the diagrams are clear.

The description of the process of ossification of bone is perhaps not up to the standard of clarity of the other chapters.

The last chapter consisting entirely of diagrams is very good—well explained and labelled.

TRUDA WAREHAM.

THE COMMON DISEASES OF THE SKIN, by R. C. Low and G. A. G. Peterkin. 4th Edition, Oliver and Boyd, 1949, pp. x + 282, illus. 148. Price 21s.

This is a clear, well-illustrated book, containing the elements of dermatology necessary to student and general practitioner. Skin diseases are notoriously difficult to photograph well, but the plates of this book are excellent, and it is possible actually to understand what it is they are illustrating. The paragraph on microscopic pathology, which is included in each major disease, is of the greatest help. The multiplicity of ointments, pastes, liniments, etc., necessary for the treatment of every skin disease is always confusing, and this book does little to disperse the fog. But it is a useful book.

E. & S. Livingstone Ltd. (Publishers) will have pleasure in forwarding their latest revised catalogue to anyone who is interested.

TO LET

From beginning September, 1950, for about 15 months, Furnished Queen Anne farmhouse in East Hertfordshire. Four-five bedrooms, drawing room, dining room. Aga cooker and water heater. Main water. Own electric light. One mile from town and station. Excellent train service: 30 minutes to London. 8 guineas. Apply, Mrs. A. N. C. Bingley, Hoddesdonbury Farm, Hoddesdon, Herts. Hoddesdon 3238.

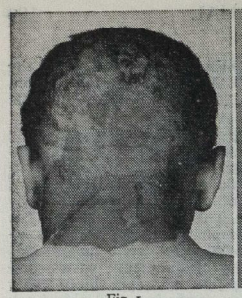


Fig. 1

Fig. 2

Fig. 3

Scald of head and neck

15TH NOVEMBER. 5 p.m. (C. W.), aged 2, scalded neck and scalp with hot soup. First Aid dressing of Sodii Bicarb. and unsterile cotton-wool applied.

7.50 P.M. Admitted to Hospital. *General condition:* An apparently healthy child; not shocked. *Local condition:* Blister burns of all occipital region. Deeper scalding of all the back of the neck with much œdema. (Fig. 1).

8.10 P.M. Given Omnopon gr. 1/15th and Scopolamine gr. 1/600th.

9.10 P.M. PLENARY TREATMENT. Routine bacteriological swab taken. Hair cut short. Burnt area cleaned with 1% Cetavlon and dressed with Penicillin cream (400 units per gramme), gauze, cotton-wool, crepe bandages, and immobilized in Gypsona P.O.P. (Fig. 2).

17TH NOVEMBER. Report from laboratory that Group A haemolytic streptococci had been cultured from swab taken on admission. Clinical condition satisfactory.

18TH NOVEMBER. Re-dressed with Penicillin cream. Gypsona P.O.P. applied over dressings to keep them perfectly in place thereby lessening the risk of the H.S. spreading to other cases in the ward. Dressings repeated at two day intervals until H.S. were temporarily eliminated.

PROGRESS. Swabs taken from scalp and neck during the next six weeks grew H.S. intermittently. Dressings with Penicillin cream were continued at frequent intervals. Final healing was delayed by the development of dermatitis and the difficulty of completely eliminating H.S. in the presence of penicillinase producing staphylococci.

26TH JANUARY. Patient discharged soundly healed.

FOLLOW UP. Seen in follow-up clinic several times until 14th December, when a final review showed a satisfactory result. (Fig. 3).

These details and illustrations are of an actual case. T. J. Smith & Nephew, Ltd., of Hull, manufacturers of Gypsona P.O.P. publish this instance — typical of many — in which their products have been used with success.

ST. BARTHOLOMEW'S

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LET'S PRETEND

There is a story told by Hans Andersen of a certain Emperor who was extremely fond of his clothes and to whom nothing could be more delightful than to be presented by his tailors with a new suit of some fine material, more exotic than any he had previously possessed. Two imposters arrived at the court and offered to fashion him a set of clothes of most exceptional material. This cloth would be invisible to everyone who was either unfit for his situation or unpardonably stupid. The spurious weavers received their commission and set to work on their empty looms. The narrative tells how the Emperor's advisers, afraid to admit their failure to see a stitch of the fabric, admired the finished product. The Emperor, in dread of appearing unfit for his post or else a fool, allowed himself to be dressed in the non-existent robes and paraded through the city. The citizens cheered heartily in admiration of his costume, but it remained for a little child to exclaim: "He has nothing on!"

In M.O.P.s the physician announces that he hears a presystolic murmur in the patient's chest. The clerk applies his stethoscope, adjusts it, reverses the earpieces and listens again. He assures himself that he hears it plainly. In the same way he localises the apea beat in the fifth left interspace in a case of dextrocardia. The student of modern art discourses at length upon the beauty of the smudge of paint before him at the exhibition. Perhaps he has never watched a schizophrenic chalking on the blackboard at Goodmayes Hospital. The Moscow Press deprecates indignantly the recent American aggression in Korea. How frequently does self-deception feature in the working of the human mind!

Let us not, however, be too disparaging about our inherent lack of truthfulness. There are times when it stands us in very good stead. It must be a pleasant boost to the self-esteem of the busy practitioner to cure a patient of a rasping winter cough. Let us not be critical of the homeopathic dosage of the drugs in his prescription nor of the fact that the cough was already resolving with the onset of the spring. The careworn batchelor with a host of functional aches and pains must perforce be flattered with the daily ministrations of the charming physiotherapist, so necessary for his recovery. The unsuccessful surgeon who achieves a startling cure of a case of intestinal colic by removing a normal appendix can rest upon his laurels with the satisfaction of a victor. Who would be so unkind as to show him the pathologist's report? We must not be scornful of our colleague on the District who regales us at the tea-table with the account of his latest delivery. Let us lend him our attentive ears and forget that mothers have a habit of delivering themselves. The businessman who wakes one morning with a mild coryza and a pronounced aversion to the thought of having to catch the early train is told by his family that he looks ill and must spend the day at home. Naturally his protests are drowned by feminine persuasion. How pleasant is the breakfast in bed and is the bustling of attendants with hot lemon drinks (flavoured of course with whisky). There may well be a pile of letters at the office but let us not disturb it as it lies buried so neatly, for the time being, in the depths of his unconscious.

"We deceive ourselves," say the psychologists, like the small child in Hans Andersen's story. Perhaps they are right. Perhaps, on the other hand, a little self-deception is the spice of life.

"Don't let my qualifying first come between us."

INITIAL DISASTER

(A Protest Against Hyperabbreviationism)

LOA APH Th J
EUA No PP All OK
ARM NBG
CSF RIP
PM by Profess. B O I Say

R. V. F.

CORRESPONDENCE

To the Editor,

St. Bartholomew's Hospital Journal.

Dear Sir,

Your last issue was very interesting. May I add to the humour of your pages, quotations from my own experience.

With regard to your criticisms upon Lecturers, I recall when I was reading Law at Oxford, there was one lecturer, who afterwards became a famous judge, of whom it was said he spent the first half-hour of his lecture in giving a résumé of what he had said in his lecture of the previous week, and the second half he spent on a résumé of what he proposed to lecture on the following week.

With regard to the quaint notices of an abberrent Sister, I remember well when I was Colonel commanding a Field Ambulance at Norwich, and S.M.O. of the area, inspecting the cookhouse, and noting that one of the orderlies was spitting, I called the sergeant-major and instructed him that upon no consideration were orderlies allowed to spit anywhere near the cookhouse. Paying an unexpected visit a few days afterwards, I found the notice displayed: "Orderlies are forbidden to spit in the soup—by order of the S.M.O."

With greetings,

JOSIAH OLDFIELD.

8, Harley Street,
London, W.1.

THEN AND NOW

By VICTOR BONNEY

I CAME as a student to St. Bartholomew's Hospital in 1890. My father, a Middlesex man, was practising in Chelsea and to Middlesex Hospital it was determined I should go, but having passed the London Matriculation it was necessary to pass what was then called the Preliminary Scientific Examination and only a few of the Medical Schools at that time taught Biology, Physics and Chemistry. Bart.'s was one of them and so there I went, being then aged 17 years.

The lecturer on Biology was Dr. Tommy Shore, who taught many generations of Bart.'s students. He was a stoutly built man with reddish hair and exceptionally skilful at drawing on the blackboard with coloured chalks. We dissected amphioxus, earth worms, dogfish and frogs and various vegetable types just as you in your turn, I imagine, have dissected them. Shaw was a fine teacher. The lecturer on Physics and Chemistry was Dr. Womack—a thin, tired looking man, my recollection is. The Biological and Chemical laboratories were then situated to the right of the Hospital as you entered the main gate and were part of the Medical School buildings. There were about 30 of us in the class, the names of whom I have mostly forgotten, but two stand out prominently in my mind; Thomas Jeeves Horder and Preston Maxwell. Horder became the most distinguished physician Bart.'s has turned out in my time, and my recollection of him is that physically and mentally he was exactly the same as he is now—a small man brimming over with energy and a tremendous worker. Preston Maxwell, together with his younger brother James were destined for the Missionary Service and both of them habitually wore the uniform of the Salvation Army, which took a great deal of courage in those days when medical students were a rowdier lot than they are at present, at least, so I am informed. Both brothers went to China where Preston became head of the Rockefeller Institute at Pekin.

The lot of a young man in London in those days was very different from what it is now. To begin with, until the Aerated Bread Company began to open its shops in the late eighties, it was impossible to get a cup of tea anywhere except at few swagger pastry-cooks and thirst had to be quenched at the nearest public house. Moreover, the custom of the time frowned on a young lady going out with a young man to a dance or dinner or any other form of amusement unless accompanied by a chaperone and the result was that the unfortunate fellows who desired female society had to consort with an undesirable class of person. There was no lack of these anywhere and Piccadilly and Lower Regent Street were crowded with them at night and remained so until, in the late nineties, public opinion compelled the police to take action against what was a crying scandal. A young fellow wishful to spend a jolly evening and not possessed of much money was driven to pass his time at a Music Hall and afterwards at a pub or pubs, from the last of which he too often reeled home to his lodgings, always liable to be intercepted by one of the herd of charmers who were always on the look-out for such a victim. No wonder that venereal disease then was vastly commoner than it is now and the seeds of future misery and ill-health were often laid in this way.

But I am digressing. Horder and Preston Maxwell put up a record when they sat for the final M.B. Examination in 1898. At that time the degree was a fully qualifying one, surgery being included in the examination. The B.S., which required a separate examination, was merely taken as a stepping stone to the M.S. The M.B. was divided into four sections: Medicine, Forensic Medicine, Surgery and Midwifery, and two gold medals were awarded to the candidates in each section who stood first and second in order of merit. Horder and Preston between them mopped up the whole lot—a feat never achieved before or since!

The Honorary Staff at St. Bartholomew's Hospital in 1890 was a very exalted one, numbering among its members four baronets and three knights. Of the physicians I recall especially Sir William Church, a heavily-built, white-bearded man and Sir Dyce Duckworth, also bearded, but smarter looking. Sir Lauder Brunton was a well known physician who did a large and fashionable practice and was the author of

a text-book. He was that very rare thing at Bart.'s in those days namely, an importation, for he came, I think, from Scotland. Then there were Gee, a very learned physician, West, Hemsley, Norman Moore, and Herringham, the last two of whom were subsequently knighted.

At the head of the surgical side and towering above all the rest was the famous Sir James Paget. He was a consulting surgeon. You will remember that as a Bart.'s student in the eighteen-thirties he noticed in the muscles of a subject he was dissecting a number of little white grains which he examined under a microscope and found in each of them a tiny coiled-up worm. He made drawings and submitted them and some portions of muscle to the celebrated paleontologist, Sir Richard Owen, Curator of the Hunterian Museum at the College of Surgeons. Owen recognised a nematode worm and gave it the name of Trichina Spiralis. But it was James Paget who, as a student, discovered the disease called Trichiniasis. Though commoner on the Continent, it is rare in this country, but during the late war there was an outbreak due to some people eating pork sausages uncooked.

It was just about this time that the new science of Cellular Pathology was being developed by Virchow, Koelicker, Cohnheim and other German pathologists. Previously diseased tissues had been examined *en masse* by the morbid anatomist, but now the cell, as the tissue unit, began to be studied under the microscope and the foundations of Histological Pathology laid. Paget, avid for advance, allied this new knowledge to surgery. He became President of the Royal College of Surgeons of England, and surgeon to Queen Victoria, and was created a baronet. Two diseases, which he discovered, are known by his name; the pre-carcinomatous eczema which sometimes afflicts a woman's nipple, and the cruel disease of bone which leaves its victim crumpled up and helpless. My stay at Bart.'s brought me the good fortune of seeing him. There was a meeting in the Great Hall to discuss a memorial to Dr. Matthews Duncan, late physician accoucheur to the Hospital and Sir James, who was sitting immediately behind me got up and spoke. I well remember his thin, keen, intellectual face and the delightful manner of his speaking. This was one of his many gifts—" silver-tongued Paget " he used to be called.

Of the surgeons on the active staff I recall Sir William Savory with his handsome, clean-shaven face and wavy grey hair, and Sir Tom Smith, thin and bearded. Savory was one of the last to contest the Listerian doctrine. He was too old to understand it or to perceive its implications. Tom Smith was best known for his pioneer work on cleft-palate and hare-lip. He was much beloved. Then there was Alfred Willett, very tall and bearded, and John Langton, clean shaven and wearing an open collar such as one associates with Mr. Pecksniff; and besides these there were Howard Marsh, Henry Butlin, Bruce Clark and Walsham. The first became Master of Downing College and the second President of the Royal College of Surgeons of England. Walsham (a small man, also bearded) was the author of a popular students' text-book of surgery. By the way, the bearded surgeon has become extinct. The coming of masks finally killed him. I remember beards which would have needed a bag to hold them.

Lastly on the surgical side I remember Harrison Cripps, Anthony Bowlby and Charles Lockwood, and I must say something about each of them. At the time I am speaking of and for many years after the obstetricians attached to the Hospital were not allowed to open the peritoneal cavity—at least, not from above—and a general surgeon was detailed off to do this for them. Harrison Cripps had the job and in addition was on the Staff of St. Mark's Hospital for Diseases of the Rectum, so that he professed two specialities, a very lucrative thing to be able to do. The wealth he acquired, however, was not entirely due to this, for he and his younger brother (later Lord Parmoor and the father of our present Chancellor of the Exchequer) had a large interest in the Company which supplied Marylebone with electric light. The Marylebone Municipality wished to take over the lighting of their own Borough and pledged themselves to buy out the Company for a sum to be decided by arbitration. To their dismay it was valued, I think, at 2½ millions, and though the Municipality disputed it at law, even to the House of Lords, they had to pay up, which was why, when I first lived in Marylebone, the price of electricity per unit was higher there than anywhere else.

Anthony Bowlby did great work in the army. He went out to South Africa in the Boer War and in the 1914-18 War was the Chief Consulting Surgeon to the British Army in France. To him is chiefly due the credit of converting the Casualty Clearing Stations, which merely gave first-aid to the more seriously wounded, into completely equipped front-line Hospitals where all injuries, no matter how grave, could be efficiently dealt with without loss of time. An immense saving of life and still more of suffering was gained thereby.

During that war I was in charge of a first line Military Hospital on the East Coast and the soldiers first sent to us all came from the Mons retreat. I would remind you that at that time the channel ports were unusable, owing to their close proximity to the Germans, and the wounded had to be sent right across France to St. Nazaire, then by ship to Southampton, and then by train to their final destination. Most of our early patients had not had their dressings changed for many days and their wounds were in a condition of deplorable suppuration. My bedroom was next to one of the wards and I used to be kept awake by the moans and cries of the patients. I remember one case in particular, a fine young Scotsman with a leg swollen to the size of two bolsters, who shrieked in agony at every movement of the stretcher. We anæsthetised him and took him to the X-ray room, where the screen showed an unfractured femur. We moved him to the operating theatre and there I explored the great wound at the back of his thigh. I felt a number of jagged spikes like a very badly splintered bone and was puzzled until I withdrew a piece of wood nine inches long and nearly four inches broad. The bark was adhering to one side of it, and each end was a mass of jagged splinters where it had been torn off from the tree, and this had been up against his sciatic nerve for ten days! He had been lying in a wood which was being shelled when he was wounded. Had front-line Hospitals then existed the dreadful torture he underwent would have been avoided.

As they came into being in the course of the war a progressive improvement in the state of our patients was manifest and towards the end of it most of them arrived with neatly stitched up and already healing wounds and all this the soldiers owed to the work of Sir Anthony Bowlby. He became the President of the Royal College of Surgeons of England and was created a Baronet besides receiving, as he richly deserved, a number of other distinctions. I had the honour in 1926, for a short time to be a colleague of his on the Council of the Royal College of Surgeons.

Charles Lockwood, as I remember him, was a very good-looking man, always smartly dressed. He possessed scathing powers of speech and tales of how he used it are still, I expect, current amongst you. He was interested in bacteriology at a time when that important subject was not at all widely known, and indeed, the first lectures on it at Bart.'s were delivered in 1891, '92 and '93 by him and the physiologist Dr. Vincent Harris. He set himself to improve the antiseptic ritual of the operating theatre, and before operating had cultures taken of his own hands and his assistants, so as to be able to compare them with any that might subsequently develop in the wound. Gloves were not used in those days.

Some 15 years later, when I was on the Honorary Staff of Chelsea Hospital for Women I went to see him operate and observe his technique. He was most kind and courteous and took me round his wards after he had finished operating. What struck me there was the temperature charts of his patients; almost all of them monotonously flat, whereas at Chelsea I was accustomed to a rise to 100° or 100.5° F. immediately after the operation, gradually falling to normal in the next few days.

Lockwood operated deliberately and slowly, whereas I was accustomed to fireworks and I asked myself if Lockwood could achieve such flat charts why could not I? I decided that the post-operative fever was probably due to a slight post-operative oozing, a happening extremely likely when a surgeon operates with one eye on the clock. I therefore began to amend my technique with a view to obtaining more perfect hæmostasis. I shall always feel grateful to Charles Lockwood. It was the height of irony when, as the result of a finger pricked during an operation for acute appendicitis, he died of sepsis, the very disease he had tried so hard to prevent.

There were others working on the surgical side in 1890; Sir Holbart Waring,

Sir D'Arcy Power, and Sir James Berry, as they later became, and Mr. McAdam Eccles, with whom in subsequent years I was associated on the Council of the College of Surgeons, but I cannot recall them in these days.

As regards the obstetricians or physicians-accoucheur as they were called, Drs. Francis Champneys and Clement Godson, I did not as a student come in touch with them. Champneys later played a great part in the passing of the Midwives Act which revolutionised the position of midwives and maternity nurses. The great Matthews Duncan, the outstanding obstetrician of his time, had died the year before I came to Bart.'s. He, like Lauder Brunton, was an importation from Scotland.

I must say something about the Bart.'s nursing staff, for at that time and for many years afterwards, St. Bartholomew's as a training school for nurses stood easily ahead of all the other schools, thanks largely to the fine character of the Matron, Miss Isla Stewart. All the nurses then were of gentle birth and many had taken up nursing, not primarily as a means of livelihood, but as a call: and of such women are the finest nurses made. Some of them had means of their own and there was one sister whose carriage used to call for her when she had a half-day off! The work was hard, the hours long and the housing very inferior to the conditions of today. Some of the nurses were accommodated in a building which ran along Little Britain and which was commonly called "the horse boxes." But there was no grumbling and the phrase "the *pore* nurses" was never heard. The word *pore* is a peculiarly humiliating one, for it connotes a cadging for sympathy utterly offensive to self-respect and pride, and that you hear it so often today is a sad commentary on the times. Many of the nurses were very attractive so it is not surprising that marriages between them and Bart.'s men were common. Judging from the instances I know of, such unions were invariably happy ones. I speak with special knowledge and a grateful heart. How these matters stand at the present day I do not know—but I expect that they are not greatly different.

As a very young and temporary student I saw nothing of the life of the hospital proper or of that of the Medical School. I travelled from and back to Chelsea by the river, on which there ran a regular service of steamboats, a very pleasant means of transport. My alternatives were the old two-horse bus or the stuffy Underground Railway, or my flat feet. Though there was a restaurant in the School only relative plutocrats could lunch there and most of us went to an A.B.C. shop looking out on Smithfield and situated where the Pathological Block now stands. For fivepence you coud get there a cup of tea or coffee, a roll and butter and a slice of cake, and it was extensively patronised by the more indigent students, of whom I was one, for my pocket money was only 5s. a week and even then I was a heavy smoker. A favourite amusement was throwing lumps of sugar (think of it in these days!) from the windows of the upper room in which we fed at the drivers of passing vans and I remember one infuriated vanman raising Cain after someone had hit him fair and square on the cheek.

If the day was fine we would adjourn to the old fountain and watch the Honorary Staff arriving in their carriages and pair. You must not think we were on intimate, or even on bowing terms with these great figures. There was an abyss, seemingly impassable, between them and us across which we looked with a veneration, verging on idolatry. There was a class consciousness, too, between the men of the different years, while between the students and the house physicians and house surgeons there was a great gap. In these equalitarian days when Jack is encouraged to consider himself better than his master, much of this seems to have gone by the board. No doubt the old attitude fostered a pomposity in the seniors which made them undesirably unapproachable and sometimes ridiculous, but on the other hand it is good for all of us to have something to look up to, something to pin ambition to, even if the idol worshipped is a lesser thing than we take it to be. An ideal should have a pedestal.

I made only two friends while I was at Bart.'s: Frank Nimmo, who went into the Naval Medical Service, and retired a rear-admiral, and Thomas Chave, who practised for many years in one of the southern counties. And so in the autumn of 1891 I left and went to Middlesex, but I had been long enough at Bart.'s to have become imbued with that reverence and affection

which the fine old place inspires in all who work within its walls, and I felt keenly humiliated to leave it for a Hospital so very much smaller and lacking its tremendous traditions. Looking back, however, I realise that the change was a fortunate one for me, since it led to me coming under the influence of a most remarkable man—John Bland Sutton—to whose inspiration is owing whatsoever I have succeeded in doing.

I must confess that I was a lazy and foolish student when at Bart.'s, and indeed for some years afterwards. Unfortunately I had a very good memory and could learn very quickly—what the actors call "a quick study." This gift, when conjoined with an immature mind, is a fatal one, for it promotes laziness and gives the ass something to be conceited about. The age at which individuals pass from adolescence into manhood is variable. I have known lads of 16 who for balanced outlook and resolute purpose were already fully grown men, and others who retained their larval form till well into the twenties. I was one of these latter.

I was born in the midst of general practice and many of my earliest recollections are connected with it. The period between 1885 and 1895 is a most interesting one, for during it the discoveries of the great pioneers of the previous fifty years were beginning to bear fruit, so that it forms the link between antiquity and modernity in Medicine. Just think that when I came to Bart.'s in 1890, the tubercle bacillus had only been discovered 7 years, and the discovery of the bacillus of typhoid fever (Eberth's bacillus it was called) was still more recent. The pyogenic cocci had been recognised a few years longer, but the part they played in disease was still very imperfectly known. Bacteriology was just starting to develop and bacteriologists were few and far between. Middlesex Hospital did not possess one till 1897. Tropical medicine as we know it today simply did not exist and the text-books contained various learned speculations as to why fever recurred every third day in Tertian ague and every fourth day in Quartan ague, and the reasons for the seasonal incidence of typhoid fever and its relation to the water table. I remember the sensation caused by Patrick Manson's classical paper on Filarial disease, in which the baleful activities of the mosquito were first exposed.

The drugs at the service of the physician remained much as they had been for the past 100 years; mostly of vegetable origin with a few inorganic compounds thrown in. I used to help in my father's surgery long before I came to the Hospital and even today the rows of labelled bottles in a dispensary have a fascination for me. Synthetic drugs were practically unknown; I think salicylic acid was the first of them and I remember very well the appearance of antipyrin during the great influenza epidemic of 1891. Of drugs having a definite specific effect there were only a few; mercury and iodide of potassium for syphilis, colchicum for gout and digitalis for valvular disease are all I can recall.

As aids to diagnosis the physician had only his thermometer, his stethoscope, palpation and percussion, and a few simple urinary tests, so he had to rely mainly on his own experience and (if he possessed the faculty) his own intuition. This latter gift, a sort of additional sense, was only met with in a few exceptional men. I judge your Dr. Gee to have been one of them, as certainly was that grand old Middlesex physician, Dr. William Cayley. In short, medicine in the days of my youth was not greatly different from what it had been at the beginning of the nineteenth century, though the grossest errors of its then practice had been eliminated.

Turning to surgery the Listerian doctrine had been accepted, but its application left much to be desired. When I went to Chelsea Hospital for Women as Resident Surgical Officer in 1898, a surgeon, about to operate, took off his coat, put on a mackintosh apron, turned up his sleeves, and having washed his hands in a basin of water immersed them in a strong antiseptic solution in a futile attempt to render them sterile. Gloves were not universally adopted till ten years later, though I began to use them in 1902. There was no steam sterilising and the wraps covering the patient and the swabs were wrung out of a mercurial solution. The theatre was a well-lighted room and the only apparatus in it besides the operating table was an instrument steriliser heated by two spirit lamps. At Bart.'s in 1890, as far as I can remember, there were only two operating theatres, one in Abernethy block, and another attached

to the gynæcological ward, which I never saw.

The twenty years between 1870 and 1890 had witnessed in surgery great pioneering efforts; the work of Spencer Wells and Lawson Tate, the removal of a stone from the kidney by Henry Morris, and the removal of a cerebral tumour by Rickman Godlee, and of a spinal tumour by Victor Horsley, while towards the close of the period Treves was developing the surgery of the appendix, Mayo Robson that of the gall bladder and stomach, and MacEwen that of the bones and mastoid sinuses. But all these were exceptional men, whose leads were only just beginning to be followed. The surgeon had no X-rays to help him, the cystoscope and all the other "scopes" had not been invented, and the surgery of the prostate, the lungs, the heart and the great blood vessels, and all plastic surgery, lay years ahead in the misty cone of the future.

I have elsewhere described surgery as "an Art waited on by Science," for the essence of Art is individuality, and the manual feat of operating, like any other feat of craftsmanship, is essentially individual. But with Medicine it is different. So long as the individual qualities of the physician remained the chief factor in its practice it too was an Art, but Science, at first brought in as a servant and humble helper, has changed all that. I had the curiosity to ask a physician friend of mine to scribble down such of the aids now enjoyed by a physician, as he could momently remember. The list, which he admitted was far from exhaustive, numbered 50 items and I think near 100 as a full estimate would not be wide of the mark. And so today, thanks to chemical, biochemical, physical, electrical and sub-atomic research, accurate diagnosis and accurate treatment is commonly founded on a dossier of scientific reports. I think, therefore, that while we should still call Surgery an Art, we ought to speak of the Science of Medicine. And lest it should be deemed presumptuous for a mere surgeon to discuss the affairs of the physician, I must in defence tell you that the subtle problems of medicine early attracted me and I originally intended to become a physician. It was a mere chance which threw me into surgery.

In the past 60 years the stream of discovery, at first a relative trickle, has become a roaring torrent which every year increases in magnitude and force. I recall some words of the late Sir Buxton Brown, then 97 years old. He was speaking at a big luncheon party and looking round the room said: "I see many young faces around me" (I suppose to him we all seemed young) "and some of you may live to write 2000 at the top of your notepaper. I envy you! What wonderful things you will have seen." The grand old man! What a splendid message to those who carry on the fight, as you men are destined to do. Two lines from an old Masonic song spring to my mind:

"Antiquity's pride we have on our side
It maketh men just in their station."

Well, antiquity surrounds you here and as for the word "just," it means in this connection that reverence for the traditions of your historic Alma Mater and for the great men of the past who made her what she is; which keeps a fellow aiming high and scornful of mean things and mean ways.

I am grateful to you for inviting me, an erstwhile very undistinguished Bart.'s student, to address the Abernethian Society, whose very name is a romance. May it and you continually flourish. Don't wince at the idea of growing old; it is, I assure you, quite good fun and there is a certain excitement about it, like climbing higher and higher on a mountain. You will find that health plays a much greater part in it than the mere number of years. A sick man is an old man whatever his age. As the spool of Time turns and turns, picture succeeds picture on the screen, but in all of them, down to the last, you can discover things which stir the imagination and call out for action; in short, slightly altering the words of another famous song:

"Fights for the fearless and Goals for
the eager
Forty and Fifty and Sixty years on."

An Address to the Abernethian Society on June 22nd, 1950.

ROYAL COLLEGE OF SURGEONS

Mr. Frankis T. Evans has been appointed Vice-Dean of the Faculty of Anæsthetics.

THE LIFE AND WORKS OF SIR D'ARCY POWER

The Subject of the Wix Prize Essay for 1950

II. THE WORKS OF SIR D'ARCY POWER

By M. B. McKERROW

IT must indeed be a rare occurrence in the history of surgery for a single lifetime to encompass such a revolution in knowledge and practice as that which took place during the 85 years of the life of Sir D'Arcy Power. His childhood saw the year 1864 which he later described as the "annus mirabilis of modern surgery," a year in which the work of Pasteur was finding expression in the surgical advances of Lemaire, Spencer Wells and Lister. In his own childhood, too, anæsthesia had overcome the prejudice that had attended its inception and was greatly broadening the bounds of surgery. His early years witnessed, in the work of Billroth, Trendelenburg, Treves and many others, the great improvements in operative technique for which the practice of asepsis had laid the foundation. He saw the advance in diagnosis brought about by the discovery of X-Rays, and in his closing years he saw the beginning of the revolution in medical and surgical treatment resulting from the use of chemotherapy. This extraordinary progress provides the background against which the work of Sir D'Arcy Power must be viewed. The activity of his era is reflected in Power's own writings; for up to 1930 his publications numbered over 600, and in this article it is impossible to do more than to indicate the broad trends of his work.

In 1882 Power qualified, and the 16 years that elapsed before his appointment as Assistant Surgeon at this Hospital in 1898 were years of hard work and the slow garnering of experience. In their passage we see Power's attention gradually turning from an early interest in pathology to surgery, the basic study giving way to the applied.

In his writings on pathology two main streams—malignant disease and orthopædics—soon became discernible. His interest in the former, which may perhaps have been stimulated by his early association with Sir William Savory, remained one of his principal interests for 40 years. His earliest published papers on the subject were a few written while he was curator of the Hospital Museum on the descriptive pathology of sarcomata; but of greater significance were several articles, published in the last decade of the century, which gave the results of his own experiments on the causation of cancer. In this work he was one of the forerunners of the intense research on the artificial production of cancer which was conducted in the early years of the present century. The first of these articles, published in 1893 under the title *Some Effects of Chronic Irritation upon Living Tissues, being First Steps in a Rational Study of Cancer*, described his experimental introduction of cancerous tissue into the epithelium of rabbits already subject to chronic irritation. In this and subsequent papers he described the changes produced in the tissues and the appearance of certain large cells which he, in accordance with the accepted view of the time, called "cancer bodies." These "cancer bodies" were believed to be an integral part of the causation of the disease, but Power's later writings show a growing doubt whether they were anything but undifferentiated cells in the cancerous growth, and he finally repudiates altogether their function as causative agents. But Power's search for the cause of cancer was not confined to the pathological laboratory, and as early as 1894 he began to consider the possible effects of environment on cancer and he published his findings in *Cancer Houses and their Victims* (1894) and other papers.

In orthopædics the passing years again show a trend from the purely pathological to the surgical standpoint. His first orthopædic paper was *An Account of Four Cases of Intramuscular Synovial Cysts associated with Joint Disease*, published in 1885. Two years later he read before the Pathological Society an interesting paper on Colles' fracture. In this he correlates the results of a painstaking examination of museum specimens in the London hospitals with details of actual cases treated while he was a House-Surgeon and he points out how frequently the fracture may be a comminuted one by its extension into the joint.

In the field of clinical surgery Power's

writings during these years reflect the experience he gained as Surgeon to the Victoria Hospital for Children. In 1895 he published *Surgical Diseases of Children and their Treatment by Modern Methods*. This book is a treatise on those aspects of children's surgery which differ from that of the adult, and it appeared in an era when the text-book on a surgical specialty was still comparatively rare. When, in 1896, Power was appointed Hunterian Professor of Surgery and Pathology at the Royal College of Surgeons, he chose as his subject the *Anatomy, Pathology and Surgery of Intussusception*, and his lectures represent the result of careful study. To us the most interesting part of the work is contained in the last chapter which deals with treatment. The accepted treatment was the irrigation of the bowel with hot saline under a low pressure. Laparotomy, which Power here advocates for certain cases and which is now the usual treatment for nearly all, was then generally considered too dangerous. Power deals also with the problems of enterotomy and enterostomy and gives us his opinions, again of interest in view of later trends; he deprecates the use of mechanical aids such as bobbins and buttons, and writes, "for the present Murphy's button seems to have the advantage, though I think it is but a temporary one." And temporary it has proved.

During these 16 years Power had gained a valuable groundwork for a surgical career, and on the resignation of Sir Thomas Smith in April 1898 he was elected to an Assistant Surgeonship. In the four years during which he held this appointment his interests came to be centred in abdominal surgery, and the *St. Bartholomew's Hospital Reports* for these years contain several of his articles on this subject.

In 1904 he succeeded Mr. John Langton as a full Surgeon, and his years of tenure of the appointment until his resignation in 1920 marked the zenith of his surgical career. His main interest continued to be abdominal surgery. He early became concerned in the treatment of peptic ulcers and in the operation of gastro-jejunostomy, then a newly found surgical treatment for duodenal ulcer. The operation had not been long enough in use for the high proportion of recurrences to reveal itself, and so the number of "complete cures" claimed in his papers seems remarkably high. His interest in cancer, which in his earlier years had been in the pathological and research aspects, now came to be centred in cancer as a surgical problem, especially in its diagnosis and treatment in the intestinal tract.

Although abdominal surgery became his chief concern, Power's interests remained wide and he explored many by-ways of surgery. Thus we find arterial surgery claiming his attention, and no account of his work in this period could omit mention of his study of syphilis. To us in the present day such a study seems remote from general surgery, but 40 years ago, when the later stages of the disease were more often encountered than now, syphilis took an important place in surgical diagnosis, and some of its manifestations were not beyond the scope of surgical treatment. His principal work on the subject was his edition, in collaboration with J. Keogh Murphy, of *A System of Syphilis*. These six volumes, written by many authors, are a vast compendium of knowledge on all aspects of the subject; the very size of the work precluded a wide circulation, and perhaps its chief claim on posterity lies in its comprehensiveness.

The Great War provided Power with close personal experience of surgery in military hospitals, and this experience found expression in several published works. He wrote principally on two problems which become of transcendent importance in war, the treatment of wounds and venereal disease. He deals with the former of these problems in his *Wounds in War*, one of the series of Oxford War Primers of which he became general editor in 1915. It is a book on practical surgery under war conditions, which make standardisation of method essential and at the same time render ineffectual many of the accepted means of treatment. For, as Power wrote, "It [the War] has thrown us back to the time before Lister, when most wounds suppurated. It has taught us that a part of our boasted advance was useless, for the wounds to be treated were already deeply infected before there was any possibility of treating them." Another work of this period, which received wide circulation, was a treatise on venereal disease entitled *Against his own Body*. It was based on a clinical lecture given at this Hospital.

When, in 1919, the pressure of Power's military work was decreasing he was appointed Bradshaw Lecturer at the Royal

College of Surgeons, and he chose as his subject *Cancer of the Tongue*. His method of attack on this problem is of interest, for it is at once scientific and historical, and shows how, by a broad approach to such a subject, use may be made of data denied to the purely scientific observer. He correlated the increased incidence of the disease in the 16th century with the increased consumption of tobacco and spirits and with the wider prevalence of syphilis during this period. His conclusions, in which he was supported by records of cases in this Hospital, comprised a predisposing and an exciting cause for the rapid increase. He found a predisposing cause in the degenerative change taking place as a result of spirochætal infection, often accentuated by alchohol, and an exciting cause in local irritation, usually from tobacco smoking but occasionally from carious teeth. In the same year there appeared the three volumes of the *Practitioner's Surgery* under the editorship of Power. The plan of this work is similar to that of *A System of Syphilis* in that it is written by many authors and provides a comprehensive, if unwieldy account of its subject.

In 1920 Power reached the age of 65 and resigned his Surgeonship at this Hospital. His interest in surgery remained paramount in his life, but from this time onward he drew from the experience he had gained and no longer advanced into unknown country. Few surgical papers came from his pen in his later years, and of those few the greater part were on general principles rather than in a specialty.

Such, in bare outline, were the activities of the surgeon; we must however turn also to the historian and scholar to gain a balanced picture of Power's work as a whole and to discover the source of the great influence he bore over his contemporaries and how he himself was influenced by the past.

"I could always write," he once remarked, and the truth of these words is evident in the ease of style and clarity of his surgical works; but in his historical writings there is revealed another gift, of value equally to the medical man and to the historian, that of human understanding. For the basis of history is human personality, and so we find that Power's approach to history is usually through biography. No one was more deft than he in bringing before us a picture of a bygone age, but in that picture there is always a central figure who is drawn true to life. Necessary as these innate gifts are to the historian, they must be supplemented by a sound general and detailed knowledge of his subjects. It is not sufficient merely to be aware of the events in their lives, for, Power writes, "It is not possible to describe them satisfactorily unless we know the circumstances under which they lived, something of their personality, the age at which they began to write, and their social surroundings." A study of Power's works makes it clear that the source of his interest in history was not mere curiosity; for he fully realised that the work of those he depicted was of value not only in their own day, but to us who study it now, and that their work cannot be separated from their personal history. The aim of biography, he writes, is "to hand down to a future age the history of individual men or women; to transmit enduringly their character and exploits. Character and exploits are inseparable for the purposes of biography . . . and when combined constitute biographic personality. The whole art of biography is to satisfy the commemorative instinct by the exercise of its power to transmit personality."

The ability of a writer to transmit personality is nowhere more taxed than in the articles of a few hundred words which make up the *Dictionary of National Biography*. The "D.N.B." was an early training-ground for Power in the writing of biography. His first article, on Robert Liston, was written in 1893, and was the forerunner of over 200 contributions throughout his life. He wrote similar biographies for the *British Medical Journal*, *The Times* and for his edition of *Plarr's Lives of the Fellows of the Royal College of Surgeons*. This work was conceived during the 19th century by a librarian of the College, who did not live to publish it, and Power was appointed to revise and complete it with the assistance of W. G. Spencer and Professor G. E. Gask. It was published in 1930 in two volumes and is kept up to date by the issue of decennial supplements.

The art of writing short biographies such as those in the *Dictionary of National Biography* differs so widely from that of presenting a longer "life" that the two cannot be considered together. The ability to portray character and to maintain accuracy of detail are the only attributes common to both. In

the shorter article, brevity and a shrewd assessment of the essential are required. In the longer, the study of the individual forms a background for the age in which he lives; the biographer and historian become one. In the arrangement of biographical and historical material Power received early training in his edition, published in 1886, of John Flint South's *Memorials of the Craft of Surgery in England*. The author of this work had for a lifetime been collecting his material and had accumulated far more than he could arrange. It was from this accumulation that Power produced his edition. The book contains an interesting account of the evolution not so much of Surgery as of the Surgeon from the earliest days to the establishment of the Royal College of Surgeons in London in 1800.

Power's writings show a wide knowledge of medical history, but three figures stand out, of whom he made special study. They are John Arderne, William Harvey and John Hunter. One of his early long biographical works was his edition, which appeared in 1910, of John Arderne's *Treatises of Fistula in Ano, Hæmorrhoids and Clysters*, from an early 15th century manuscript. This he followed in 1922 with a translation of Arderne's *De Arte Phisicali et de Chirurgia*, and later by further shorter works.

By his work on William Harvey, Power placed himself in the forefront of Harvey's biographers. His first book, a biography published in the "Masters of Medicine" series in 1910, was at once accepted as authoritative. It is a work of sound scholarship and is of interest to the general medical reader, especially perhaps for the excellent presentation of the arguments put forward in *De Motu Cordis* to prove the circulation of the blood. This work was followed in 1913 by *Portraits of William Harvey*, a slender quarto volume produced at the suggestion of Sir William Osler and containing an assessment of Harvey's known portraits. From the publisher's viewpoint it was not a success, for the public of that day showed little interest in this type of work. The book showed its influence, however, in Power's later work, for he gave considerable thought to the place of portraiture in biography. He realised that neglect of portraiture is always followed by the acceptance of an idealised portrait often bearing little likeness to its subject, and he was careful not only to record the existence of known portraits of those whose biographies he wrote for *Plarr's Lives* but also to assess their accuracy. He followed this work with a number of short articles including an interesting paper entitled *Dr. William Harvey and St. Bartholomew's Hospital*, which was published in the Hospital Reports in 1924.

It was as biographer and historian that Power studied the lives of John Arderne and William Harvey, but it was as a surgeon, too, that he studied and became the disciple of John Hunter. The legacy of a master mind like Hunter's is two-fold. It includes the actual triumphs of a lifetime's work, but of value, too, is the story of their process of achievement. The former shed much of their glory when the next step is taken; the latter is immortal and remains an inspiration to posterity. But Power's own debt to Hunter included also a more direct legacy, for, as he once explained when giving an account of his surgical lineage, the mantle of Hunterian surgery had fallen on this Hospital, and only three generations of teachers separated himself from Hunter: "Sir William Savory, my revered master, learnt from Sir William Lawrence, and he from John Abernethy, who himself sat at the feet of John Hunter, and was ever afterwards his eulogist." Of the papers which Power wrote on John Hunter, the most important is the Hunterian Oration, which he delivered at the Royal College of Surgeons in 1925. He chose as his title "John Hunter: Martyr to Science," and put forward the view that the illness from which Hunter died was not angina pectoris, but was in fact the third stage of the syphilis with which he had injected himself experimentally 26 years before. This view has not gained general acceptance, though there is no doubt that to the end of his life Hunter was suffering from the effects of his experiment.

For over 60 years Sir D'Arcy Power was connected with this Hospital, and during that time the Hospital had much cause for gratitude to him. He gave freely of his surgical prowess, he gave his valuable advice to the Hospital, he shed on it a reflected glory by his counsels elsewhere, but not the least service he did to the Hospital was in unfolding to us its history. His first article on the subject appeared in the *St. Bartholomew's Hospital Journal* in 1897, and this was followed by many more during the succeeding 30 years, all showing his genius for infecting his readers with his own enthusiasm. But of these articles none is more worthy of permanent record than *Some Episodes in the History of the Hospital*, which appeared in the *Journal* in 1918. The article is the record of an address delivered before the Abernethian Society in December 1917. Its theme is expressed in its opening words, "Memory and the mind's eye sometimes play strange pranks with those who, like myself, have been long connected with this Hospital and who know something of the history of London." He tells how in imagination he sees re-enacted the great events—and also the legends—of the eight centuries of the Hospital's history. He recounts first the dream of the mother of Thomas à Becket, who saw her infant son swathed in fine linen which, when unwrapped, reached from Poultry to Smithfield, to a site where she foretold a hospital for the poor should arise. In his next vision Power sees Rahère and the first Hospitaller in the Prior's lodgings of the hospital he has founded. Later, in 1381, he sees the wounded Wat Tyler dragged within the Hospital gates, given aid, and later seized by the Mayer and Aldermen who "without more ado chopped off his head just in that space which still remains vacant between the porter's lodge and the Hospital chapel." There follow the jousts in Smithfield, and then the evil days of the 16th century which robbed the Hospital of its revenue and reduced its effective size to a mere two or three beds for the sick. He sees the Hospital restored and its reputation enhanced, as the years passed, by such names as William Harvey, Percivall Pott and James Paget. So his visions end and give way to his own recollections of his early days in the Hospital and of the growth of the Medical School during his lifetime. This lecture is not one of Power's major works, but it illustrates well his gift in historical writing.

The best known of Power's works on the history of the Hospital is undoubtedly his *Short History of St. Bartholomew's Hospital*, written for the eight hundredth anniversary of its foundation. This book was beautifully produced in the days when the physical make-up of a book was not dictated by the need for economy in paper. Power was responsible for two out of the three sections in which the first printing of the book was divided. The first section—the Past—finds the author at his best, delving among the records of the Hospital, treating his subject with care, almost with reverence, laying before his readers extracts from old documents, and with sure judgment selecting those aspects of ancient history and customs which appeal to the modern reader. The second—the Present—lacks perhaps the interest for the mid-20th century that it had for the reader of 1923. For the Present of 1923 has slipped into the Past of 1950, and detail of some events then fresh seems superfluous now. But this book, fast running out of print, deserves a fresh span of life in a new edition, as a fit memorial to its author.

Sir D'Arcy Power's interest in history was not confined to its medical aspects, and indeed without a wider interest his medical history might lack many of those qualities which make it pre-eminent. Power was a Londoner by birth. He spent most of his life there, and the history of London was a special study of his. It was this interest that, in 1903, prompted him to found the Samuel Pepys Club and to take an active part in its management for a quarter of a century. Members of the Club were the audience of an interesting address he gave in 1911 on *Why Samuel Pepys Discontinued His Diary*. In this paper the Surgeon gave himself a busman's holiday and let his knowledge of ophthalmology run loose among his historical interests. The result is an analysis of the course of Pepys' eye-trouble from its occasional mention in his Diary to the last poignant words, "And so I betake myself to that course which is almost as much as to see myself go into my grave; for which and for all the discomforts that will accompany my being blind, the good God prepare me!" Finally Power leaves the realm of factual reasoning and in a delightful excursion into conjuncture he prescribes:

"For Samuel Pepys, Esq.,
Spectacles
+ 2 D. c + 0.50 D. cyl. axis 90,"

the glasses with which the Diary might have been continued.

Power's later years were devoted largely to his literary work. In 1927 he published his last purely surgical paper, and in the same year an attack of pneumonia and pleurisy left him in impaired health and compelled him to curb his activities. The stream of his historical works in no way lessened, and the works he produced in the succeeding 10 years mark the culmination of a lifetime's study in medical history. In these years he contributed many articles to the *British Journal of Surgery*. In 1927 he began a series lasting for nearly three years under the general title

"Epoch-making Books in British Surgery," and between 1934 and 1937 he followed this series with another entitled "Ipsissima Verba." The pattern of these latter articles is uniform throughout the series; an introduction sets the scene for the reader and is followed by a long passage quoted from the "very own words" of the ancient author; but through them all there runs a thread of biography, weaving a continuous pattern in the whole series and marking all as the work of the one craftsman.

In addition to articles appearing in various journals, a number of Power's historical works of this period appeared in book form. In 1930 he gave a series of lectures at the Johns Hopkins University at Baltimore, which were published the following year with the title *Foundations of Medical History*. In these delightful lectures he tells us what a lifetime of experience had taught him of the art of history and biography, of bibliography and even, in "Dining with our Ancestors," of gastronomy. Two years later his excellent little *Short History of Surgery* was published, and this was followed in 1939 by *Mirror for Surgeons*, his last work in book form.

Closely allied to Power's historical and biographical interests is his study of bibliography. It is no rare thing for medical men to take an interest in "the systematic description and history of books, their authorship, printing, publication, editions, etc." For many, such a study provides relaxation from other duties, but for Power it was the natural complement of his close contact with the old medical books used in his historical researches. His enquiring mind wished to know not only the words of their authors, but something of the story of the books themselves and how they had been received in their day. His interest in the subject is wide, but he chose as his particular sphere the printed medical books which began their existence in the 16th century. The results of his study formed the basis of several addresses to the Bibliographical Society, including papers on *Three 16th Century English Books Connected with the London Hospitals* (1921) and *The Birth of Mankind or the Woman's Book* (1927). Power joined the Bibliographical Society in 1915 and in 1926 he was elected President for a year.

Yet, for all his activity, Power's closing years were lonely. When he could no longer share in the companionship of an active surgical life he spent much of his time in the Royal College of Surgeons where, in 1929, he was appointed Honorary Librarian. In the discharge of this office he rendered a great service to the College, for his knowledge of the treasures contained in the library was unsurpassed, and this knowledge formed the basis of many of his own writings.

When, in 1930, he reached the age of 75 Sir D'Arcy Power received honours which were a formal expression of a deep and universal respect shared by all who knew him. An issue of the *British Journal of Surgery* was dedicated to him, and a book of his *Selected Writings* was produced. The idea of this book was conceived by the Osler Club of which Power was a member, and the cost of its fulfilment was defrayed by a fund supported by many subscribers, some quite unconnected with medicine. No more graceful compliment could have been paid, and the book has done much to preserve in accessible form some of the author's finest works.

It is too early to attempt an assessment of Power's own place in history, but it is certain that he will be remembered longer as an historian and interpreter of Surgery than as a practising surgeon. This is in no way to deny his surgical skill, nor to minimise his service to Surgery, for, while few become great surgeons, fewer still can interpret and integrate not only their own work but also that of others. This latter was Power's greatest contribution. He was, moreover, the natural ambassador of a world of surgery rapidly becoming more specialised and withdrawn to the world of letters. The further Medicine advances in its technical fields, the wider becomes the gulf that separates it from the Arts, and the more indebted we are to those few men who, by the breadth of their intellect, can bridge this gulf.

If the precise place of Sir D'Arcy Power in Surgery as a whole cannot yet be determined, his place of respect and honour in this Hospital is assured. By his skill as a surgeon he upheld a tradition for sound surgery established by such men as Paget, Abernethy and Pott, and by his standing in the world of letters he proved himself a worthy figure in a line of surgeons of broad humanity who have for so many years brought distinction to the Hospital.

The authors of this and the article appearing last month wish to record their grateful appreciation of assistance given by relatives of the late Sir D'Arcy Power and others.

TEACHING OF OPTHALMOLOGY IN A GENERAL HOSPITAL

By H. B. STALLARD

THE training of the general practitioner has recently received marked attention in the medical, and indeed in the lay, press (*The Times*, May 26, 1950). We are constantly reminded by our medical administrators that St. Bartholomew's is not a hospital for the "sick poor," but its purpose is the teaching of undergraduate medical students, the majority of whom will serve as general practitioners. What should the student be taught about ophthalmology, nothing or something? In one famous London teaching hospital the instructional aim in ophthalmology goes no further than to make the student appreciate that "something is wrong," that there is a condition which does not comply with the normal physiological and anatomical state of the eye, a modest but desirable ambition. Probably this academic "ceiling" accounted for the cryptic notes I used to receive in the Army Ophthalmic Unit in Belgium from one of my trainees, brought up at this particular hospital. The note invariably ran: "To see O.C. Unit. Diagnosis—Deep-seated trouble." One has received in St. Bartholomew's Hospital the verbal "brief" for out-patient teaching: "Tell them something about conjunctivitis and blepharitis and send them away."

What are the responsibilities of a general practitioner in regard to ophthalmology? He is the front line of our profession and on his quick appreciation of the diagnosis and prompt action may depend a patient's sight, not only in one eye but in both. Examples of this are failure to recognise acute glaucoma, acute iritis, obstruction of the central retinal artery, and a penetrating wound with or without an intra-ocular foreign body. The majority of patients requiring ophthalmic attention in this country go first to opticians who have had no medical training. Many of these men are careful and realise that "something is wrong" refer the patient to a doctor, usually the general practitioner, for him to make the diagnosis and give treatment or to refer the patient to a consultant. In remote parts of this country, in the Colonies and Imperial outposts there is no one but the general practitioner to take what action he can to save an eye or eyes in acute glaucoma, injuries, severe intra-ocular inflammation and other emergencies.

The war revealed the defective absorption of special department teaching in our general hospitals. The general duty M.O. in the Services, and indeed the surgical specialist, wasted man-power, money and sometimes human eyes by decisions which were sometimes droll but often serious. The visual acuity standards were not appreciated. Many M.O.s seemed to have little knowledge or imagination as to what tasks a man could perform with certain visual acuity. Soldiers were evacuated from the front line during an action with drifting refractive errors. Sometimes artificial eyes were not recognised, and I remember five instances in which the prosthesis was accorded visual acuity varying from 6/36 to 6/6! Men with such gross ocular defects as anterior staphyloma, well-marked corneal nebulae, retinitis pigmentosa, optic atrophy and severe choroido-retinitis were not only recruited and trained after a fashion, but passed as fit to serve in a theatre of active military operations and in tropical climates. Their immediate return home after coming and going 30,000 miles was costly as well as futile.

In France and the Middle East surgical specialists in Casualty Clearing Stations held for a long time the erroneous idea that an eye with an intra-ocular foreign body must be excised, a failure to realise the advances of conservative ophthalmic surgery, and they excised eyes in a manner which showed clearly that they had never seen such an operation done nor read about it. The sockets were packed with ribbon gauze to which adhered much of the orbital fat and thus were ruined aesthetically. This failure to realise the possibilities of conservative eye surgery led to a tragic decision by a general surgeon during the evacuation of Dunkirk when a field medical card accompanying the soldier contained a note to the effect that "the second eye had also been excised to avoid sympathetic ophthalmitis." It seemed that time had stood still for twenty-six years and that there prevailed the opinion of the Consultant Surgeon in France in 1914 which was that Ophthalmic Surgeons were unnecessary for an Army in the field, for the only

operation to be done for a wounded eye was excision and the general surgeons were able to do this.

The catastrophes in civil practice are no less, chronic glaucoma is often missed until there is no perception of light in one eye and a much reduced field in the other; acute congestive glaucoma is treated with lotio. boric ac. or worse still by atropine until all hope of saving any sight is gone, and failure to recognise the significance of the vomiting and prostration accompanying this disorder has led to exploratory laparotomy for assumed intestinal obstruction.

An infant with glioma retinae, a highly malignant and very radio-sensitive growth is brought first either to the general practitioner or the Infant Welfare Centre, the mother remarking on the "cat's eye reflex." Every year such cases are missed, the delay jeopardising both the child's eyes and its life.

Failure to diagnose acute iritis may lead to blindness from occlusion of the pupil with exudate; and if there is a delay of one hour in the treatment of central retinal artery obstruction recovery of vision is improbable. Delay in the proper treatment of strabismus is the cause of loss of visual function in an anatomically healthy eye.

These are some of the more serious ocular disorders which may cause patients to seek first the advice of their general practitioner, and so it would seem proper to teach students about the recognition of these.

Ophthalmic medicine. We try to impress upon the student that ophthalmology is not a specialty limited to disease in one special sense organ, but that many ophthalmic disorders are associated with systemic disease, and that the eye through the transparency of its media affords a great opportunity of studying by means of the ophthalmoscope and the slit-lamp and binocular microscope living and active pathological processes of general medical significance. The retinal arterioles and venules are seen under 15 times magnification with an ophthalmoscope and the effects of pathological capillary leakage may be studied with the binocular microscope and slit-lamp, with which instrument the movements of red and white blood corpuscles and inflammatory cells may also be seen. Pathological changes in the arterioles and venules may suggest similar alterations in those of the kidney and the brain; and a water-hammer pulsation of the central retinal artery indicates a leaking aortic valve before any added sounds are heard at the base of the heart. The retinopathies associated with arteriolar sclerosis, renal disease and diabetes are readily diagnosed with the ophthalmoscope.

Ophthalmoscopic examination of the optic nerve head and retina may also afford important information concerning diseases of the central nervous system such as raised intracranial pressure, tabes dorsalis, disseminated sclerosis, Friedrich's ataxia and other diseases.

Inflammation of the uveal tract may be caused by and associated with systemic diseases due to focal sepsis, syphilis, tuberculosis, leprosy and disease of the reticulo-endothelial system, such as Boeck's sarcoidosis and uveo-parotitis.

The effects of vitamin deficiency may be seen in the conjunctiva, cornea, lens, retina and optic nerve. Virus diseases affect several ocular structures, certain poisons and drugs have characteristic and tissue-selective actions. The acute exanthemata, some tropical fevers, dysentery, and blood diseases have ocular complications. Skin diseases, particularly of the face and scalp, are complicated by blepharitis, conjunctivitis and keratitis and some are associated with pathological changes in the lens.

Skeletal abnormalities such as arachnodactyly are associated with ectopia lentis, hydrophthalmia and high myopia; oxycephaly with bilateral exophthalmos, optic atrophy and divergent strabismus; gigantism and acromegaly with visual field defects; fragilitas ossium with blue sclerotics. The presence of an artificial eye may be of considerable diagnostic significance in a case of spontaneous fracture, a mass in the abdomen or a cough. Abnormal posture of the head and facial asymmetry is seen in ocular torticollis due to congenital paresis of one of the elevators of the eye and overaction in its contra-lateral synergist and ipsolateral antagonist. Indeed, an abnormal head and face posture characterises paresis of any extra-ocular muscle in the patient's attempt to limit the field of diplopia.

Some disorders of the endocrine glands have associated changes in the eyes, visual pathways and orbit. Many syndromes characterised by lesions in ectodermal and mesodermal structures have associated ocular changes.

The above is only a brief sketch of the contact of ophthalmology with general medicine, neurology, endocrinology, dermatology, orthopaedic and ear, nose and throat disorders.

There is no need to teach students the technique of refraction. It is sufficient to make them realise the significance of headaches due to refractive errors and ocular muscle imbalance.

Ophthalmic surgery is so specialised, so highly technical, its precision and delicacy demand long and gradual training, and it is in many respects so unlike general surgical technique that it is obviously wasteful of students' time to watch major operations. It is, however, important that general practitioners should know what is done to their patients suffering from cataract, glaucoma, retinal detachment, squint, penetrating wounds and lacrimal duct obstruction so that they may be better able to appreciate points in the post-operative care of their patient and the need for skilled supervision.

For this purpose the preparation of coloured films enable students to see in a short time the essential steps in these operations and their purpose.

For general practitioners likely to practice in remote places where specialist help may be delayed for several days it is well for them to learn a few less difficult operations such as posterior sclerotomy as a temporary measure in acute congestive glaucoma when help is unavailable within 24 hours and the intra-ocular pressure is not reduced by miotics within safe limits; carbolization of a corneal ulcer, incision of a lacrimal sac abscess which is pointing; injection of alcohol around the ciliary ganglion to relieve pain in a hard blind eye; and evisceration for panophthalmitis.

It is essential for all doctors to learn how to remove aseptically, cleanly and with minimum trauma a superficial foreign body on the conjunctival and corneal epithelium and when to leave well alone any deeply placed foreign body. About 600 eyes with corneal foreign bodies are lost every year in this country through the rough and dirty attentions of enthusiastic amateurs who favour such weapons of surgical attack as well-sucked camel hair brushes and disused toothpicks. Too often the patients present themselves at last where they should have gone first to the eye department or eye hospital, their cornea well ploughed up and infected by a succession of hard triers from the "mate at the works," the first-aid man, a chemist, and even the O.P. casualty officer of a hospital where such necessities as a good ophthalmic lamp, a suitable table, a tranquil surround, proper instruments, absolute asepsis and a sure and gentle pair of hands are not available. A diffuse dense corneal scar and even panophthalmitis and subsequent evisceration are heavy prices to pay for a trifling initial injury.

Is it possible to impart these essentials of ophthalmic practice to undergraduate students in a general hospital? In a crowded curriculum 12 afternoon sessions shared with "fevers," football matches, festivals, funerals and holidays are allocated to ophthalmology. A very high average for a keen and industrious student is seven or eight attendances. The difficulties of providing suitable clinical material for teaching have been increased since the war, for the absence of adequate in-patient accommodation has necessitated the diversion of acute ocular disorders and injuries to the over-worked Moorfields and Westminster Eye Hospitals.

Every London teaching hospital except Bart.'s and one other has an ophthalmic ward in London from which it is possible to draw appropriate clinical material for teaching students. This defect means that good teaching cases go elsewhere, for it is soon realised by doctors and patients alike that adequate in-patient services are not available here.

We hope, now more faintly than we did five years ago (for promises have been broken), that in the course of some more years of patient waiting, and depending on the relative inertia of administrators and architectural renovators, a once famous and indeed the oldest special department in this hospital may have again an opportunity to work under reasonable conditions, to give our patients the service they had in better days, and in so doing to provide the right material (a little more than conjunctivitis and blepharitis) for teaching future general practitioners.

CHANGE OF ADDRESS

Dr. G. A. Harrison to Norton House, Fishbourne, Chichester, Sussex.

EXAMINATION RESULTS

UNIVERSITY OF OXFORD

2nd B.M. Examinations

Trinity Term, 1950

Medicine, Surgery and Midwifery

Cairns, J. D.
Dossetor, J. B.
Fowkes, A. S.
Gilks, J. M. L.
Godden, J. L.
Morris, G. C. R.
Raynor, M. J.
Riseley-Prichard, R. A.
Watkins, P. H.

UNIVERSITY OF CAMBRIDGE

Final M.B. Examination

Easter Term, 1950

Part I. Surgery, Midwifery and Gynæcology

Baker, A. M.
Bennett, J. F.
Brown, P. B.
Clarke-Williams, M. J.
Currie, J. C. M.
Holmes, R. P.
House, M. L.
Juckes, H. F.
Kendrew, M. E.
Lodwick, J.
Rowson, K. E. K.

Pat II. Principles and Practice of Physic, Pathology and Pharmacology

Brown, P. B.
Hodson, J. M.
Holmes, R. P.
Juckes, H. F.
Kendrew, M. E.
Lodwick, J.
Milligan, J. L.
Muir, B. J.
Steel, P. C.
Strong, J. D. E.

SOCIETY OF APOTHECARIES

Final Examination

June, 1950

Pathology	Medicine	Surgery	Midwifery
Gould, G. T.	Bexon, W. H.	Gould, G. T.	Gould, G. T.
		Mangan, M. K.	Wallace, J. R. C.

The following student, having completed the Final Examination, is granted the Diploma of the Society :—

Mangan, M. K.

UNIVERSITY OF LONDON

July, 1950

Examination for the Academic Postgraduate Diploma in Bacteriology

Andrews, B. E.
Le Bouvier, G. L.

CONJOINT BOARD

Final Examination

July, 1950

Pathology			
Blakeway, I.	Cookson, T. S.	House, M. L.	Wise, M.
Clulow, G. E.	Hindley-Smith, R. F.	Moyes, P. D.	
Medicine			
Blakeway, I.	Lewis, H. E.	Thomas, W. C. T.	Wiseman, D.
Kinsman, F. M.	Rowson, K. E. K.	Turner, W. J. A.	
Surgery			
Clarke-Williams, M. J.	Kinsman, F. M.	Smith, I. G.	Turner, W. J. A.
Currie, J. C. M.	Nielsen, J. S.	Thomas, W. C. T.	
Midwifery			
Apthorp, G. H.	Cookson, T. S.	McCloy, J. W.	Smith, D. P. Q.
Aubin, D. F. A.	Currie, J. C. M.	McKinna, C.	Taylor, J.
Bapty, A. A.	Dean, D. W. J.	Matthews, P. D.	Taylor, W. N. A.
Barnes, J.	Drysdale-Anderson, R. J.	Montagnon, J. L.	Thomas, G. E. M.
Birch, G.	Hodgson, D. C.	Parrish, J. A.	Trevan, A. C.
Bowers, K. E. J.	Ibbotson, R. N.	Phillips, G. D.	Turner, W. J. A.
Carroll, D. S.	John, A. H.	Scott, A. E. R.	Wallace, J. R. C.
Connell, P. H.	Lumley, P. W.	Sims, A. J.	Williams, D. K.

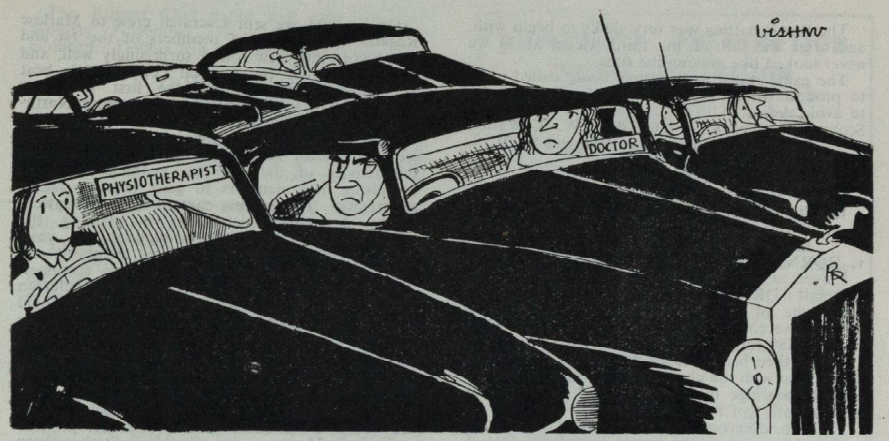
The following students have completed the examination for the Diplomas M.R.C.S., L.R.C.P. :

Kinsman, F. M.	McCloy, J. W.	Thomas, W. C. T.	Wiseman, D
Lewis, H. E.	Rowson, K. E. K.	Turner, W. J. A.	

First Examination

June, 1950

Anatomy			
Godwin, M. H. G.	Mears, M. E.	Walker, L.	Zilliacus, J. O.
Physiology			
Godwin, M. H. G.	Mears, M. E.		
Pharmacology			
Allan, R.	Goff, E. G.	Kenney, P. M.	Waddy, G. W.
Beale, I. R.	Gretton, A. H.	Lamplugh, A. N.	Watmough, G. C.
Butcher, R. H. G.	Harries, E. H. L.	Lockett, H. I.	Watts, M. G.
Cochrane, R. C.	Heckford, J.	Manuel, J.	
Courtenay, P. H. E.	Hick, B. D.	Middleton, G. W.	
Davies, P. E.	Johnson, R. J. R.	Norman, M. H.	



SPORT

CRICKET CLUB

v. BROMLEY C.C.

Played at Chislehurst on Sunday, July 2.

Result : LOST by 8 wickets.

With many of the Hospital's better players resting themselves on this occasion, Bromley showed themselves to be the superior team in every respect.

For once the Bart.'s batting didn't thrive on early disasters and the total of 127 on a perfect wicket was not likely to result in a close finish.

The Bromley batsmen had no difficulty in knocking off the runs with plenty of time to spare.

The eight bowlers who were tried met with equal success except for Clappen who took a wicket.

Scores : Bart.'s 127 (J. B. Ellingham 5-43).
Bromley 128-2 (J. Summers 74).

PAST v. PRESENT

Played at Chislehurst Sunday, July 9.

Result : Present WON by 39 runs.

A day of almost uninterrupted sunshine contributed towards this most enjoyable match.

The Present just won by taking the last wicket only ten minutes before stumps were due to be drawn.

PRESENT	
D. C. Hodgson c Schneerson b Heyland	64
P. B. Biddell c O'Connell b Heyland	16
J. D. W. Tomlinson run out	36
J. D. Cairns c Lucas b Schneerson	5
H. B. Ross b Heyland	10
J. P. Waterhouse not out	35
J. W. Mellows b Heyland	4
D. F. A. Aubin b Schneerson	5
P. G. Haigh b Schneerson	18
P. D. Moyes b Heyland	13
B. K. Arthur not out	5
Extras	7
Total for 9 wkts. dec.	218

Bowling : Heyland 5-60; Lucas 0-37; Schneerson 3-75; Harold 0-31; Ware 0-7.

PAST	
A. Schneerson b Aubin	19
J. North b Aubin	5
J. T. Harold c Hodgson b Arthur	17
M. Bates st Moyes b Ross	17
R. Heyland run out	33
C. S. M. Stephen ct Aubin b Haigh	49
R. Gilbert b Ross	2
M. Ware st Moyes b Ross	5
N. C. Oswald ct Ross b Aubin	19
I. Lucas not out	5
J. E. A. O'Connell b Aubin	6
Extras	2
Total	179

Bowling : Aubin 4-38; Haigh 1-38; Arthur 1-70; Ross 3-31.

v. HAMPSTEAD

Played at Chislehurst on Saturday, July 15.

Result : LOST by 11 runs.

Bart.'s fielded first, and in between showers Hampstead were dismissed for 120. This low total was largely due to some very accurate bowling by Haigh and Foy.

When our turn came, we were no more successful and wickets fell steadily in spite of spirited resistance by Moyes and Third. The last wicket fell just before 7 o'clock with our total at 109.

Scores : Hampstead 120 (P. G. Haigh 5-30; B. N. Foy 4-30). Bart.'s 109 (A .R. Mason 4-24).

v. FINCHLEY C.C.

Played at Chislehurst on Saturday, July 22.

Result : DRAWN.

Finchley batted first and were able to declare at tea time with 156-7, mainly due to an innings of 75 by W. B. Walton.

The Bart.'s batting was very shaky to begin with, and after the fall of the third wicket at 34 we never looked like making the runs.

The game ended with Arthur being called upon to produce his customary nought not out in order to avoid defeat.

Scores: Finchley C.C. 156-7 dec. (W. B. Walton 75). Bart.'s 102-9 (J. A. Clappen 38; R. S. Norrish 6-45).

v. BUCCANEERS C.C.

Played at Chislehurst on Sunday, July 23.

Result: DRAWN. Rain stopped play.

Scores: Buccaneers 111 (J. A. Clappen 6-25). Bart.'s 10-2.

v. HORNSEY C.C.

Played at Chislehurst on Saturday, July 29.

Result: DRAWN.

In spite of fielding a side of almost cup tie strength we could only dismiss four Hornsey batsmen for 189 runs.

Bart.'s then had to score pretty rapidly in order to keep up with the clock and although Tomlinson and Braimbridge made very useful contributions we gradually got behind time.

Even so, everyone down to number eight tried to force the pace in the happy knowledge that if their wickets fell cheaply Moyes and Waterhouse at nine and ten could put up the shutters.

They did.

Scores: Hornsey C.C. 189-4 dec. (P. Kelly 63; P. Crawford 71).

Bart.'s 154-8 (J. D. Tomlinson 43; M. Braimbridge 48).

BOAT CLUB

At the Annual General Meeting of the Club held in June the following were elected officers for the coming year:—

President—Dr. B. W. Town

Vice-Presidents—Prof. L. P. Garrod, Dr. N. C. Oswald; Mr. O. S. Tubbs, Prof. K. J. Franklin, Dr. M. Donaldson, Dr. J. H. Coulson.

Captain—R. G. D. Newill.

Hon. Secretary—R. Goldsmith.

Committee Members—G. S. Banwell; P. E. Mann, M. Cohen, P. J. G. Smart.

No crews were entered for the Metropolitan Head of the River Race on April 1, most of the club being on holiday at the time. On May 20, the 1st Eight entered for the Sawtell Cup at Thames Ditton Regatta. After dead-heating with a London Transport crew in our first heat and winning the re-row, we were defeated by a powerful eight from Lensbury Rowing Club who went on to win the cup. However, we had the satisfaction of having given them their closest race. On the same day the 2nd Eight were entered for the Junior Division of the London University Allom Cup Regatta. This crew had had little previous training together and were eliminated in their first heat.

Owing to illness and consequent changes in the crew, the 1st Eight were unable to improve on the promising standard shown at Thames Ditton, and we had no success at Chiswick or Richmond Regattas.

The President's Sculling Cup was held on June 21, with a record entry. The winner, Paul Smart, won all his heats easily, and both he and the other finalist, Peter Mann, displayed a good standard of sculling.

On June 24, we sent a scratch crew to Marlow Regatta. Composed of members of the 1st and 2nd Eights this crew rowed surprisingly well, and did not disgrace the hospital colours. We beat a Thames R.C. eight in the first heat but succumbed to a more polished crew from Northampton Engineering College.

Though without success in regattas, nevertheless we had a most enjoyable summer's rowing, and the activity of the club has enabled our most promising new members to gain valuable racing experience. The retiring captain, Gerald Banwell, is to be congratulated on maintaining the enthusiasm of the Club throughout the year, particularly among the pre-clinical members, and thus laying the foundation for future successes.

The rowing year was brought to a conclusion by a most enjoyable River Ball which was held on a Thames Launch, and which upheld the reputation of the Club for producing successful dances.

Members of the two crews which represented the Hospital this summer were:—

	1st Eight		2nd Eight
Bow	P. J. G. Smart	Bow	W. M. Berry
2	P. E. Mann	2	M. T. Stather-Dunn
3	J. Randall	3	J. H. Stevens
4	R. G. D. Newill	4	W. P. Fitt
5	R. Goldsmith	5	I. H. Cochrane
6	J. F. Pearce	6	A. K. Thould
7	G. S. Banwell	7	W. G. Harris
Str.	D. H. Black	Str.	P. G. Burton
Cox	P. A. Clark	Cox	H. E. Rowley
Sub.	I. R. Beale	Sub.	M. H. Akeroyd

First Eight Colours were awarded to: J. Randall, D. H. Black, R. Goldsmith, P. A. Clark, P. E. Mann.

We congratulate our wartime hosts, Queen's College, Cambs., on winning The Marlow Eights Challenge Cup at Marlow Regatta—no mean feat!

RUGBY CLUB

For Season 1949-50 the following have been awarded Honours:—

K. A. Clare
D. G. Dick
A. H. John
R. F. M. Jones
P. D. Moyes
G. Picthall

The following have been awarded Colours:—

V. G. Caiger
K. A. Clare
M. J. A. Davies
D. G. Dick
A. J. Gray
C. W. H. Havard
W. G. Holland
R. J. Heylings
A. H. John
R. F. M. Jones
G. Mears
P. D. Moyes
J. K. Murphy
G. Picthall
A. J. Third
A. P. Wynne-Jones

Season 1950-51

The rugger season opens on September 30, with a match against Woodford. We generally play them early in the season and they always surprise us by their fitness. This year we must endeavour to be fit ourselves and start off the season on the right foot. A practice game is therefore being arranged against the Civil Service on September 23 and there will be practices down at Chislehurst on the Wednesday and Saturday preceding this. In addition members of the club are asked to start exercising themselves before these dates so that the trivial injuries too common in the early stages of the season may be avoided.

The Rugger Club dance will take place on Monday, November 27, in the Victoria Halls, Holborn. Details will be announced later.

GOLF CLUB

HOSPITAL CHALLENGE CUP (At Ilford G.C.).

On July 12, the Hospital Challenge Cup was won by D. H. Rushton at a replay after having tied with L. R. Gracey, both scoring 75. His 77, on a windy day, represented very steady scoring.

The best net score was returned by C. J. R. Elliott with a 65.

v. CITY OF LONDON POLICE (Away)

On July 19, at what must be one of London's prettiest golf courses—Langley Park—Bart.'s defeated the City of London Police by 4 games to 3. Unfortunately, at the last moment, R. V. Fiddian was unable to play, which meant that L. R. Gracey had to tackle, single handed, H. Niven and F. Branch, 6 and 8 handicaps, respectively. The task of beating these two he nobly accomplished on the 18th green after being two down at one point of the game. D. H. Rushton always had plenty in hand in his match against Sgt. Ponton and J. P. Waterhouse accomplished the no small feat of beating the Assistant Commissioner of Police by 2 and 1.

RESULTS: L. R. Gracey bt. H. Niven and F. Branch 1 up; D. H. Rushton bt. J. Salmon 4 and 3; Dr. M. B. McIlroy lost to W. Ponton 4 and 3; C. J. R. Elliott bt. F. Watts 2 and 1; A. B. Lodge lost to J. Dallaway 9 and 7; J. S. Dodge lost to J. Miller 4 and 3; J. P. Waterhouse bt. Captain Griffiths 2 and 1.

ST. BARTHOLOMEW'S

HOSPITAL JOURNAL

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THE REFECTORY

"At the Coffee-house, where much talking about a very rich widow, young and handsome . . . She is reckoned worth 80,000l," was part of what Mr. Pepys had to say of his day's activities on January 1, 1663. We would not perhaps count it very creditable to succumb to the temptation of morning coffee on the first day of the year, particularly if the conversation was to centre round such frivolities as rich young widows. Yet even if we are strong-willed enough to stick by our "no-coffee" resolutions for a few weeks at the beginning of the year, there can be few of us who are not lured down to the refectory from time to time by the aroma of the coffee urn. How very pleasantly can the moments pass by as we idly twiddle our spoons and as nonchalantly turn our chatter around the time-worn topics of women, landladies and work. There are some indeed who, despising the greater text-books, claim to learn the art of medicine from their more learned colleagues across the refectory table. What profound words of wisdom must pass at meal-times between those at the great round table in the corner! Who knows the deep thoughts that are engendered in those master minds and what mighty operations are planned? It is fitting that great plots should be hatched in the cellars of the Hospital. Let us not heed those that scorn our underground eating-place as if it were some unwholesome dungeon.

The word refectory itself rings with the glamour of another age. An ancient Priory Hospital could never have a canteen, and even a dining-hall would sound too worldly. The long oak tables down the centre of the room complete the picture. The presence of the ladies in such monastic surroundings must be forgiven. There are some who criticize the fine glazed tiling of the walls. Panelling might be more suitable but after all, Bart.'s is a hospital, and as such puts hygiene before beauty. At least we have bold heraldic emblems emblazoned around us, a bright alternative to the craftsman's linen-fold carving.

What opportunities are afforded for the study of the Hospital dignitaries! The student world, the humdrum plebs can gaze with awe upon the tables of the housemen and chief assistants and at the great Olympus of the chiefs. Can one picture the scene if some weary house-surgeon inadvertently drew up his chair with the registrars or if one of the latter presumed to sit beside his chief? At tea-time the tables are turned and the humblest of us can take his seat at the round table in the corner—perhaps "some mute inglorious Horder" (in the words of R.B.P.) whose talent is to pass unrecognised into the busy run of general practice, and who will never sample fame within the walls of his alma mater.

So much and more could be said of the æsthetic and philosophical glories of our eating-place: but what of the bill of fare? A more varied menu might be desired but could not easily be found in any City restaurant where prices meet the pocket of the student. What is more, the dish of the day—the "special"—the chef's chef-d'œuvre is provided for a paltry eighteenpence. Let those that favour beer and gherkins step across the road and let the grumblers hie them to the Smithfield cafés. There are some who slander our refectory—what Philistines!

CORRESPONDENCE

LECTURE ACCOMMODATION

The Editor,
St. Bartholomew's Hospital Journal.

Sir,

Your correspondents in the August JOURNAL who wrote complaining of the accommodation in the new practical surgery room appear to have overlooked the fact that a lecture is meant to be listened to and not written to.

Moreover, as the standard of lectures at Bart.'s is reputed to be appallingly low (*vide* July JOURNAL) we feel that the designer of the lecture theatre by making "note taking" as difficult as possible is merely seeking to discourage the perpetuation of so much mediocrity.

On the other hand we would join with your correspondents in asking the designer of the new lecture theatre to make the seating accommodation as comfortable as possible, if only to encourage the lecturer to be stimulating enough to keep his audience awake.

Yours, etc.,
W. P. FITT,
F. WINSTON.

The Abernethian Room,
St. Bartholomew's Hospital.
August 23, 1950.

AN OPEN LETTER

To the Secretary,
The Recruiting Board for National Service.
Dear Madam,

Recently you sent me a letter, the envelope of which bore my correct address, but this was preceded by the offensive legend "*Mr. J. McOstrich.*" This was unfortunate.

For some years now I have been accustomed to being addressed "*J. McOstrich, Esq.*" A modest courtesy title, of which I consider myself not undeserving. You, Madam, beg to differ. You employ the offensive prefix *Mr.*

In a decade of medical studies I have been known as Mr. . For the next decade I expect still to be known as Mr. . My envelopes, however, must bear the abbreviation Esq.

Your recent discourtesy caused some domestic uncertainty. My mother, who bears the same initial (Mrs. J. McOstrich), seeing the envelope, and unaware that there are still dissenters who choose to disregard my claim to Esquire, was alarmed to open it and read that her recent examination failures rendered her liable for call-up.

My mother, you must understand, is aged 75, and has been attempting her Red Cross Examination since she was quite a girl. Judge, Madam, of her consternation. She spent Tuesday and Wednesday frantically trying to telephone her contingent Commandant, who was in Italy at the time. When I arrived home for my weekend on Thursday, I found my mother prostrate, and quite unfit for household duties.

As a result, the cook gave notice, the under-housemaid gassed herself accidentally while attempting to take over further duties, and finally I was compelled to do the week-end cooking myself, to the detriment both of the household meat and of any further studies I may have wished to pursue.

So you will understand, Madam, that I have a heavy claim against your office for negligence. Furthermore, I have instructed the solicitors of the under-housemaid (deceased) to proceed, at my expense, with an action for damages arising out of your discourteous negligence in the first instance.

I am, Madam,
Yours faithfully,
J. McO.

THE JOURNAL

Contributions to the JOURNAL should be sent to the Editor by the 1st of the month for inclusion in the issue of the following month.

EXAMINATIONS

By REGINALD M. VICK, O.B.E.

ALL my teaching life, I have tried, to the best of my ability to instruct medical students—not only how to be good doctors and good clinicians (and I would remind you that the two terms are not synonymous) but as far as possible to tell them anything that I could which would help them to get through their examinations.

There are some superior people, who think that "examination teaching" is wrong.

But, after all, one of the many things that you all have to do before you can practise as doctors is to have enough skill, knowledge and ability to enable you to convince the members of the examining boards that you have these requirements in adequate amounts.

There will, of course, be some who will not agree with the advice that I give you but that only makes it more interesting to give it.

I feel that I am well qualified to advise you having been examined myself for full sixteen years and having examined in many universities and for the Conjoint Board covering a period of twenty-eight years and I have not stopped examining yet.

I must, at once, admit that I was not always successful in my own meetings with examiners and I can state categorically that when I failed to pass the fault was my own on every occasion.

I can well remember that when I was an undergraduate at a certain famous college in Cambridge—I found myself in an institution where sport was more important than hard work.

And after having done no work at all for many terms I was ploughed for the third time in the First M.B.

At first I was filled with a sense of grave injustice but after a time it dawned on me that perhaps some attention to one's studies was advisable even for these elementary examinations.

And this is the first point that I would make. If you wish to get through your examinations, it is advisable to have a modicum of knowledge in the subjects concerned.

There are things, which may help you to get through without this modicum, but I can assure you that it is better to have it.

Many years ago, I remember reading a most amusing article by a Bart.'s man, now famous—Dr. Philip Gosse—describing the ritual of progress from the Hospital to the Examination Hall which was then on the Embankment.

He gave details of the correct route by way of the Old Bailey and Sea Coal Lane—the propitiatory gifts to beggars—and the final casting of an offering in silver to Father Thames.

If the candidate met a funeral on the way, it was no good going on.

If, in the pre-motor days, he saw a horse's tail before its head, the prospects were not too good.

As far as I remember, these methods were not strikingly successful.

I trust that you will not be offended by my next bit of advice. When you go up for your vivas, see that you are well turned out.

See that your linen is scrupulously clean and that your hands are well looked after.

I do not suggest that an examiner consciously looks at a candidate's hands but there is no doubt that if a man looks untidy and unkempt a vague feeling of doubt as to his suitability as a doctor may arise even before he has begun to talk.

Women do not require this advice. They know without being told. Try and go up for your vivas looking and feeling fit. For years I have told men going up for the Final F.R.C.S. to stop work altogether the weekend before the paper and go away and play golf or whatever game they enjoy and come back the evening before the examination begins.

Look up complicated classifications on the morning of the paper—run over the pathology of the thyroid gland and other little understood subjects and then go up realising that there are other things in life more pleasant and more thrilling than the Final Fellowship.

As far as I know, no one has ever taken that advice except myself. And many a man has gone up for his Fellowship utterly stale and has thus seriously mitigated against his success.

And now a word about your papers.

After that agitating moment, that first cursory glance at the paper to see whether

there happens to be anything in it that you know about, read it through very carefully.

You would be amazed at the number of times candidates answer questions that have not been asked.

I remember once a most distressed student asking me the day after the paper whether it mattered that, in answering a question about the elbow joint, he had written entirely about the shoulder joint. My answer was that, if he knew lots about the shoulder joint, all might yet be well. But that, if he did not, it was just too bad.

Having read the whole paper through—answer the question first about which you know least. And make the best of the little that you do know.

Don't leave the question that you know least about until the end when your brain—such as it is in this time of stress—is tired.

Each question is marked on its merits and, in most exams, you have to answer them all.

The well tried stunt of "No time for more" died years ago. Nor is the method of shelving the subject any good.

Don't imitate the candidate who, in a scripture paper was asked to give an account of the reign of King Ahab and answered, "The less said about Ahab the better. I will now give you a list of the Kings of Israel."

Always map out your answers before you start and then go ahead. Usually, it is better to allow the same time to each answer. If there are six questions to be answered and three hours to do them in, take half an hour for each.

This is very simple arithmetic and yet often forgotten. Write as well as you can. Try and make your answer readable, however badly you write. Examiners have many papers to correct and, if they have to decipher some utterly illegible writing both their energy and their patience may be exhausted.

Unless you are a very good draftsman and know what you are drawing—never draw a diagram.

If you draw a diagram, it must be the first thing that catches the examiner's eye. If it is a good one, it helps a lot. But if, as so often happens, it shows some fantastic inaccuracy—well it is better that it should not be there.

Try and spell correctly. The satisfying modern theory that bad spelling is hereditary does not alter the fact that it is distressingly common.

Don't make lists but do make each part of your answer stand out. Don't underline unnecessarily. Don't be too brief but, on the other hand, don't imagine that "in the multitude of words lieth wisdom."

Often enough most of it is blather and a skilled examiner recognises this at one glance.

All your papers are corrected by two examiners—just as in the same way in your vivas one examiner does all the asking while the other is helping to assess your knowledge.

If you feel able to answer the questions in the order in which they are asked so much the better. But that is not essential.

And a last word of advice, when you have written the whole paper leave yourself a few minutes to read it over.

To summarise this advice:

DO—Read the questions through carefully before you start.
Space out your answers according to the time allowed.
If anything, spend more time on the question that you know least about.
Write as clearly as you can and make the examiner's work as light as possible.
Read the whole of your paper through at the end, however much its contents may distress you.

DON'T—Don't draw diagrams unless you are good at them and know that your diagram is correct.
Don't imagine that you can bluff by exuberant verbosity. And, on the other hand don't be too brief. It looks as if you did not care, which is the last impression that you want to give.

And now about your vivas. Remember the terse description of a viva "You are telling me."

Go into your vivas looking as bright and eager as you can but don't overdo it.

In the clinicals, the first ordeal you are faced with is an interview often far too brief with a long case.

You will have about ten minutes—or, in some exams, much longer with this individual.

In that time, you have to find out what is the matter with him. Don't spend much time on history. It really matters relatively little what his grandfather died of. What you want to find out—and quickly is what is the matter with him.

If you are unlucky enough to meet a talkative patient, control him or her and keep to the point.

If you are faced with a deaf patient, your luck is out but you must just yell at him enough to get out the salient points in his history.

Examine him carefully and concentrate on all definite findings. Most of the cases are perfectly straightforward.

Unless you are instructed to do so, don't write out a clinical history but collect in your mind all the important facts.

Now and again, patients lie to the candidates but they are soon found out and they do not attend again.

As to the type of case, you will often find them orthopædic in character. The reason for this is obvious. They generally have very clear clinical manifestations of their disability and they are not easily hurt. A candidate has to be unusually rough to hurt a patient with a bony ankylosis of the hip.

Don't be taken aback if you see patients with out of date diseases like Charcot's joints. In fact, the examination hall is one of the few places where you and they may meet.

If the diagnosis is obscure, don't worry too much.

You are not likely to be ploughed because you do not know what is the matter with a patient when the correct diagnosis is really in doubt. No examiner is likely to plough you because you cannot give him a definite diagnosis of a patient's condition, when he is not even sure of it himself.

And now you have to face the Examiners.

This is the first time that you meet them face to face. They may, or may not, impress you but, at this point may I say a few words to you about examiners as a class.

The men who examine you in your final surgery for instance, are all men who have been in active surgical practice for years and on the staff of teaching Hospitals.

Some of them have made their names in one or other specialised branch of surgery but they are examining you in general surgery and it is unusual for them to give even the faintest indication that they have got any speciality at all.

One word of advice I would like to give you at once. DON'T LOOK UPON THE EXAMINERS AS YOUR ENEMIES.

After many years of examining, I am perfectly clear on this point. More candidates are helped through their examinations by the reasonable and friendly attitude of their examiners than ever dream of it.

I have many and many a time heard an examiner helping out a diffident candidate.

Some candidates cannot be helped.

I heard a very good story of a viva the other day from an Australian surgeon. He was examining a medical woman and she was very near to tears. After a few fruitless efforts, he said "Well, we don't seem to be getting on, tell me something that you do know about and we will talk about that." Her answer was "I am afraid that I don't know anything about anything." This answer made the rest of the viva incredibly difficult.

I can remember, on one occasion, examining a particularly uncommunicative candidate and we wandered on from patient to patient. At last, we arrived in front of a man of about 28 years with a blotchy face and signs of an obvious addiction to the bottle.

He was suffering from a radial palsy of recent origin. The candidate stood lifting the patient's hand up and letting it drop and saying nothing.

At last, in despair, I said to him "Well, let me help you. Have you ever heard of Saturday night palsy?"

And for the first time, he replied promptly. "He distinctly told me it was Sunday."

When you go into your vivas approach them with courage and determination. Don't be truculent but be definite.

And always be polite but not servile. An old friend of mine got his Final F.R.C.S. at the 11th attempt in 20 years. By that time he was senior surgeon at a large provincial Hospital.

What he did not know about practical surgery was not worth knowing. But he failed again and again because he would argue with the examiners. On one occasion he was shown a patient with a gumma of the testicle. He diagnosed it as a neoplasm. And the examiner said "What would you say if I told you that this patient has a triple plus Wassermann."

His answer was "I should get another pathologist."

Develop good examination manners. When you have examined a woman with a typical scirrhous carcinoma of the breast—stand back and don't touch this patient again.

Say exactly what you have found and be concise. If you are sure of the diagnosis—and that may often be so—say "This patient has a scirrhous carcinoma of the breast for the following reasons."

If it is a perfectly clear case, don't hedge. Describe exactly what you have found and your conclusions. On the other hand, let us suppose that the patient has chronic interstitial mastitis with a firm cyst in it.

You can then say "I find that this patient has a tumour in her breast. I believe it to be a tense cyst in a breast with chronic interstitial mastitis—but it is very firm and it may be an early carcinoma."

And I would expect you to get a very good mark.

Don't go on handling the patient after you have finished your examination. I remember years ago, Sir William Thorburn examining a candidate and showing him a small pedunculated fibroma of a patient's arm with a slender pedicle and the candidate would not let go of it.

Finally, Sir William said, "Don't pull it off: there are other people to come."

Remember that your viva is short and in that short time you must make it clear to the examiners that you know what you are talking about.

The clinical part of the examination is far and away the most important. In fact, if you fail in your clinical, your chance of a successful issue is lamentably small.

So, when you are training, see every case you possibly can. However diffident you may be about your own powers, press yourself to the front in the classes—especially if you are afraid of being asked questions. Do all you can to get used to being "ragged."

Don't make any attempt to find out what cases are going up to the Examinations.

Years ago, when the Final F.R.C.S. Examination was a quiet, peaceful affair the number of examiners was small and great efforts were made by some candidates to find out about the patients going up.

On one occasion, a candidate thought he knew all the cases going up but when he entered the room, he was taken at once to a patient about whom he had found out nothing.

He immediately said to the examiner "I am sorry, Sir, but I am afraid that I have seen this patient before." So the examiner took him on to another case.

This showed a courage worthy of a better cause and, of course, he was taking a great risk.

On another occasion, a candidate walked into the room, laid his hand on a patient's abdomen and said without further ado, "This is a psoas abscess." The examiner—a cynical man—answered "Oh, no. The psoas abscess is over there, this is the desmoid tumour."

Now just a word or two more about examiners.

There are, of course, just as many types of examiners as there are types of men.

The rude, loud voiced examiner of the past is gone. His passing caused no regret.

You will not meet one like the famous gynecologist, who was twice removed from a certain board of examiners because he would call the boys "B——y young fools" and they did not like it.

I can remember one or two examiners in the past who were anathema to the candidates. People were filled with dread when they found themselves confronting these particular men.

But my experience was that these examiners marked the candidates kindly. And, after all, what does a little toughness matter, as long as you get through.

I was once examined by an eminent surgeon, with a face just like the moon—and he was about as responsive to my remarks as the moon itself.

The type I like least is the cynical examiner—The one I can recollect who, after the candidate had done his very best used to say "You don't really mean that, do you?" A most soul destroying remark.

Some examiners talk a lot themselves during a viva. Well, up to a point, let him talk—it saves you making mistakes.

But it is very difficult with such people, to assess how you are getting on. Others show whether they like what you are saying or resent it.

Try to develop a sense of atmosphere. If what you are saying is obviously unpalatable, switch on to some other line.

Always remember that you are being examined by two examiners, though only one is asking the questions.

Don't ever show that you know who the examiner is. Most exams are run impersonally—and it is much better that way.

Whoever the examiner is and of whatever type—whether you like his face or not—remember that, for the moment, he has you at a disadvantage.

Be as pleasant and efficient as you can.

Don't look depressed, however awful you may feel.

It is practically impossible for any candidate to know exactly how he is getting on and there are many surprises—not all of them unpleasant.

When the viva is over don't go about worrying what the cases really were—just get ready for the next viva. It does not help you to get anxious about what is over and done with.

A word or two about the *surgical anatomy vivas.*

They are always a bit of a strain—especially as most students in for their finals have forgotten most of the anatomy they ever knew.

But, in the M.R.C.S., this is a surgical anatomy viva—not pure anatomy. It deals mostly with the anatomy of operations—and instruments and is not so very difficult.

Pathology vivas.

These vivas are started by the candidate being asked to look at a museum specimen—and at the R.C.S. you will see the finest museum specimens in the world.

When looking at a museum specimen, always look at both sides of the bottle. As an example, a specimen of a Richter's hernia—a knuckle of dark bowel showing in front and behind a perforation with a glass rod in it—indicating clearly that the patient died of peritonitis, before any operation was done.

Having looked all round the specimen would enable you to give a correct description of what had happened.

This viva is both pathological and clinical—and, often, more clinical than pathological. Which is, perhaps, a "good thing." You will be asked to discuss first the pathology and then the clinical side of the condition illustrated by the specimen.

It is, in the Conjoint, a very peaceful viva—held in the comfortable surroundings of the Royal College of Surgeons.

And with it, your examination comes to an end and you must wait with what fortitude you can for the results.

Stimulants.

I do advise you never to take any form of stimulant before your vivas. If the knowledge is not there, no form of stimulant will bring it out.

I am told some students take benzedrine—I have known candidates take caffeine or, even, alcohol.

Apart altogether from the moral and physical disadvantages of stimulants at such a time, always realize that your viva may be delayed and the effect may have passed off.

I remember a man, who bolstered himself with champagne but by the time the viva came, he had reached the depression stage.

Once I examined a man who was friendly drunk. He breathed all over the examiners on a hot summer afternoon with disastrous results.

I remember a Cambridge man—who, afterwards, became a very successful doctor—who went out and celebrated in the forenoon and then came up for his clinical. When shown his first case, he made no noticeable progress towards elucidating the diagnosis.

So the examiner said: "Would you like to see an X-ray?" The candidate indicated that he feared that that would not help him. He was then asked at which hospital he was trained.

The examiner said: "But, surely, you have got an X-ray department at your hospital": to which the candidate replied: "Yes, but it is no damned good."

Of course, if you wish to celebrate after the result that is entirely your own affair. You need no advice from me about that.

Two stories of incidents after the result.

In one instance, a candidate, on being handed his pink paper, knocked out the official who gave it to him who, poor man, had nothing whatever to do with it.

In another, an infuriated Australian, after the 1914-1918 War, is said to have pinned his pink paper up in the Hall of the R.C.S. and put six revolver shots into it.

This fusilade must have sounded ominous to the Court of Examiners sitting upstairs.

And now, I have come to the end of my suggestions and words of advice. I do hope, from the bottom of my heart that, although I have told you nothing new, my advice may help some of you to meet and defeat the various boards of examiners.

There is a great deal of criticism today of the whole organization of examinations and it may be that drastic alterations will come into force.

But having examined medical students and nurses without intermission for 28 years, I am prepared to say that I have come across very few examples, indeed, of harshness or unfairness on the part of examiners.

And certainly, as far as the higher examinations are concerned the candidates usually admit—after the first, very natural and bitter disappointment of failure, that they have had a fair deal.

Once only to my knowledge did a candidate sue the Board of Examiners, and just when everyone had settled down to what looked like being a most amusing Tribunal, the Judge dismissed the case as frivolous—with costs against the plaintiff.

And so my final advice to you all is—work hard. Use your common sense as well as your knowledge in your examinations, realizing that, in the final issue, you will be judged by that knowledge and the way you transmit it. Be alive be good witnesses—have a good heart and plenty of courage, and all will be well.

I end by wishing you all the very best of good fortune in the important testing times that lie in front of you.

The Subject of a Clinical Lecture.

ABERNETHIAN SOCIETY

The meetings to be held from October to December, 1950, are:—

October 12 Dr. E. B. Strauss, on "Scientific Belief."
October 26 Mr. Dennis J. Browne, on "Some Errors and Omissions in Orthodox Anatomy."
November 9 Clinical Evening.
November 23 Sir Henry Dale, O.M., G.B.E., on "Medical Treatment at the Beginning of the Present Century."
December 7 Professor Robert Platt, on "Renal Function in Disease."

All meetings will be at 5.30 p.m.

WESSEX RAHERE CLUB

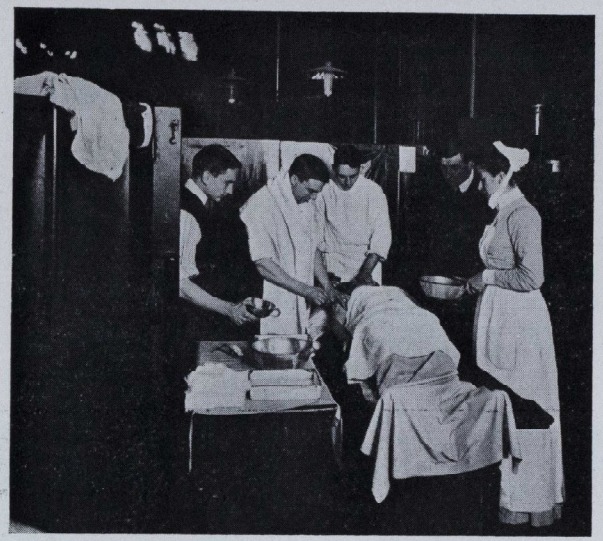
The Autumn Dinner of the Wessex Rahere Club will be held at the Spa Hotel, Bristol, on Saturday, October 21, under the chairmanship of Professor R. A. Brocklehurst, and it is hoped that the President, Sir Holburt Waring, will be able to attend. Membership of the Club is open to all Bart.'s men in the West Country. The Hon. Secretary is Mr. A. Daunt Bateman, 3, The Circus, Bath.

TO GREENSLEEVES

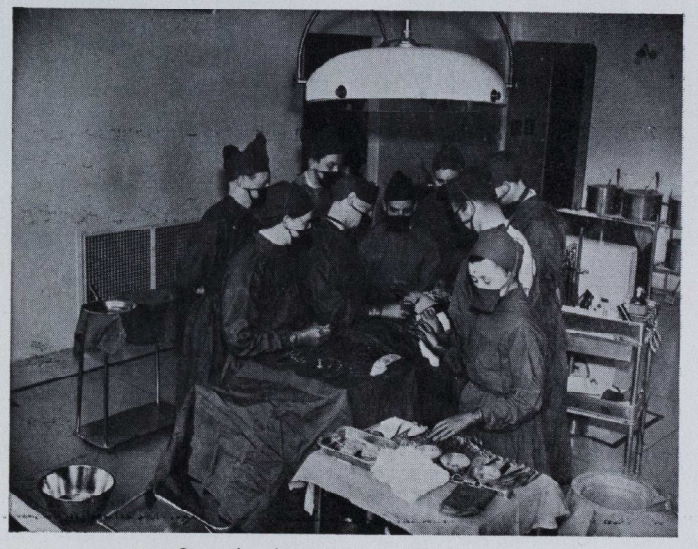
I wonder if, without that cap, her hair falls flowing down;
Or if her hidden nose bespeaks a lady of renown.
Her figure, too,
Is hid from view
Neath baggy folds of gown.
And yet despite the green disguise
I love her for her sparkling eyes.

My sympathy is with the Shick, that bold and gambling male,
Whose choice of future paramour is hindered by her veil.
Perhaps, like I,
He takes her eyes
To be her true portrayal.
But why this eulogy in verse?
—I've fallen for the theatre nurse.

PLUS CA CHANGE . . . .



Operation in the Surgery.



Operation in progress in Theatre D.
—By courtesy of the Dept. of Medical Photography.

MATTHEWS DUNCAN'S HISTORY OF MIDWIFERY

By C. P. WENDELL-SMITH

James Matthews Duncan (b. 1826) was elected physician accoucheur and lecturer on midwifery to the Hospital on September 20, 1877, and continued to serve it faithfully until his death in 1890. He made many contributions to the advancement of his speciality, wrote widely and was a brilliant lecturer. He began teaching in Edinburgh in 1853, the material which follows being reproduced from his original introductory lecture notes of that period.

The material is worthy of note on several scores; it is the work of a great man; it has never been published; and finally, no such history in small compass is easily accessible. It is published by permission of the Committee of the Medical College Library with whom the manuscript and copies of the portraits are lodged. A minimum of annotations has been made.

The first portrait is of Miss Jane Hotchkis, daughter of a Dumfries-shire laird, at the time of her engagement to Matthews Duncan in 1860. It is a chalk drawing by William Crawford, R.S.A. The portrait of Matthews Duncan is an oil painting on a wood panel by William Fettes Douglas, later knighted and President of the Royal Scottish Academy. It was painted in 1850 at the request of Mrs. Miller, wife of the Edinburgh professor. The original portraits are held by a son of the obstetrician.

Imagine Matthews Duncan, as portrayed, giving his lecture from these notes—a slow, intense, speaker—a youthful enthusiast who said, "[I] like lecturing as a daily intellectual gymnastic. Find it a useful lesson to myself to do so, doubly as teaching me my ignorance and teaching me knowledge, and further valuable as an incitement to study."

THE HISTORY OF MIDWIFERY

In the earliest times the *art* of midwifery must have been, to a certain degree at least, cultivated. It is scarcely to be supposed that even Cain was born by his mother with no more care and attention than is the lot of brutes. This care was the first embryo—the primordial germ of Midwifery. Very soon indeed did the human family come grievously to desiderate the services of this art. In his romantic history Moses relates that while Jacob was on his way from Bethel to Ephrath his wife "travailed, and she had hard labour. And it came to pass, when she was in hard labour, that the midwife [the first known of the class] said unto her, Fear not; thou shalt have this son also. And it came to pass, as her soul was in departing (for she died) that she called his name Benoni; but his father called him Benjamin. And Rachel died, and was buried in the way to Ephrath, which is Bethlehem. And Jacob set a pillar upon her grave; that is the pillar of Rachel's grave unto this day." Gen. xxxv, v. 17. The same author relates to us, as occurring soon after, the extraordinary case of twins and spontaneous evolution (a long anticipation of the discovery of Denman). "And it came to pass in the time of her [Thamar's] travail, that, behold, twins were in her womb. And it came to pass, when she travailed, that the one put out his hand: and the midwife took and bound upon his hand a scarlet thread, saying, This came out first. And it came to pass, as he drew back his hand, that, behold, his brother came out: and she said, How hast thou broken forth? this breach be upon thee: therefore his name was called Pharez. And afterward came out his brother, that had the scarlet thread upon his hand: and his name was called Zarah." Gen. xxxviii, 27. At this time you will observe there were midwives, a class of female practitioner who appear to have had in their hand the care of lying-in women. This state of matters continued until what may be called recent times, for the education and practice of males as obstetricians is not of old institution. At all times it is probable, and in regard to several eminent medical men of antiquity it is certain, that in difficult and dangerous cases males were consulted. [1]In the writings of Hippocrates, of Celsus, of Moschion and of Galen there is not only evinced a considerable acquaintance with midwifery generally but we also find the description of instruments used in their rude operations of perforation and embryulcia.

But in classical times, not only was the ordinary practice confined to the female sex, but in difficulties, some of the numerous lady deities of Olympus were appealed to: The ancient Greeks prayed for the protection of Eilithyia, daughter of the supreme Zeus and dedicated temples to her honour. The Romans had a host of goddesses, each presiding over some part of the function of producing and rearing children. But the chief of all, and specially devoting herself to the care of the birth of mankind, was Lucina—often glorified as Juno Lucina. Prayers for her propitious countenance were no doubt numerous and the "Casta fave Lucina, tuus quin reprat Apollo" of Virgil or the "Parce precor, gravidis, facilis Lucina, puelles: Maturumque utero molliter effer onus" of Ovid may have afforded the matrons of regal Rome as much comfort as the presence of a beloved physician does in our time, or an oft repeated Ave Maria.

In ancient times and until the close of the Middle Ages the *science* of midwifery can scarcely be said to have existed and its *art* was certainly in the rudest condition. There was, no doubt, a variety of received empirical laws to guide practice, as can be shewn from numerous parts of ancient authors and is attested by the reputation for obstetric skill which certain individuals attained. But so little is the amount of knowledge of obstetrics evinced by old authors, and so greatly do they copy from one another that I shall do little injustice in seeking to impress on your minds, at present, the name of the great father of Medicine alone—Hippocrates who flourished in Greece four and a half centuries before the commencement of the Christian era. Several of the books contained among what are called the Hippocratic writings relate to woman, her diseases and their remedies. In regard to them I shall only say that the more they are studied, the more admiration will they attract. They require profound literary study on account of the difficulties of penetrating the full meaning of an author from

[1]J.M.D.'s marginal note: "should be enlarged."

whose ways of thinking and writing we are thoroughly estranged — our science and literature having only the remotest connexion with his, it being entirely a modern structure.

As the 16th Century dawned upon the world a new era commenced in medicine. The whole circle of sciences was now destined to be rescued from the mysticism or dogmatism of ancient philosophers and schools. Observation and experiment were the instruments by which the whole face of the scientific world was to be changed, and the immortal name of Bacon has for ever supplanted the autocracy of Aristotle. In medicine, philosophers had already begun to lay the necessary foundations in exposing the anatomy of the human body, till then scarcely at all known. On the science of anatomy are for ever engraven the names of Vesalius, Fallopius, Eustachius, the pioneers of all the branches of medicine, because the founders of our information on that subject, which is the necessary beginning of all the others. In 1573 Ambrose Paré published a pamphlet entitled "Manière d'extraire les enfants du ventre de leur mère."[2] The great Paré's name forms, as you well know, an era in surgery as well as in medicine from his invaluable discovery of the advantages of ligatures over the cautery in arresting arterial hemorrhage. This pamphlet contains the first attempt to systematise two great obstetric doctrines which remain still the doctrines of schools. These are:—

1. That pelvic presentations of the child are not dangerous, and
2. That in cases of malpresentation of the child the best operation is podalic not cephalic version.[3]

About the same time Guillemeau,[4] who adopted with eagerness the doctrines of Paré —reduced to a distinctly stated rule the treatment of great hemorrhages in labour—viz: that in such cases the membranes must be ruptured and the woman speedily delivered.

In 1668 Mauriceau[5]—the Nestor of the Obstetrics of his day—in a work abounding with positive errors, made, among several minor contributions in the progress of our art, one worth notice by showing that presentations of the face can terminate spontaneously.

In 1672 Portal led the way to an accurate knowledge of the pathology of cases now known as those of placenta prævia—by pointing out the error of all his predecessors, who, on finding the placenta coming before the child, never fancied but that it came there during labour in consequence of being detached from some position higher up in the uterus. Portal pointed out that in these cases it was adherent to the os. Unfortunately, however, he did so in a manner so cursory and brief that it was long after his time before the profession were put in possession of the important discovery. To Portal's name attach several other important points in practice which although not so great as to get mention among the landmarks in obstetrical history yet point him out as an able and original observer.

About the end of this the 16th century Great Britain enters the field and earns her first laurel in obstetrics. Chamberlen discovered a plan of delivering women in difficult labours without injuring mother or child.[6] This immense practical discovery was easily recognised to be of great pecuniary value, and, according to the custom of the time, was kept a secret from all who did not pay for its disclosure. But it was at length made public and immediately the instrument was subjected to a thousand ingenious alterations —some of them, happily, improvements. To this day the instrument remains as the most important of obstetric resources and continues to be twisted into an infinite variety of forms, according to the caprice or perhaps the ingenuity of the accoucheur.

1742. Ould, a practitioner in Dublin, first corrected the erroneous notions as to the antero-posterior position of the head in labour, and pointed out that it lay more or less transversely. He, in fact, began the study of the mechanism of the child's progress, a labour which it was left to the celebrated Naegele to complete.

1747. Levret, for a long time the most celebrated of obstetricians, made several improvements in his art. His name is celebrated, chiefly, for the application of the forceps to the head when high in the pelvis—the long forceps in short thus rescuing from murderous instruments a new class of cases.

1760. About this time appears the name of Smellie to adorn English midwifery. Smellie made no single improvement in midwifery so great as to be worthy of being coupled with his illustrious name. But his contributions to the progress of midwifery were very great. As in medicine Cullen, whose friend and fellow countryman he was, so Smellie systematised the science of midwifery for our country and left the stamp of his mind upon it for ever. His works on midwifery are among the most rich and copious in any language.

About the same time Macaulay and Kelly first introduced the plan of inducing premature labour in cases of narrow pelvis.

1774. W. Hunter published his great work of Plates of the Gravid Uterus. He thus completed and finished the foundation of the science and the art of midwifery in a work which will ever endure as an imperishable monument of his greatness. Dr. Hunter's claims to our consideration do not rest solely upon his contributions to obstetrical anatomy. The observation and study of this wonderful part of Nature's works led Hunter by a natural process to an admiration of the scheme and a confidence in the powers supplied by nature. Ignorance, empiricism and conceit had led to the accumulation in our art of a host of useless and supererogatory rules of interference to a constant suspicion and distrust of nature which could not subsist under the light cast on them by the labours of Hunter. It was to be expected, then, that this great man should in his teaching advocate a simple and uncomplicated midwifery—that the powers and actions of nature are not to be intermeddled with or assisted in difficult cases without due consideration, in natural cases still more so—and that even in the worst accidents their powers are our safeguard and mainstay. This grand change, amounting to a revolution—dethroned for ever the old race of midwives and has formed the keynote whereto every good accoucheur has since then accommodated himself.

1775. About this time Baudelocque became the autocrat of midwifery not only in Paris but almost everywhere else. He was a good systematiser and published largely on midwifery. From the high position he secured and the extensive if not universal influence he obtained by his valuable works, his name marks an era in midwifery.

1777. Sigault excited a great ferment in the profession by his proposal to substitute symphyseotomy for Cæsarean Section.[7]

1787. Denman published his work on midwifery which remains to this day one of the standard works for reference.[8] He illustrated, confirmed and gave precision to many of the most important practical laws of obstetrics. With his name also is connected the doctrine of spontaneous evolution, an important contribution to the science of parturition which has been illustrated and corrected by the labours of Dr. Douglass of Dublin.

1813. Boivin published her work on midwifery.[9] This lady also published a standard work on the diseases of females, including valuable researches into the arrangement of the muscular fibres of the pregnant uterus. Along with her contemporary Lachapelle, she established the reputation, skill and ability of the other sex in all that relates to midwifery and the diseases of women and children. These two ladies occupy an honorable position among the most distinguished cultivators of the science and practitioners of the art of midwifery.

1818. M. Major of Geneva discovered the fœtal heart's pulsations by ausculting the abdomen of a pregnant female. In this way he suddenly made one of the most valuable discoveries in obstetrics. Books have been and are written on the diagnosis of pregnancy. Till Major's lucky listening that sign

[2] First published Paris 1550 as "Briefve collection de l'administration anatomique: avec la manière de conjoindre les os, et d'extraire les enfans tant mors que vivans du ventre de la mère, lors que nature de soy ne peult venir à son effet."

[3] i.e. Internal podalic version *in labour*. Internal cephalic version had been used since classical times for cases of malpresentation *in labour*. Wigand is usually credited with the introduction of external cephalic version for such cases (prior to labour) in 1807. Bipolar version was introduced by Braxton Hicks in 1860.

[4] J.M.D.'s marginal note: "enlarge Guillemeau." See Thornton, J. L. In Our Library No. XIII St. Bart. Hosp. J. 53, 1949, p.16.

[5] J.M.D.'s marginal note: "Consult Biographie Universelle."

[6] This refers, of course, to the obstetric forceps.

[7] Baudelocque was admitted to the Paris College of Surgeons in 1776 after presenting a thesis on symphyseotomy.

[8] Denman published his lecture notes in 1782 and his main work in 1794.

[9] First edition 1812.

of pregnancy was unknown, which is tantamount in value probably to all the rest put together.

1821. M. Lejumeau de Kergaradec, in a memoir addressed to the Royal Academy of Medicine of Paris, advanced the subject of auscultation in pregnancy far beyond the discovery of M. Major and announced the discovery of what is generally called the placental bruit.[10]

1822. Naegele, professor of midwifery at Heidelberg, published a small and unassuming volume on the mechanism of parturition. The other labours of this man form almost an era in midwifery. W. Hunter laid the foundation of the entire science and art of midwifery by describing, with unerring accuracy, the anatomy of the gravid uterus in general and of its several parts and component tissues in particular. In the temple of Lucina Hunter occupies the place of Kepler, succeeded by Naegele, the Newton of our science. The Heidelberg professor was the first to demonstrate how the fœtus in parturition is itself arranged, how the pelvis is constructed for the passage—how the one is nicely adopted to the other—showing the beautiful arrangements for effecting, in accordance with law and thus easily and safely, the transit of the child, whose head, peculiarly formed as it is, would everywhere meet with obstruction, unless guided by those now simple, but tardily discovered, mechanical relations, which constitute the most important elements of our sciences. If Hunter's labours are the foundation of midwifery then the works of Naegele form the entire skeleton or framework of our knowledge of the phenomenon of parturition. The works of W. Hunter and of Naegele, gentlemen, form the essence of our entire science. Without them we should be in the grossest darkness. Our science would have little claim to that honourable title, and the practitioners of our art would be left at the mercy of empiricism of prejudice of precedent. In almost every lecture we must refer to the works of these men. Most of their labours will be thus made familiar to you during the course. But in addition to this, every one of you who desires to excel in the science or the art must make the special works of these authors your most careful and particular study—making every idea your own and seeking to group or crystallise, as it were, all your other obstetric knowledge around the central truths and doctrines of the science.

In our own times midwifery has not lagged behind the other sciences in their rapidly progressive march. The difficulty which prevents us from entering on the improvements of our own day is not merely the somewhat invidious nature of the task, but also the impossibility of saying what are the great and central points most deserving of notice amidst the great number of competing views and schemes. But there is one to which I must call your attention prominently, being the most important advance made in uterine pathology. By the labours of Dance and Trunellé in France and of Davis, Robert Lee and others in this country the real nature of puerperal fever has been discovered and its analogues with the phlebitis of surgical open wounds pointed out. By the observations of numerous obstetricians,[11] especially of M. Semmelweiss in the Vienna hospital, one of the chief means of its production and propagation has been discovered and already by an easy prophylaxis numerous maternal lives have been rescued from this scourge and terror of the parturient female. The observations of M. Semmelweiss are so important that I cannot omit now noticing them.

In the great Vienna hospital the obstetric department, established in 1784, was increased in 1833; the newly added wards formed a separate clinic, but there was no difference in regard to the architectural arrangements, the beds, the food and the attendance in the two clinics; they were moreover in the same locality being only separated by a wooden door. Into these two clinics the male and female students were admitted promiscuously, and in both the mortality was very much alike, varying from about eight to four per cent. In 1839 a change was introduced in one of the circumstances of the two sets of wards or clinics. This consisted in dividing the clinics so that one was reserved solely for the midwives while the other was devoted exclusively to the male students. Shortly after this change attention was

10Called so erroneously, for it may still be heard after expulsion of the placenta. Uterine souffle or bruit is better.

11A. Gordon, A Treatise on the Epidemic Puerperal Fever of Aberdeen, London 1795, C. White, Treatise on Management of Pregnant and Lying-in Women, London 1773, O. Wendell Holmes, The Contagiousness of Puerperal Fever, Boston 1843.

strongly drawn to the great mortality of the women from puerperal fever. The leading men of the profession in Vienna were consulted in regard to this matter. They were struck by the fact that the mortality was far greater on the wards oft devoted to the medical students, than in those of the midwives. When the students and midwives were mixed the mortality was from eight to four per cent . *Now* it was found that in the midwives' clinic the mortality was reduced to from seven to two per cent., whilst in the wards devoted to the male students the mortality varied from fifteen to five per cent. Many different explanations of this awful difference were suggested and experiments in prophylaxis were accordingly tried. But ever and anon—sometimes after apparent success—the disease returned with its murderous virulence. In 1847 Dr. Semmelweiss was newly appointed assistant physician in the wards where the high mortality occurred. He immediately applied his mind to discover the cause of the epidemic under his care. Numerous explanations suggested themselves, but on investigation they all failed. He was soon forced to conclude that the whole cause of difference in mortality lay in the fact that in his ward the patients were attended by the students instead of the midwives. He then remarked that the former were almost without exception daily engaged in assisting at post-mortem examinations or at the practice of obstetric operations upon the dead subject, while the midwives had little or nothing to do with such labours. In May 1847 it was resolved that before making any examination of the women everyone should be required previously to wash his hands in solution of chloride of lime and make use of a nailbrush. The value of this precaution became immediately apparent. In 1848 the mortality in the hospital was less than two per cent—lower than it had ever been since 1827—that is, for twenty years. Moreover, the mortality in the two clinics was now equalised. In Kiel[12] a similar experiment has been tried and with the same happy results.

Puerperal fever in its various forms is the greatest danger that lying-in women have to encounter. It carries off probably nine-tenths[13] of all women who died from causes connected with childbirth. And any fact as to its causation, such as that verified by M. Semmelweiss, must be of infinite value. It was always known that a dissection wound or the inoculation of the human body with some subtle material generated in decomposing carcasses and probably only at a certain early stage of this change, was dangerous and might be fatal. Of this fact medical students have long been everywhere familiar from due experience. The extreme subtility of the poison, the inefficacy of ordinary washing of the hands to remove it from them, the dangerousness of using hands washed in the ordinary way in obstetric manipulations were first shown in Vienna—and one cause of mortality removed from a great institution and probably cancelled all the world over.

12By Schwarz.

13As recently as 1945 sepsis was responsible for one quarter of maternal mortality. This quarter, however, was of a total mortality of 1.8 per thousand live births. The proportion of deaths due to sepsis fell during the period 1936-1940 when sulphonamides began to be used extensively, and yet again during the period from 1944 onwards when penicillin was made available.

BIRTH

KEHOE. To Terry, wife of Dr. Michael Kehoe of 23, Grove Road, South Woodford, Essex—a son.

DEATHS

Dr. A. E. A. Carver, medical director of Caldecote Hall, Nuneaton, on May 30, 1950.
Surg.-Capt. A. Woolcombe, R.N., of Trowlesworthy, Station Road, Okehampton, Devon, on June 9th, 1950.

SO TO SPEAK . . . .

Classification . . .

"Skin diseases may be divided into two groups—those that itch and those that don't. Those that itch may be sub-divided into those which are relieved by calamine and those which are not."

—From a lecture by a noted psychiatrist.

A Thought for Today

". . . and if you haven't got this in mind you won't think of it."

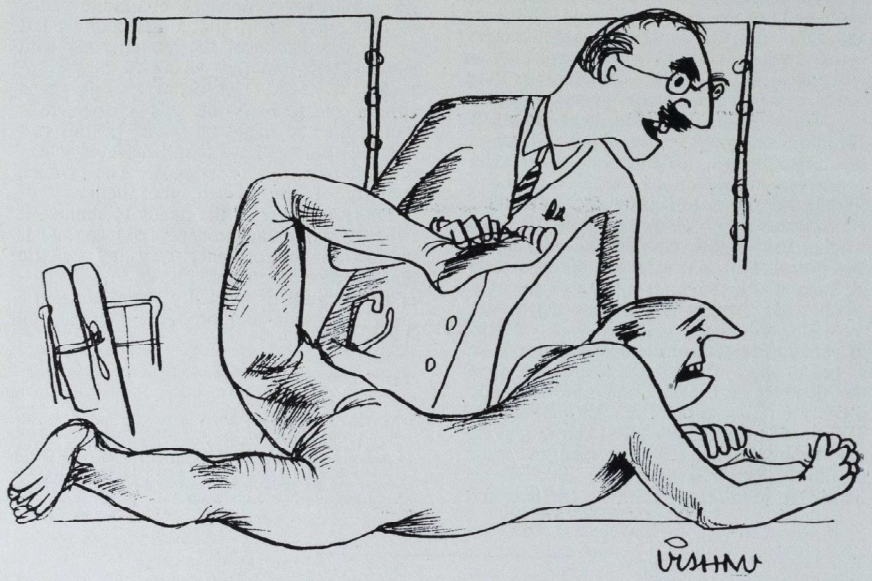
—From a clinical lecture.

Privileged Classes

". . . for example, you can always lay on the District Nurse."

—From a lecture on Geriatrics.

Contributions for this series would be welcomed.



"I think we should get your chest X-rayed."

ROUND THE FOUNTAIN

The fifth edition of this anthology of verse and prose from the JOURNAL, 1893-1949, was published in December of last year.

Copies are still available and it is expected that there will be a great demand for them again this Christmas.

The price is only four shillings (by post, four and ninepence).

HONORARY PHYSICIAN TO THE KING

Surgeon-Captain G. F. Abercrombie, V.R.D., R.N.V.R., has been appointed an Honorary Physician to the King.

MICROFILMS AND RESEARCH

The difficulty encountered in providing storage space for periodical literature has recently been modified by the introduction of *microfilm*. Most scientific institutions are making use of this medium. Thus microfilm copies of material not readily available to readers in book or periodical form may be obtained from sources such as the Army Medical Library, the Science Museum Library, and the Royal Society of Medicine. Little or no cost is involved in obtaining microfilm copies, as these are sometimes loaned free of charge.

By this method printed material is reproduced in a reduced size on to non-inflammable film. Thus a double page of this JOURNAL would occupy only 1in. x 1in. of film. This film requires little storage space, and can replace the bookcases normally occupied by a periodical of several hundred volumes.

The apparatus necessary to magnify the microfilm to the required size for comfort to the reader is available for use in the Charterhouse Branch Library. It is simply operated, and members of the staff and students are invited to make use of it with their own microfilms, or those available in the Library. The Royal Society of Medicine generously supplied our Library with microfilm copies of material destroyed during the war, where we were unable to replace it.

A new development of special interest to readers of the JOURNAL is the reproduction of the JOURNAL by this medium. Through the kindness of the *University Microfilms* a copy of this JOURNAL in positive microfilm will be available at low cost to subscribers to the paper edition. The film will be furnished on metal reels, suitably labelled. An entire volume, available shortly after publication of the last number, will be on one reel, and can be obtained from University Microfilms, 313, N. First Street, Ann Arbor, Michigan.

J. L. T.

CHOCOLATE CYSTS AND CINEMAS

(Back-chat in Theatre J)

Wilfred Shaw, at the table,
Deprecated Mr. Gable.
"Films which make the maidens coo
"Should," he stated, "be taboo.
"Going to the picture shows is
"Cause of endometriosis.
"—Substitute for Walter Mitty
"Morris Dancing in the City."
O'Sullivan did not agree.
"—They'd come with prolapse then," quoth he.

ACCOMMODATION WANTED

Bart.'s student and wife (no children) urgently require unfurnished accommodation, preferably in N.W. London area.

Please reply to the Manager of this JOURNAL.

CHANGE OF ADDRESS

Dr. C. Langton Hewer to 33, Stormont Road, Highgate, N.6. (Tel. Mountview 1388.)

SPORT

CRICKET

SUSSEX TOUR

v. BOGNOR C.C.

Played at Bognor on Sunday, August 6.
Result: LOST by 4 wickets.
Scores: St. Bartholomew's Hospital 81 (R. A. Edwards 6-14). Bognor 82-6.

v. IFIELD C.C.

Played at Ifield on Monday, August 7.
Result: WON by 13 runs.
Scores: St. Bartholomew's Hospital 126 (J. P. Waterhouse 55, D. F. A. Aubin 32). Ifield 113 (R. Ryan 59, J. A. Clappen 5-38).

v. ROTTINGDEAN C.C.

Played at Rottingdean on Tuesday, August 8.
Result: LOST by 34 runs.
Scores: Rottingdean 109 (P. G. Haigh 4-40, J. A. Clappen 5-40). St. Bartholomew's Hospital 75 (J. A. Clappen 33, R. E. Gibson 5-7).

v. LITTLEHAMPTON C.C.
Played at Littlehampton on Wednesday, August 9.
Result : WON by 21 runs.
Scores : St. Bartholomew's Hospital 157-6 dec. (J. A. Clappen 47 n.o., H. B. Ross 44). Littlehampton 136 (R. Edgson 62, P. G. Haigh 6-64).

v. BARCOMBE C.C.
Played at Barcombe on Thursday, August 10.
Result : WON by 6 wickets.
Scores : Barcombe 141 (J. Clarke 48, H. B. Ross 5-53). St. Bartholomew's Hospital 142 4 (D. C. Hodgson 47, J. P. Waterhouse 48).

v. LINDFIELD C.C.
Played at Lindfield on Friday, August 11.
Result : WON by 1 wicket.
Scores : Lindfield 93 (P. G. Haigh 6-21). St. Bartholomew's Hospital 94-9 (H. B. Ross 34, J. A. Clappen 33, S. D. Marjoribanks 6-40).

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v. OLD MILLHILLIANS C.C.
Played at Mill Hill on Saturday, August 19.
Result : DRAW (Rain stopped play).
Scores : St. Bartholomew's Hospital 147-8 dec. (P. B. Biddell 43). Old Millhillians 71-5.

v. FOREIGN OFFICE C.C.
Played at Hillingdon on Sunday, August 27.
Result : WON by 8 wickets.
Scores : Foreign Office 73 (J. A. Clappen 8-31). St. Bartholomew's Hospital 74-2 (P. B. Biddell 42).

2nd XI

2nd XI v. STANMORE 2nd XI
Played at Chislehurst on Sunday, July 30.
Result : TIE.
St. Bartholomew's Hospital 2nd, 105-7 dec. (Ross 41).
Stanmore 2nd 105 (May 5-31, Ross 3-40).

Bart.'s won the toss and decided to bat on a wicket that gave the bowlers very little assistance. The Stanmore bowling was accurate but did not deserve the respect paid to it by the Bart.'s batsmen. Only Ross showed us how easy the bowling really was. He was out trying to quicken the almost pathetic rate of scoring. However, many catches were either dropped or not taken, and Bart.'s were able to declare leaving Stanmore ninety-five minutes to score one hundred and six runs.

The earlier Stanmore batsmen found little difficulty in scoring, and they looked set for a win. With one over to go they needed three runs to win and had four wickets in hand. But in that over the game took a surprising turn. Three wickets fell with the first three balls, one run was scored off the fifth ball, and in trying to gain the two runs for victory off the last ball of the match, the last batsman was run out by a very good return from third man. A most exciting finish to an otherwise unexciting game.

RIFLE CLUB

Having come 1st equal in the University Small Bore League the Rifle Club have completed their second full-bore season almost as successfully.

Five trips as a Club were made to Bisley, and several members went individually or with University of London parties.

At the United Hospitals Prize Meeting the Club was extremely successful, winning every prize. With 245 points out of 280 they beat the second team, Guy's Hospital, by a margin of 7 points. M. C. Hall and J. E. Cradock-Watson tied with 63/70 each for the Aggregate Prize and Benetfinck Cup, these being awarded after a second shoot to the latter.

The 600-yard prize was also awarded to Cradock-Watson, and the 300-yard prize to Hall, after a tie shoot with B. D. Lascelles.

On United Hospitals Cup Day the position was reversed, Guy's beating Bart.'s by 471 to 459. After the shoot a pint pewter was awarded to J. E. Cradock-Watson and a half-pint pewter to F. P. Thoresby for the best aggregate and the best score at 600 yards respectively. The result of the match was undecided until the completion of the last round, Bart.'s leading at the end of the second round, but scoring badly at the 600-yard range, thereby losing the Cup in exactly the same way as last year. The weather was very variable, part of the shooting taking place in heavy rain for which we were ill-equipped—perhaps the explanation of some of the poor scores.

During the Imperial Meeting a number of men from the Hospital and University stayed at Bisley and entered for the King's Prize and other competitions. It provided an opportunity for practice of a kind which can only be obtained at such a meeting, and the University Club is planning to organise a larger party in 1951.

The Club had no success in the King's, probably due to nerves, but B. D. Lascelles got into the prize list of the Alexandra Cup (600 yards).

During the summer a "B" team has been shooting once a fortnight in the County of London League and despite the difficulty of finding members during the holidays are at present second in their division.

Next season, two teams will be entered in the University League and friendly matches will be arranged for a third; apart from United Hospital and University team shooting.

The Annual General Meeting of the Club will be held on October 16, when it is hoped all present members will be able to attend, bringing new members with them.

As far as possible, matches will be fixed to leave the range available for practice shooting on Wednesdays between 2 and 5 p.m. and Fridays between 4 and 7 p.m.

WOMEN'S HOCKEY

At the Annual General Meeting of the Women's Hockey Club the following officers were elected for the season 1950-51.

Captain, Miss A. Caldwell; Vice-Captain, Miss J. Wetherall; Secretary, Miss G. France; Match Secretary, Miss K. Reid, Treasurer, Miss P. Humphris; Committee, Miss I. Cree.

The following were awarded colours for last season: Misses Cree, Humphris, France, Reid, Romanes, Wetherall, Pippett.

Miss G. France has also been elected Secretary of the United Hospitals Women's Hockey Club.

EXAMINATION RESULTS

UNIVERSITY OF LONDON

Ph.D. Examination for Internal Students
Faculty of Science

June, 1950

Watkins, W. M.

Special B.Sc. Examination in Physiology

June, 1950

Brown, J. R. (Hons.)

Examination for the Academic Post-graduate Diploma in Public Health

June, 1950

Adams, K. J. Phillips, H. T. van de Linde, P. A. M.

Special First Examination for Medical Degrees

June, 1950

Arthur, J. K.	Clark, P. A.	Ford, P. G. T.	Murphy, J. K.
Ashbee, C. R. N.	Cohen, L.	Gordon-Watson, M. A.	Owens, M. J.
Berry, W. M.	Ellis, C. D'A.	Grant, B. H.	Roche, W. D.
Bugler, R. A.	Evans, T. A.	Harris, W. G.	Sladden, J. M.
Burrage, M. V.	Farmer, D. R.	Langham, G. D.	Smart, P. J. G.
Burton, M. F. D.	FitzHerbert-Auckland, S. J.	Luscombe, A. H.	Swinburne, K. A. M.
Burton, P. G.	Fletcher, F. M.	Lytton, A.	Taylor, C. G.
Catnach, T. B.		Mann, P. E.	

The following Higher School Candidates have qualified for exemption from the First Medical

Black, D. H. Irwin, M. H. K.

Examination for the Academic Post-graduate Diploma in Medical Radiology

July, 1950

Diagnosis
Wilson-Sharp, C. D.

Therapy
Emery, E. W.

Special Second Examination for Medical Degrees

July, 1950

Adam, R. M.	Fisher, F. M.	Ivory, P. B. C. B.	Reid, K. M.
Andrewes, D. A.	France, G.	Keet, S. J.	Rimmer, A. H. M.
Arthur, T. I. F.	Godwin, M. H. G.	Mackay, A.	Rowley, H. E.
Baker, A. S.	Gorsky, A. J.	Martin, R. M.	Staunton, M. H.
Brazenor, E. L. F.	Grassby, G. C.	Matheson, P.	Thompson, S. G.
Cairns, I. F.	Hick, R. D.	Mears, G. W. E.	Whitting, H. W.
Cudkowicz, M. R.	Hill, E. J.	Morlock, R.	Wilkinson, D.
Cuthbert, D. M.	Hyland, R. K.	Mules, R. J.	Wint, A. S.
Duffy, T. A.	Iles, D. S.	Pearsons, D. E.	Prior, J. J.

M.D. Examination

July, 1950

Branch I (Medicine)
Cook, J. B. Helps, E. P. W. Millichap, J. G.
Galbraith, H-J. B. Mackenzie, W. Thomson, J. L. G.

Branch II (Pathology)
Evans, R. J.

Branch IV (Midwifery and Diseases of Women)
Picton, F. C. R. Sophian, G. J.

Branch V (Hygiene)
Phillips, H. T.

SOCIETY OF APOTHECARIES

Final Examination

July, 1950

Pathology	Medicine	Surgery	Midwifery
Hadley, D. L.	Hadley, D. L.	Hadley, D. L.	Hadley, D. L.

The following candidate having completed the Final Examination is granted the Diploma of the Society :—

Hadley, D. L.

ROYAL COLLEGE OF SURGEONS

At the Primary Examination held in July, 1950, the following were successful :—

Ballantyne, P. T. Keynes, W. M. Murley, A. H. G. Noon, C. F.
Timmis, P.

BOOK REVIEWS

COMBINED TEXT-BOOK OF OBSTETRICS AND GYNÆCOLOGY, Edited by Douglas Baird. Livingstone, 1950, pp. xii + 1,411, Illus. 594. Price 70s.

This excellent product of the Scottish school very properly stresses the physiological approach to reproduction and its subsidiary functions. This has been the approach at this hospital for many years and is heartily commended. Few, however, will agree with the rather complacent statement in the Preface: "There is now little scope for improvement in maternal mortality." At first sight a maternal mortality rate in the region of one per thousand live births does seem to leave little scope, but a detailed analysis as conducted by Prof. Baird reveals that the mortality from some causes (e.g., "shock") has not fallen at the same rate as that due to others (e.g., infection); further an examination of the absolute as opposed to the relative maternal mortality gives a better picture of the vast wastage of reproductive womanhood, a lot of which is surely due to "primary avoidable factors." The reader is advised to ignore this part of the Preface.

But this is a small point and does not detract from the inherent value of the work as a whole. The treatment throughout is orthodox and acceptable, and the information is on the whole comprehensive. It has suffered slightly by its multiple authorship—Chapter II states that the significance of the "interstitial gland" of the ovary will be discussed in Chapter IV—Chapter IV, that it has already been discussed. It is also difficult to correlate Fig. 37 and Fig. 416—this latter, however, does but show that two views exist and that different contributors disagree.

Some will feel this book a little large, but it should be remembered that it covers a field usually covered by two books, and it is so eminently readable that its unwieldiness is easily forgiven. It can be recommended unstintingly.

MODERN PRACTICE IN OPHTHALMOLOGY, Edited by H. B. Stallard. Butterworth, 1949, pp. xx + 525, Illus, 231, Plates xxx.

This book is intended to give the general practitioner an outline of the modern practice of ophthalmology and enable him to share in an understanding of cases referred for specialist opinion.

It consists of chapters written by fourteen well known ophthalmologists, and although this entails some duplication of material the diversity of style and approach add much to the vitality of the book.

The emphasis throughout is on the close relationship of general medical conditions to ophthalmology, the sections on pathology, medical ophthalmology and retinal conditions being particularly valuable from this point of view. The Therapeutics chapter gives sensible schemes of treatment with modern antibiotics, and useful details on the preparation of the more commonly used ophthalmic drugs.

The anatomy of the eye and orbit, and methods of examination (including a perhaps unnecessarily long description of the correction of refractive errors) are followed by descriptions of diseases of the lids, conjunctiva, cornea and the uveal tract. A useful chapter on tropical ophthalmology and an appendix giving the Standards of Vision for the Services, etc., are included.

The commoner surgical operations are clearly described and beautifully illustrated by the Editor who also contributes lucid chapters on the lens, glaucoma and injuries of the eye. Modern views on the treatment of squint, the necessity for early occlusion and the place of orthoptic treatment will be valuable to general practitioners.

The book is eminently readable, well illustrated and should be most valuable to those students and general practitioners who wish to acquire more than a superficial knowledge of opthalmology and yet who are daunted by the more formidable text-books in this speciality.

E. S. PERKINS

OSTEOLOGY FOR DISSECTORS, by R. K. Howat. Henry Kimpton, 1950, pp. 292, Illus. 46. Price 15s.

This little pocket book is designed to obviate the porterage of the present cumbersome standard text-books into dissecting room or museum in the study or revision of osteology: it is meant to be read with the actual parts in view. Its content is essentially that of the standard treatises but amplified by a very readable and attractive text which makes appropriate excursions into myology and arthrology and into clinical or functional anatomy as occasion demands. The illustrations are line drawings, deliberately simplified (sometimes to the point of crudity) to assist orientation of individual bones and the ready comprehension of their topographical anatomy.

The quality of the information provided is good and few blemishes are observable. No anthropologist, however, could agree that the shape of the cranial vault is wholly determined "by that of the brain within" (p. 182) for, despite the admitted influence of brain upon skull, a definite racial factor plays a dominant part in cranial configuration. The mandible is the origin, not the insertion (p. 242), of the digastric's anterior belly: "fossas" for "fossæ" (p. 67) is shatteringly ugly, and "choanæ" is misspelt (p. 257).

The book provides a clear and informative account of the bones and their adnexa and the student should find it a helpful guide to the business of establishing a sound knowledge of the human frame.

A. J. E. C.

PROGRESSIVE PROFESSIONAL NURSING, by Mona E. Grey. Livingstone, 1950, pp. 104. Price 6s.

This is a brief account of the history of British Nursing, with more attention than is usual to Northern Ireland. Plenty of facts are provided, and here is a sample of the style: "The degree of much ill-directed criticism from all sources has focussed modern British nursing in a vivid medley of colour, where it was once a dignified and gentle background."

ESSENTIAL UROLOGY, by Fletcher H. Colby. Baillière, Tindall & Cox, 1950, pp. x+580, Illus. 342. Price 61s. 6d.

This text-book has been written mainly for students and emphasis has been laid on the basic sciences. The development, anatomy and pathology of the genito-urinary system are well described and amply illustrated. The vascular and nerve supply to the ureters are more completely described and illustrated than I have seen elsewhere. There are only brief references to treatment and discussions on the indications for treatment are on the whole poor. This is a weak point and would appear greatly to detract from the book. Most clinical text-books should be kept as the basis of a library to be used throughout one's professional life and this book would not be much help in practice.

Many of the illustrations are good but some of the operation specimens are poorly prepared for photography and give little help to the text. At its price with its rather limited sphere of usefulness the book is probably too expensive for most students in this country.

ELECTROENCEPHALOGRAPHY: A symposium on its various aspects. Edited by Denis Hill and Geoffrey Parr. Macdonald, pp. vii + 438. Price 78s.

This book is written by some of the pioneers of electroencephalography in this country. Every aspect of the subject is covered and there are long sections on technique, and the physiology and biochemistry of the subject in addition to full surveys of the E.E.G. findings and their interpretation in various neurological and psychiatric disorders. This book fulfils a need as it is the first authoritative and detailed work on electroencephalography published in this country. It has been written primarily for workers in E.E.G. departments and is too detailed for the use of medical students.

J. Aldren Turner

AN INTRODUCTION TO PATHOLOGY, by G. Payling Wright. Longmans Green, 1950, pp. x+569, Illus. Price 30s.

The book, as the title suggests, is an introduction to the study of pathology and comprises an excellent description of general pathological processes. The book is written with a strong philosophical bias and is well illustrated by numerous charts and photographs.

The book can be recommended with confidence to all students of medicine as it gives the basic facts which a student must understand if the processes involved in disease are to be appreciated.

The author expresses a pious hope that students may find time to read many of the references given in the extensive bibliography, though, in an already overcrowded curriculum, this will be impossible for most.

THE VITAMINS AND MINERALS of various foodstuffs. Four pamphlets issued by Vitamins Ltd., Upper Mall, W.6. Price 6d. (8d. post free).

These four-page pamphlets show clearly and colourfully in chart form, the mineral and vitamin content of various foods.

AMONG THE DOCTORS, by Alfred Cox. Christopher Johnson, 1950, pp. 224. Price 12s. 6d.

Dr. Alfred Cox, former secretary of the B.M.A. gives an interesting and informative account of his work in the early days of the corporate organisation of medical practice. The author is in a peculiarly advantageous position to provide authoritative and unbiased comment on the background and history of the National Health programme. He also tells the story of his early experiences in general practice sixty years ago when the current difficulties and problems were in many respects so different from those of today. A concise and straightforward style well suited to the subject matter adds to the attractions of this book.

NOTES ON COMMUNICABLE DISEASES OF LABORATORY ANIMALS, by H. J. Parish. Livingstone, 1950, pp. vii + 69. Price 3s.

This paper covered book, written by the Clinical Research Director of the Wellcome Research Laboratories, is intended to provide general and not too detailed notes on the commoner contagious diseases of laboratory animals. Sections are devoted to all the usual laboratory animals, and rarer diseases are mentioned. It should be of real value to all those who have to look after laboratory animals.

THE STERILISATION AND CARE OF HYPODERMIC SYRINGES, a booklet issued free of charge by Hodgson and Walkley Ltd.

ST. BARTHOLOMEW'S

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DIGS

The student is traditionally a carefree individual. Apart from an occasional encounter with the examiners he is not called upon to bear many of the burdens that the irksome world imposes on the human race. If, however, there is one factor that mars his otherwise blissful existence it is the eternal problem of finding digs. With the background of a handsome bank balance one could quite easily settle into the most desirable lodgings and bask comfortably under the care of the perfect landlady. The medical student, with his notoriously empty pockets, is in a far less rosy situation. He only seeks a place with inexpensive terms and a minimum of disadvantages.

Never before have digs been so difficult to obtain. Whether because of this or for other reasons, there has been a noteworthy change in the disposition of the homeless student. The fact is that so many young men of the present generation prefer to live in flats. Rather than be tied down by the regimens of landladies they choose to have a place of their own and manage their domestic affairs for themselves. An Englishman's home is certainly his castle and we all like to feel independent to some degree. It is new, however, for the idle male to carry his freedom to the extent of forfeiting the ministrations of a landlady. The impecunious Bob Sawyer would not have taken kindly to the idea of preparing his own breakfast. Perhaps this revolution is a gesture of defiance against the enfranchisement of women.

"Look how well we can tackle a man's job," say the ladies.

"Indeed?" say the gentlemen, hastily scraping the charcoal off the toast. "No doubt with a little practice we shall make a very creditable showing at these culinary gymnastics."

In these days some ten per cent. or more of students are married. For such couples a flat makes an excellent temporary home and the husbands are naturally prepared to do their fair share of domestic work. One cannot enjoy the privileges of married life without foregoing some of the pleasures of bachelorhood. What is strange, however, is that the single men are forgetting their right to these pleasures.

The possible habitats of the single man are limited in number. For the man of means and worldly status there is the comfortable home and housekeeper. For others there are the standard lodging-house and the free-booter's flat. These we have already considered. For the student there is a fourth type of dwelling-place available. It is an arrangement for convenience, as sound as it is old—the community life. The older universities through the centuries have found the system to be the most economical and pleasant for the student. It is when people live and work and talk together that thought and learning become directed along the most fruitful channels. The ideal community for this purpose is the non-departmental, where students of all arts and sciences can share their several branches of knowledge to their mutual advantage. A colony made up of students of one faculty alone might prove to be less stimulating and this may be the reason why the teaching hospitals have never developed to any extent the system of college life. The foundation of a residential medical college at Bart.'s would, nevertheless, be an experiment worthy of trial.

An hostel on these lines is now nearing completion in Charterhouse Square. *College Hall*, as it is to be called, is to be used primarily as quarters for clinical students. Rooms will not be available there for Junior

Housemen. Dressers and clerks doing their first appointments will be given an opportunity of serving as residents on their firms for one month at least out of the three. It was intended that the building should be completed by October of this year, but as is the way with most projects nowadays the ideal has not been fulfilled. No definite date of opening can be given, but we can look forward to it with eager anticipation. Good luck to *College Hall*!

CORRESPONDENCE

A REGISTER OF BART'S MEN

The Editor,
St. Bartholomew's Hospital Journal.

Sir,

May I make a strong plea for the compiling and publishing of a Register of qualified and clinical undergraduate Bart.'s men with their addresses and other relevant professional data on the lines of those published annually by other University Colleges and teaching Hospitals?

I am aware that the *Journal* occasionally publishes changes of address, but this is but a poor substitute when so few Bart.'s men continue to read the *Journal* when they leave the Hospital*.

There must be many old Bart.'s men who have lost touch with their contemporaries and who would welcome the chance to see what has happened to their once fellow clerks and dressers; and I feel that not only would it supply a "long felt want" to these men, but that the present generation, too, would find it interesting to see how large a proportion of leading men in the profession were trained here.

There would seem to be scope for some form of Old Bart.'s Society; an annual dinner and register of members would be the bare essential.

Yours, etc.,

P. G. CRONK.

* NOTE: There are over 1,000 old Bart.'s men who subscribe to the Journal.—*Editor.*

MISSION TO THE UNIVERSITY

The Editor,
St. Bartholomew's Hospital Journal.

Sir,

"There are issues on which it is impossible to be neutral," said Sir Hector Hetherington, Principal of Glasgow University. "These issues strike right down to the roots of man's existence. We cannot live a full life without knowing exactly where we stand regarding these fundamental issues of life and destiny."

Time for the consideration of these issues is not always easy to find. Yet some opportunities may be provided by the meetings to be held throughout London University from November 5—19 under the traditional title —"Mission to the University." In addition to the central meetings at Kings College, Strand, Bart.'s is to have special speakers at meetings on November 7, 10, 13 and 17, which may commend themselves to the early notice of your readers.

The Mission is of particular interest to all in Bart.'s because the Rev .Dr. D. Martyn Lloyd-Jones, M.D., M.R.C.P., formerly of the Hospital staff, is leading it. Its title, "God has spoken," calls attention, in our search for truth, to the fact that the revelation of God through Jesus Christ is as apposite to our present condition as to that of past centuries.

I am, Sir,
Yours truly,
GAIUS DAVIES.
(*President, Christian Union*)

Abernethian Room,
St. Bartholomew's Hospital,
London, E.C.1.

ROUND THE FOUNTAIN

The fifth edition of this anthology of verse and prose from the JOURNAL, 1893-1949, was published in December of last year and is still on sale.

Order your copy now. The price is four and ninepence (post free).

THE JOURNAL

The editor regrets that owing to the printing dispute this issue of the JOURNAL is late in appearing.

DELEGATION OF DUTIES AND TRESPASS TO THE PATIENT

By W. M. LEVITT

A case of importance to members of hospital staffs was recently tried by Lord Justice Singleton in the Kings Bench Division (*Michael v. Molesworth, Folkestone Herald,* June 9, 1950, and *British Medical Journal,* July 15, 1950).

The facts of the case were as follows. The plaintiff consulted the defendant surgeon for advice regarding his hernia. The surgeon, who was a senior member of a hospital staff, admitted him to a public ward in his hospital and an operation was subsequently carried out by the house surgeon. This operation was completely successful. The plaintiff sued the surgeon—

(1) for breach of an alleged contract under which, he claimed, the surgeon undertook to carry out the operation personally, and
(2) for procuring the house surgeon to commit a trespass to the person upon him.

He did not sue the house surgeon.

The Court found—

(1) That the surgeon had not entered into any contract to operate personally and the action, therefore, failed under this head, and
(2) That the surgeon did procure the house surgeon to operate upon the patient without his consent and in respect of that he was guilty of a technical trespass for which the patient was awarded the nominal damages of 20/-. The plaintiff, however, was not allowed costs against the surgeon, although the surgeon remained liable for his own costs in the case.

It is considered that this decision may contain important implications for medical men having charge of patients in hospitals and it has, therefore, been thought worth while to prepare this note on the legal principles involved.

It will be convenient to consider separately the two separate causes of action, in contract and in trespass respectively.

(1) Action in Contract

In this action the patient said, in effect, "you promised to operate on me personally and I promised to pay you a fee of 25 guineas in return. You failed to operate on me personally and you are, therefore, in breach of your contract for which I claim damages." The surgeon's answer was, in effect, as follows—"I never promised to carry out the operation personally and I never obtained from you a promise of a fee of 25 guineas."

What the Court had to decide in this action, therefore, was a question of fact and not of law. Who was to be believed? The Court preferred the surgeon's account and it was accordingly held that there was no contract.

Comment.—In English law a contract, to be valid, unless made by deed, must show consideration, that is to say, some payment, forbearance, detriment or responsibility, given, suffered or undertaken by the one party in return for the benefit he receives from the other. A promise to pay a fee in return for a promise to carry out an operation is consideration and accordingly an exchange of such promises will produce a valid contract. Where, therefore, a surgeon undertakes to carry out an operation in return for a fee, he will be under a legal obligation to carry it out personally unless some subsequent new arrangement is made. Few surgeons would find fault with this liability. What, however, of the case where the surgeon promises to operate without fee, e.g., in the public ward of a hospital? It will be clear from the definition of consideration (supra) that this need not be monetary. Any detriment suffered by the patient may be sufficient to support a contract and it is well settled that consideration need not necessarily be adequate; indeed, comparatively trifling consideration in relation to the benefit has frequently been held by the Court to support a contract. It may well be that the very detriment suffered by the patient in entering hospital and submitting himself to the operation may be sufficient to support the contract and to render a promise which may, perhaps, be made lightly by the surgeon, enforceable in law, and this may be so whether the promise is made to a National Health Service patient at a visit to out-patients or by a private patient at a preliminary private consultation. There is also the possibility in the latter case that where a fee has been paid for the consultation which is greater than the normal fee, consideration might be found in the excess.

The lesson to be learned seems to be that a member of a hospital staff should not

lightly promise a patient to undertake any particular part of his treatment personally. Even more important, however, than the possible liability in contract is the implication which may be contained in such a promise, however lightly made, that consent by any other person to operate upon the patient is excluded and, therefore, any person operating without express consent may find himself liable in trespass as may also any person who procures his doing so (e.g., the surgeon who delegates him to act.

(2) The Action in Trespass

In this action the plaintiff's claim was in effect as follows: "I authorised you and no other person to carry out the operation. In procuring the house surgeon to operate upon me, therefore, you procured a trespass." The defence was in effect as follows: "I never undertook to carry out the operation personally and therefore your consent must be implied to the performance of the operation by any person to whose lot it would properly fall in accordance with ordinary hospital routine. Moreover, I delegated the performance of the operation to the house surgeon in your presence and inasmuch as you made no protest, your consent must be implied from that."

The Court found that consent to the operation by the house surgeon could not be implied and had not been expressed. The house surgeon would, therefore, have been liable in trespass had he been sued (which he was not), and the surgeon was held liable for procuring the trespass.

Comment. — Any unauthorised interference with the person is a trespass and gives rise to an action for damages. Trespass is one of the oldest actions in English law and is one of the very few actions in which the plaintiff may succeed although he has suffered no actual damage. Indeed, in the case under consideration, the patient had actually benefited by the trespass inasmuch as the operation was a complete success. In strict law, therefore, the consent of the patient is necessary before anyone may even put a hand upon him. This consent, however, need not necessarily be expressed. It can be implied from the circumstances and will be implied where the circumstances are such that any reasonable person would imply it. Thus, if a hospital nurse approaches a patient in the ward with a syringe in her hand and with the obvious intention of giving him an injection, and the patient makes no protest, his consent to the injection may be implied. In the same way, if a patient in a hospital makes no objection to examination by a student, his consent to this examination may be implied. Where, however, a patient is unconscious at the time when some procedure is being carried out upon him, the position is not so clear. Doubtless, if a patient is brought into hospital unconscious, or becomes unconscious and an emergency exists, consent may be waived to anything that is done for his benefit. But where a patient of sound mind is to be taken to the theatre for the purposes of an operation, ought express consent be obtained to the surgeon who is proposing to perform the operation? Prior to the decision in the case at present under consideration, one would have answered with some confidence that unless the patient has stipulated for a particular surgeon, or unless a particular surgeon has promised to undertake the operation, consent would be implied to the performance of the operation by any person properly qualified for the purpose to whom the task had been properly delegated. One would have argued that any reasonable person entering a hospital must know that there are junior doctors as well as senior doctors and the person in whose nominal charge a ward is, cannot be expected to undertake all the work of that ward. In such circumstances, one might reasonably conclude that consent would be implied to the performance of any procedure by a properly qualified person deputed to perform it by the person in charge of the patient, unless of course, consent had previously been excluded by some such stipulation or promise as is mentioned above. This view is still probably correct although the decision in Molesworth's case is a little disturbing. In Molesworth's case, the Judge, having found that there was no promise by the surgeon to carry out the operation personally, proceeded to find the defendant guilty of procuring the trespass by the house surgeon. It is not suggested that such a finding was illogical. All that it means is that the Judge found as a fact that the patient expected to be operated on by the surgeon, and not by anyone else and, therefore, that consent to the operation by any other person could not be implied. What is disturbing about this finding is that a surgeon may find himself liable in trespass as a result of a pure misunderstanding. It is true that

the Judge said in this case that the action should never have been brought, awarding only nominal damages. This was, however, a case in which everything had gone well and the patient was cured of his hernia. The result might have been very different if, following such a misunderstanding, things had gone wrong at or after the operation.

The lesson of this action serves to emphasise that of the former, that a member of a hospital staff should take care not to convey to a patient the impression that he will personally undertake any part of his treatment or diagnosis. If he makes a promise to this effect and finds he cannot keep it, he should consult the patient first and obtain his consent to any other person to whom he intends to delegate the task. It will be recollected that in Molesworth's case, the patient saw the surgeon first at a private consultation and, doubtless, the risk of a misunderstanding is greater when the patient sees the surgeon first in private, but it can still exist in purely hospital practice.

The question has been asked as to whether liability in trespass could be excluded by adding some suitable formula to the form of consent to operation. In the present case, the plaintiff had signed a document by which he agreed to accept the ministrations of the hospital staff, including the house surgeon, and it was contended that the operation was performed as part of the services given by the hospital. Lord Justice Singleton held, however, that this document consenting to the operation was not a bar to the right of the plaintiff to sue in trespass. It would appear, therefore, that in order for a document to be effective, it would have to state in clear terms that consent were given to the performance of the operation by the surgeon under whose care the patient nominally was, or by any person deputed by him to perform it. The validity of such a document, however, might fail to be upheld where the patient had previously received a promise of personal attendance by a surgeon and pleaded that he regarded the document as a purely formal one, the contents of which he failed fully to apprehend.

This note is based on the report of the case of *Michael v. Molesworth* reported in the *Folkestone Herald* of June 10 1950, and in the *British Medical Journal* of July 15 1950. The case has not so far been reported in the law reports and may not be so reported. No authoritative record of the judgment is therefore available, but it can probably be safely assumed that the material parts of the judgment have been accurately reported in the press.

LECTURES ON THE HISTORY OF MEDICINE

A course of ten lectures on the history of medicine is being held during the 1950/51 Session, the lectures being given on alternate Mondays at 5.45 p.m. in the Clinical Lecture Theatre. Mr. Geoffrey Keynes delivered the Inaugural Lecture on October 9th, and Prof. A. J. E. Cave spoke on "The Beginnings of Anatomy," on October 23rd.

In connection with each lecture, an Exhibition of Books and Prints is held in the Gallery of the Lecture Theatre on the day of the lecture, and also on the following day. Forthcoming lectures:

6th November	Physiology	Prof. K. J. Franklin
20th November	Biochemistry & Chemotherapy	Prof. A. Wormall
4th December	History of St. Bartholomew's Hospital	Dr. Gweneth Whitteridge
18th December	History of Infant Feeding	Dr. I. G. Wickes
8th January	Dermatology	Dr. R. M. B. MacKenna
22nd January	Surgery	Prof. Sir James Paterson Ross
5th February	Pathology & Bacteriology	Prof. J. W. S. Blacklock
19th February	Anaesthesia	Dr. A. W. Franklin

DEATH

We announce with regret the death of Dr. Claude D. Henry of Wellington, New Zealand.

FAITH AND HUMOUR IN THE SUDAN

By NORMAN F. SMITH

The article JUNGLE MEDICINE? which opened the March issue of this journal rightly pointed out two great advantages of practice in the Colonies. First, the early assumption of responsibility. Secondly, that the Colonial Medical Service is not an intellectual backwater.

It is now more than twenty years since I completed six years of service with the Sudan Civil Medical Department. Most of the time my wife was out there with me and scarcely a day passes when we do not reminisce happily about those six years. We forget the heat, the sand storms and the sandflies, the mosquitoes and the scorpions. We remember the sunrises and the sunsets, the miracle of a flight of flamingoes taking off from their feeding ground and the swish of crocodiles playing round the tiny sailing boat when we tied up for the night.

Responsibility there was in plenty. A short briefing and you were off by camel or Nile boat for weeks or even months at a time —on your own—knowing that headquarters would not worry you nor worry about you, unless you were imprudent enough to betray your whereabouts by sending a telegram to Khartoum. And even the great ones there were several thousands of miles away from their lords and masters at the Foreign Office. What freedom! But, if I may repeat it, what responsibility. Between tours the young medical inspector would find himself in charge of a large hospital or of a quarantine station. It is no light task to hold up the pilgrims returning from Mecca or to dispose of a group of smallpox patients—perhaps twenty or more—housed in tents in the doctor's garden pending his return.

As to the intellectual backwater, you always carried "Osler" in your medicine box (he still smells faintly of thymol). You were perpetually on the job of prevention or cure. But best of all there was the warm welcome that awaited you on return to the larger centres. An incomparable bunch of colleagues were all eager to hear you and aspirations in the light of their own more equally eager to discuss your difficulties and mature experience. Discussions went on until the moon rose high in the sky and the party crept away noiselessly to their beds on the roof, leaving their host asleep on his lawn, lulled by the ceaseless croaking of the bull-frogs.

But the leaven of this life was to be found in the humour and faith of the people of the country. I would like to give a few instances to illustrate these characteristics.

Near that sharp kink in the Nile which you can see in any map of Africa, below parallel twenty and between the third and fourth cataracts, we tied up one day to replenish our stock of firewood from the scrub. It was a completely desolate spot, just limitless sand. Soon, however, a middle-aged Arab appeared on a donkey. He scrambled to the ground and, after the usual small talk, said he had seen the medical flag which flew from the mast. Oh no, he was not ill but he thought it a good opportunity to ask why one of his breasts was a little harder than the other and a little larger. He had an early cancer. I said I would be at a certain hospital in about a fortnight's time. On arrival at the hospital I was told that my middle-aged Arab had arrived the night before. He had ridden two hundred miles to keep his appointment. I, in my turn, was able to keep faith with him. Two years later I had a message that he was alive and well.

Then there was an unexpected crowd which pressed round my wife and me one morning, whilst I was inspecting a tiny town. A woman insisted on kissing my hand. One of her kinsmen, from the crowd, informed me in Arabic that she who had been blind could, thanks to me, now see. Cataracts are not confined to the waters of the Nile. Everything seemed to be going my way that morning until the headman drew me aside and suggested that, as I had been able to restore sight to the woman, it would be quite easy for me to make his teeth grow again. He was edentulous and when I said that a visit to the dental surgeon (about four hundred miles) was his only hope, I knew for certain that my stock had fallen heavily. After my brief uplift earlier the sand felt unusually hot under my feet.

The faith of these people in vaccination against smallpox must be seen to be believed. It was born of long and bitter experience. The first indication of an epidemic would often be a small cloud of sand, from which would emerge a breathless man gasping the fateful word and asking for help.

At one hospital centre, after only twenty-four hours' notice, we vaccinated three thousand persons between breakfast and lunch. In the remoter parts it was a heartening sight to see crowds appearing across the apparently uninhabited desert in the hope of receiving vaccination for themselves and their children, particularly for those born since the last visit of a doctor.

Which reminds me!

A violent thunderstorm overtook us one evening on the top of a small rocky hill. There was no form of shelter except the stinking bodies of our camels which we barracked in a circle. The thunder roared, the lightning hissed about us and I should say that about an inch of rain must have fallen in the hour. When we reached the little village where we were to spend the night, we found every sign of rejoicing and a grand welcome. We were invited to dine with the sheikh and the lamb for dinner had its throat slit as my wife stepped over its body. "Grand reception for you," I murmured, "but you must remember that you are only the fourth white woman ever to accomplish this journey." The atmosphere in the hut was such that we elected to sleep in the rain in our riding kit. Before leaving at dawn I thanked the sheikh for his hospitality and the cordiality of his people. I felt he was a little hurt at our refusal to let him turn out of his hut for us. His comeback, delivered with the most delicious twinkle in his eye, was: "Yes, my people were very excited last night. You see, it has not rained in this neighbourhood for twenty-five years!"

Gambling and the entertainment of ladies are two endearing traits which bring one's servants into low water when their monthly wage is exhausted. These debts of honour, however, are loyally discharged—at the expense of their employer, of course. The technique is well illustrated in the following two incidents.

Every morning before dawn the cook goes to the market for daily supplies. After breakfast he renders an itemised account and is reimbursed. One day the bill was high because we were giving a dinner party that evening. Next morning, however, the following conversation took place: "Seven piastres for that little fish?" said my wife. "Not possible, Cook. Why, that's the same price that you paid yesterday in preparation for the party and tonight we dine alone!" Cook: "It takes as much time and trouble to catch a little fish as a big one." There was not a flicker on his face and he got his money.

Amongst our equipment on trek we always carried two large shallow metal tubs about three feet in diameter. These had many uses. Clothes could be washed in them, for instance; also the human frame, when infestation of the Nile with bilharziasis or crocodiles rendered it unsuitable for that purpose. "Tisht" was their name. We pulled in for a few nights near to a village where the servants claimed to have kinsmen. Sounds of revelry filled the air far into the night. Next morning one tisht was missing. Unfortunately, we were told, it had inadvertently slipped overboard when nobody was looking. Next day the other was reported missing. This was serious but we were amazed to learn that Allah had wanted it. "Bring that tisht back before sunset," my wife ordered, "and tell Allah that next time he wants a tisht he can buy one like anyone else." This reply was greeted with broad grins and the tisht reappeared, whereupon we departed with speed in order to save Cook from his creditors.

These people live their religion and are prepared to discuss it with tolerance and humour. On one occasion we lay off a tiny island which was subject to total immersion whenever the Nile was in full flood. Yet it was one of the many reputed birthplaces of Mohammed, on the analogy of "Queen Elizabeth slept here." "Not much of a place for your great Prophet to choose to be born in," I said. After a sensible pause the reply came: "Your Jesus of Bethlehem didn't choose much of a place to be born in either, did he?"

Stories such as I have told could be multiplied almost without end, but perhaps I have written enough to establish my point. The novelty of treating your first lepers or of holding your first malaria clinic soon passes. Even a confinement in a second-class compartment of a train wandering across the waterless desert to its next stopping place, eight hours ahead, becomes but another pleasant memory. And now, of course, cars and planes have largely superceded our camels and sailing boats. But if the essentials, as I believe, remain, it must still be a delight to live and work in a country where an invitation to dinner ends with the sentence: "And may the nightingales of contentment ever sing in the garden of your heart."

THE SPA TREATMENT OF ASTHMA

By F. WINSTON

Last summer a party of English physicians, led by Lord Moran, visited several French spas, and a report of the visit was published in the *Lancet*[1]. Among the spas visited was Le Mont Dore, widely regarded as the "providence des asthmatiques" and the "capitale de l'asthma."

A short account of Mont Dore and its history appeared in this journal last year[2], and recently articles by asthma sufferers claiming to have derived great benefit from the treatment given at this spa have appeared in both the *Leader* magazine *and the Sunday Express*.

It is, of course, difficult to assess the value of this sort of treatment, but there appears to be no doubt that a change of environment, the institution of a strict regimen and the apparent attempt to do something positive in the way of basic treatment of the underlying condition, as distinct from the immediate relief of symptoms, has a profound effect on the asthmatic patient.

It was pointed out by the late Sir Arthur Hurst that "the best treatment for asthma is not to have it," and any procedure which breaks the vicious circle of asthmatic attacks and offers some hope of a permanent cure must be of enormous benefit. Most of the patients treated at Mont Dore appear to be "satisfied customers" and the writer knows personally of at least five cases whose symptoms have been considerably alleviated by this form of treatment.

In this scientific age all mention of spa treatment for asthma appears to have crept out of the text books, though it is, of course, generally agreed that a good holiday involving a change of scene is of inestimable value in this complaint. The more fortunate patients are still sent to Switzerland and the Savoy Alps to dwell above the asthma line (4,500 feet) to relieve their symptoms, but at Mont Dore positive measures are taken aimed at providing relief not only during the treatment but afterwards when the patient has returned home. Similar stations exist in Germany, Northern Italy and in the Pyrenees but there is no doubt that Mont Dore is supreme in this field.

It is thought that some further details of the treatment offered may be of interest.

The Thermal Waters[3]

The waters of Mont Dore gush forth from eight springs (at a temperature of 38-44 degrees centigrade according to the source), from the volcanic rock into the interior of the Thermal Establishment. The gaseous waters contain silica, mixed bicarbonates, iron, magnesium, potassium oxide, iron oxide, sodium chloride, sodium sulphate and aluminium. They are slightly arsenical and radio-active. The total mineral content varies between 2G.50 and 3G per litre. The carbonic acid content is about 2G.55 of free gas per litre and is an important element in the spa treatment.

Carbon dioxide is not only found in the spring waters, but issues from numerous fissures in the rock around the Establishment and is admixed with minute quantities of oxygen and the rare radio active gases (argon, helium, neon, krypton and xenon).

The Thermal Establishment

The thermal establishment is situated in the centre of the town at an altiude of 1052 metres and has been constructed on a hillside on the ruins of the Gallic-Roman baths.

The Treatment

The properties of the waters of Mont Dore and the specialisation of the spa have had the effect of adapting the thermal practice to the treatment of affections of the respiratory apparatus. The mineral waters and thermal gases are administered by mouth, inhalation and hydrotherapy.

Inhalations

The inhalations of Mont Dore, which constitute the essential part of the cure are carried out according to a technique peculiar to the station, devised by Michel Bertrand in 1835. It consists in making the patient breathe in a warm fog of microscopic droplets of the thermal waters. The temperature of the fog is maintained at 30 and 32 degrees centigrade according to the room. The twenty inhalation rooms are in groups of two, each group being used by a different category of patient. The rooms are communal. The patients stay there for a variable time, 10 to 60 minutes, perhaps longer. They are dressed in a special costume which facilitates breathing and perspiration. On leaving the rooms they are dried in warm

lobbies before returning to their hotels to rest. The inhalations are taken in the early morning before breakfast. Private cabins are available for those not wishing to use the communal inhalation rooms. Two inhalation rooms, with water and vapour douches adjoining, are reserved under the supervision of nurses for the use of children under ten years of age.

Nebulisations (Thermal Aerosols)

The patient is made to breathe an aerosol of mineral waters at normal room temperature, which does not wet the clothes. This takes place in small cabinets holding three or four patients. No fatigue is involved and in certain cases these are used as an alternative treatment to the inhalations.

Treatment of the upper respiratory tract

Affections of the upper respiratory tract are treated by:—

(1) Gargling;
(2) Naso-Pharyngeal Irrigations;
(3) "Humages" and "Pulverizations" which enable a fog or jet of thermal waters to be directed onto the naso-pharynx.
(4) Nasal applications of thermal gases.

The thermal gases are brought to special departments where by means of a canula the patient introduces the gas into each nostril alternatively, for five to ten minutes.

Hydrotherapy

Numerous hydrotherapeutic practices are used in order to obtain sedation or decongestion. These include complete and hip baths and general, local, and vapour douches.

The hip baths (demi bain Roman) and foot baths are given in the hope of obtaining a decongestion of the respiratory tract, and for their sedative effects.

Numerous douches are given for their stimulating or sedating effect—according to pressure and temperature of the water. The patient stands at one end of the room and hydrotherapist directs water from a jet on to his skin at varying temperatures and pressures, according to the physician's instructions, with the object of obtaining sedating or stimulating effects on the underlying organs. For example, douches are given over the right hypochondrium and lower thoracic region with the object of stimulating liver function! Scotch Douches are given for their stimulating effects.

Vapour douches onto the thorax are supposed to produce very energetic "revulsive" effects on the lungs and pleura. The rationale appears to be the same as that of "cupping," which practice is still much used in France but not in the treatment at Mont Dore.

Respiratory re-education

Under the direction of a physiotherapist general and respiratory gymnastic exercises are carried out either in the open air or in the Thermal establishment. These exercises are for certain patients an essential complement to the cure, notably those having deficient vital capacity and thoracic malformations.

The above is an account of the main services available and these should, of course, be used in accordance with the instructions of the physicians of whom there are about twenty in residence at the spa.

The Action of the "Cure"

One theory put forward to explain the rationale of the Mont Dore treatment is that the asthmatic attack is caused by the hypersensitivity of the bronchial mucosa to irritating toxins circulating in the blood. It is said that not only is the threshold of sensibility of the mucosa lowered, but that in many patients the level of toxins in the blood is abnormally high due to faulty liver function. However, it is believed that if the sensibility threshold of the bronchial mucosa is raised without a reduction of the level of circulating toxins, manifestations of the equivalents of asthma (hay fever, eczema, and, say the Mont Dore consultants, arthritis) are liable to occur. Therefore the treatment at Mont Dore aims at (i) lowering the excitability of the bronchial mucosa, and (ii) "clearing the system of irritating toxins."

This explanation is, of course, merely based on a somewhat nebulous hypothesis, but some evidence as to the action of the waters on the asthmatic state has been obtained.

". . . [3]In the course of several researches carried out at Mont Dore, Santenoise has stated that the cure has a remarkable action on at least two of the elements constituting the 'terrain asthmatic.' He has observed that the threshold of excitability of the respiratory centres to carbon dioxide, habitually abnormally elevated in asthmatic patients, was rapidly brought to normal under the action of the treatment. Secondly, by means of researches on the 'reflexe Solaire' and the arterial blood pressure, he has shown that the cure exercises a very pronounced action

on the sympathetic nervous system and more particularly on the pulmonary vascular spasms seen so frequently in asthmatic patients . . .

". . . But the most convincing proof of the action of the cure on the general asthmatic condition appears to be the constant fall of the blood eosinophilia during the course of the thermal treatment. Other researches have shown that the waters of Mont Dore lower the pH of the blood and the alkali reserve."

The local action of the cure is said to be sedative, antispasmodic and decongestive. The antispasmodic action of the waters has been demonstrated on the isolated bronchus.

" The action of the cure on the asthmatic state and on the respiratory apparatus is most marked when the patient is young and the symptoms of recent onset. For this reason the results obtained with children are almost always excellent."

Indications for treatment

While asthma in all its forms is the major indication for treatment at Mont Dore, emphysema, bronchitis, the after effects of respiratory affections and the sequels of gas poisoning are also treated.

Among conditions of the upper respiratory tract which are treated are spasmodic coryza, hay fever, congestive rhinitis, non-purulent catarrh, and catarrhal sinusitis.

Contra-indications to the treatment

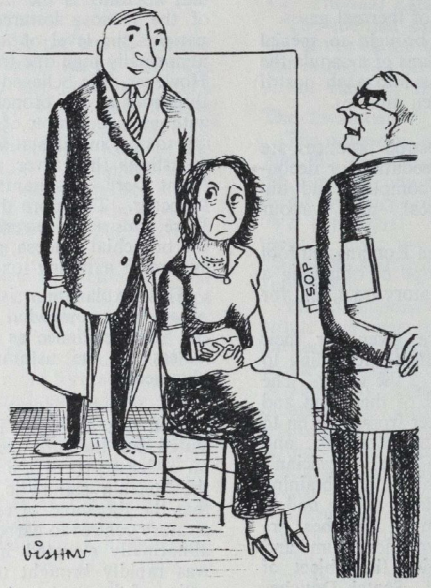
are Pulmonary Tuberculosis, cardiac asthma and chronic suppuration in the respiratory tract.

References:

1 See "Lancet," 1949, ii, 1187 et seq.

2 "St. Bartholomews Hospital Journal," October, 1949, p. 215.

3 The following information has, with certain alterations and additions, been translated and abridged from "Le Mont Dore-Momento Medical," prepared by the Société de Medicine du Mont Dore, 1948.



"So you think we should send her to the psychiatrists . . ."

HORACE IN WONDERLAND

It was getting late and Horace had given up his seat at the desk for a comfortable armchair. With a textbook of pathology on his lap he paused in his reading to yawn.

"What an excellent soporiphic this is," he thought. "I must remember it—*Mist. Dible c Davie*—pages 3—*nocte*——"

He stopped in surprise, for there before him was a White Cell, muttering to himself as he pulled a plasma cell from beneath him and read the time from its clock-face nucleus.

"Oh dear, oh dear, I shall be very late. It's half an hour since I had my call-up papers from L.P.F."

"Who's he," said Horace, "and anyway, who are you?"

"What ignorance, indeed," replied the White Cell. "My name's Luke—Luke O'syte, you know—and he's my promoting factor."

"Of course," said Horace, feeling somewhat ashamed, "I should have known that!"

"Well, aren't you coming, too? Drink some of this," said Luke, handing him a bottle labelled *Reducing Agent*.

Horace took a draught and felt himself shrinking rapidly. Before he could answer he found himself careering along a capillary with his new acquaintance just ahead. On and on they went until they noticed the vessel widening and its walls becoming very tacky. The next moment they were squeezing their way between the endothelial cells of the capillary wall to reach the floods of oedema fluid on the other side. They started to move on but were met by several disheartened-looking polymorphs coming in the opposite direction. One of them stopped to speak.

"You're late, Luke," he said, "and not for the first time. It doesn't matter, anyway—it's all over."

"What's happened?" returned Horace's friend. "Has the pH dropped already?"

"No, those penicillin molecules have got in first again. It really is a shame; we've not had a chance to form an abscess for ages. If this sort of thing goes on we shall have to stage a strike. Do you remember the agranulocytosis we organised to scotch the last lot of sulphonamides? Well, I must be off—cheerio!"

"I sensed that something of the sort had happened," said Luke, turning to Horace. "There doesn't seem to be much leucotaxine about."

"Who was that chap, and why was he limping?" asked Horace, priding himself on his clinical observation.

"He's my brother. The poor fellow lost a pseudopodium on active service. Before that he was noted for his fine amoebic gait."

"I thought I noticed a family likeness." Horace felt he was doing well.

"We're twins, you know," Luke went on. "We are said to take after our mother. She was very handsome as myeloblasts go. It's a funny thing, but when we were born our relatives thought we were daughter cells. They should have examined our chromosomes more carefully."

"Fancy making a mistake like that," rejoined Horace. "To change the subject, where was your brother going?"

"Fishing, of course," said Luke, as if Horace was behaving very stupidly. "We spend all our spare time on the banks of the lung capillaries. That's where we catch most of the stray bacteria. It's only in a really good septicaemia that you can be sure of getting a bite in other parts of the circulation. Come along now, we're wasting time. Would you like a trip to the sternal marrow to meet some of my relatives? I expect you'll find them rather primitive, but they're a good lot."

Without waiting for an answer he sped off and Horace had to swim as fast as he could to keep up with him. They were soon inside a venule and were able to float in a leisurely way while the current bore them in a central direction.

"Don't talk," snapped Luke as Horace was opening his mouth to comment on the scenery. "You want to save all the breath you've got. It's frightfully anoxic here."

The stream grew faster and the lumen wider as each major vessel was joined. Horace felt that they must be in the vena ceva and he knew he was right when a jet of rich blood from the hepatic vein swept across their path.

"We shall be in the right auricle any moment now," said Luke. "Hang on to me tightly and we may be able to slip through the patent foramen ovale. It saves so much time to by-pass the lungs—Phew! That's

done it. Now, mind the mitral doesn't nip you—. We're away."

At the next systole they were into the aorta.

"Stay close to the walls," cried Luke. "That valve is grossly incompetent."

Horace felt he would never again doubt the possibility of a paradoxical embolism. He was too exhausted to notice anything more and he closed his eyes, completely confident in his friend's ability to steer a satisfactory course. When at last they reached the marrow he received a nudge from Luke. They both took seats on a reticulin fibre and looked around them.

"A fine bunch, aren't they?" said Luke, pointing to some haemocytoblasts of particularly plethoric appearance. "If you look carefully you might see some mitotic figures. We're quite unashamed of reproduction here, you know."

"Good gracious!" said Horace, getting very excited. "Look at that big fellow crying over there."

"You mean the megakaryocyte?" asked the knowledgeable Luke. "Those aren't tears he's shedding, you mutt, they're platelets. He does that all day long. I shouldn't care for the job myself. It's too sedentary. A lot of these R.E. cells lead a very lazy life. They just sit around and eat anything that comes along. Talk about *pica*, lumps of coal would be nothing to them. Only the other day I found them wolfing away some particles of Indian ink that a pathologist had put into circulation."

"Hello, old *chiap*," said a voice behind them. "Can't stop to speak—Cheer-ho!"

"One of the local snobs," explained Luke in a whisper. "He's been very pleased with himself ever since he won his blue at one of the ancient medullary universities. It's a good job there aren't many of those basophils about. The eosinophils are quite different—very shy folk. That's why they are always blushing. In fact you usually find them in a hypersensitive state. You realise, of course, that granules are really insignificant—it's brains that count."

"Naturally," said Horace, trying to appear intelligent.

"Our cortical powers bear a direct relationship to the lobes of our nuclei. We each start with one lobe—like that myelocyte over there, for example—and as we grow wiser we bud off more. My nucleus is pentalobular, you notice," he said with pride.

"I had appreciated your talents," said Horace tactfully.

"Do you see that monocyte at three o'clock? Would you believe it, he's so ashamed of having only one lobe to his nucleus that he tries to hide it under a cytoplasm of specially frosted glass."

"I can't see many lymphocytes," said Horace, looking around him.

"No, they don't really belong here. Would you care to visit one of their nodes?"

"Well, I've seen a great deal already and I don't wish to take up too much of your time."

"Nonsense, my friend," replied the energetic Luke, "just follow me again."

Away they went back into the circulation, whirling around so fast this time that poor Horace could not think at all. "We're nearly there," said Luke.

The flow of blood was becoming slower and sure enough the travellers soon saw a littoral cell looking down at them.

"Don't cub too dear," he said. "We've got lybphadeditis—it bight be catchid."

"That sounds like sinus catarrh to me," muttered Luke. "Never mind, we're here now."

They wandered out of the sinus and looked around them. Nearby they could see an active germinal centre turning out hundreds of lymphocytes a minute on a moving belt of reticulin.

"Almost inanimate," sniffed Luke.

"And who is that important looking large lymphocyte over there?" asked Horace.

"Let me see now," his friend answered, "that must be the Minister of Antibody Production. Let's have a word with him. . . Good evening, sir."

"How do you do, gentlemen," said the austere Minister. "As you can see we are very busy at the moment. I understand that there are some Bordet-Genjou bacilli about in the pharynx. That calls, of course, for an absolute lymphocytosis."

"Absolutely," said Luke.

"Once these little chaps leave the node," he continued, "they go out of my care and come under the influence of my friend Mr. A. P. Hormone. Then, according to the present teaching they start a strip-tease act, shedding Y-globulins—very complex, but I believe it works."

"Most interesting," said Horace. "Thank you."

"We don't think much of lymphocytes," Luke said quietly as they ambled on. "They move in rather low circles. We, for instance, wouldn't dream of associating with typhoid bacilli, but they positively flock around them. In spite of what the Minister of Antibody Production said about the suspected pertussis, I should be a bit surprised if all this activity was an early lymphatic leucaemia. They're a rebellious crowd."

"Well," said Horace, "what next?"

"Another trip around the circulation might blow the cobwebs away. Off we go."

Off they went.

"Where are we now, Luke?"

"Look at the walls, man; can't you see the fibrin deposits?"

"Anticubital vein you mean?"

"Look out! There's another of those confounded venepuncture needles."

Whoosh! It was too late. Horace felt himself being sucked up a lumen of stainless steel. He flung out his arms wildly to clutch something. He succeeded.

"What are you doing, Mr. Smith?" said his landlady, as she freed herself. "There now, I've spilt your coffee."

THE ORIGIN OF THE BLUE BOARD

On Wednesday, December 6, 1825, a meeting of the Students of St. Bartholomew's Hospital took place in the Anatomical Theatre, at which certain resolutions were proposed for presentation to the Surgeons of the Hospital.

They were as follows:—

1st—That for the benefit of the Students and the economy of your time, the name, age, disease, and treatment of each patient be posted on some conspicuous part of his bed.

2nd—That all accidents admitted be registered every day in a book kept for the purpose in each accident ward.

3rd—That a notice of all operations to be performed should be pasted on the board in the Anatomical Theatre.

(Here some desultory conversation arose previous to putting the fourth and last resolution, and which, indeed, was not embodied with the foregoing; it was as to the mode of conducting post-mortem examinations, and the shameful extortion of sixpence from every pupil entering the dead house: no doubt a relic from the Ancient Universities.)

4th—That you will please to cause due notice of every post-mortem examination to be given, and will also assist in correcting the present abuses of the dead house.

On the following Saturday an operation list was posted in the Anatomical Theatre, and not long after that, the first Blue board/White board went to the foot of the bed. A copy of one of the early boards follows.

MR. LAWRENCE

PHILLIS GOAT, ætat. 26

DATE			
	Chronic inflammation of the eyes, with adhesions of the irides and cataract of the posterior lens of the right eye.		Feb. 16, 1826 S. FREEMAN
Feb. 17	Diet, Rice.	Pil. hydr. gr. v. ter die. Solut. belladon. oculis. Cal. gr. iv. Pulv jalap gr. xij statim.	
Feb. 20	,, ,,	Pergat in usu pil. hyd. Pil. aloes c myrrh, gr. x.o.n.	
Feb. 27	,, ,,	Pergat.	
Feb. 28	,, ,,	C.c. ab nucha ad xvj.	
Mar. 1	,, ,,	Hirudines, x. temporibus. Ext. belladon.	
Mar. 3	,, ,,	Emp. Lyttæ nuchæ.	
Mar. 4	,, ,,	Mist. Ammon. acetat. 4tis horis.	

The name on the right-hand space is the Dresser's; and on its left that of the Patient, with her age and nature of her malady. As the medicines are discontinued, they are underlined.

The rice diet seems to be of greater antiquity than is generally believed.

—EDITOR.

QUESTIONS ANSWERED

What dosage of penicillin is necessary in the treatment of the primary stage of syphilis to prevent the subsequent development of neurosyphilis?

The Co-operative Clinical Group in the United States analysed case histories of many thousands of patients treated for early syphilis with the old routine treatment of intravenous trivalent arsenicals and intramuscular bismuth for a minimum of one year. They found that the incidence of neurosyphilis (including those with spinal fluid changes only) was 5—6 per cent. in adequately treated patients with suitable "follow up."

Since the advent of penicillin it is the writer's experience that less than 1 per cent. of patients given adequate treatment for primary syphilis have developed neurosyphilis. On the other hand the early syphilis failure rate) mainly due to mucocutaneous or serological relapse) has been estimated within the range 7—25 per cent, by various workers. A few of these patients if they defaulted and were thus not re-treated might ultimately develop neurosyphilis.

At present in this country most clinics combine penicillin therapy with an additional three months' treatment with trivalent arsenical and bismuth or with bismuth alone. The minimal dosage advised consists of aqueous penicillin G 40,000 units three hourly for 60 injections for In-Patients. For Out-Patients treatment penicillin 600,000 units intramuscularly once daily for 8-10 days is satisfactory.

Some clinics in the United States are even using a single dose of 1.2 mega units of procaine penicillin combined with 2 per cent. aluminium monosterate for the cure of early syphilis. The writer's choice is procaine penicillin 600,000 units intramuscularly for 10 days followed by bismuth oxychloride 0.4 grams (0.3 grams for women) intramuscularly once weekly for 12 weeks.

The spinal fluid should be examined six months and two years after treatment and a careful clinical examination of the nervous system should be made.

If these prove satisfactory it is very unlikely that neurosyphilis will develop in any patient at a later date, but this can only be an interim opinion. We shall have to wait at least another 15 years before a final assessment can be made.

C. S. N.

How efficient is Streptomycin in the treatment of Tuberculous Meningitis?

The most important factor influencing the prognosis in patients with tuberculous meningitis who are treated with streptomycin is the stage of the disease when treatment is started. Vigorous treatment of early cases results in survival of about 40 per cent. of them when followed up for a period of two years. The diagnosis is difficult to make at this early stage so that unfortunately the majority of cases are advanced when treatment is started, and in this group only 10 per cent. survive. The presence of generalised miliary tuberculosis increases the mortality.

The prognosis is also influenced by the method used for the administration of streptomycin. Intramuscular streptomycin alone is unsatisfactory and the best results are given by combined intrathecal and intramuscular injections carried on for a period of at least three months. The majority of the surviving "early" cases are clinically normal and the cerebrospinal fluid returns to normal. About 15 per cent. of the survivors show signs of permanent damage to the central nervous system, the commonest being mental retardation, blindness, spastic paralysis and deafness.

G. W. H.

SO TO SPEAK . . . .

Ventrisuspension?

A twenty-one stone patient recently arrived in W.O.P.s with a letter from her doctor addressed to:

The Doctor,
Abdominal Belt Department.

Heard in the Special Department

"But he looks so respectable . . . " —*A woman student.*

Abstract from S.O.P.s

Q.: "Did you faint?"
A.: "I wasn't conscious of it."

—*A woman patient.*

DRAMATIC SOCIETY: 1950 PRODUCTION

LOT'S WIFE

At the CRIPPLEGATE THEATRE on Thursday and Friday, November 23 and 24. TICKETS by post from the Secretary, St. Bartholomew's Hospital Dramatic Society: price 2s. 6d.; 3s. 6d.; 5s.; 7s. 6d.

RECENT PAPERS BY BART'S MEN

ANDREWES, C. H., and others. Clinical trials of anti-histaminic drugs in the prevention and treatment of the common cold. *Brit. Med. J.*, Aug. 19, 1950, pp. 425-9.

*BADENOCH, A. W. Injuries of the kidney. *Med. Illus.*, 4, Feb., 1950, pp. 53-9.

*BOURNE, G. Embolism in mitral stenosis. *Brit. Heart J.*, 12, July, 1950, pp. 263-4.

BOYD, A. M. (and JEPSON, R. P.). Primary or essential hyperidrosis. *Post-grad. Med. J.*, 26, July, 1950, pp. 371-76.

BREWER, H. F. Marrow aspiration biopsy: technique and indications. *Clin. J.*, 79, Aug., 1950, pp. 208-14

*CAVE, A. J. E. Report on early Bronze Age child skeleton, from Beckhampton, Wilts. *Wilts. Archaeol. & Nat. Hist. Mag.*, 53, 1950, pp. 324-7.

CLARK, W. E. Le Gros. Progress and trends in the science of anatomy. *Brit. Med. J.*, July 29, 1950, pp. 233-8.

*COHEN, E. Lipman. Infections of the scalp. *Brit. Ency. of Med. Pract.*, Interim Supplement, 93, June, 1950.

——. Lepra. *Med. Illus.*, 4, Aug., 1950, pp. 409-10.

——. *See also* MACKENNA, R. M. B., and ——.

DALRYMPLE-CHAMPNEYS. *Sir* Weldon. Ministry of Health Streptomycin Conference. (*Corres.*) *Brit. Med. J.*, Aug. 26, 1950, p. 524.

DICKS, H. V. Education for general practice: the psychosocial factors. *Lancet*, Aug. 26, 1950, pp. 317-20.

*DONALDSON, M. Education of the public concerning cancer. *Brit. Med. J.*, July 1, 1950, pp. 35-6.

DONALDSON, M. Future treatment of carcinoma of the cervix. *J. Obst. & Gynaec.*, 57, June, 1950, pp. 411-4.

*DUNHILL, *Sir* Thomas. Hernia diaphragmatic. *Brit. Surg. Pract.*, 4, pp. 451-73.

*GILES, H. McC. Chloromycetin in scrub-typhus. *Lancet*, Jan. 7, 1950, p. 16.

*FRANCIS, G. E. C. BRAY, H. G., ——, NEALE, F. C., and THORPE, W. V. The metabolism of sulphapyridine containing radioactive sulphur in the rabbit. *Biochem. J.*, 46, no. 3, pp. 267-71.

*FRANKLIN, K. J. The renal circulation. *Proc. Roy. Soc. Med.*, 43, June, 1950, pp. 467-76.

*GARROD, L. P. Chemotherapy—1. Administration of penicillin. *Brit. Med. J.*, Aug. 19, 1950, pp. 453-5.

*——. Acquired bacterial resistance to chemotherapeutic agents. *Bull. Hygiene*, 25, June, 1950.

*HADFIELD, C. F. H. Edmund G. Boyle. *Brit. J. Anæsthesia*, 22, April, 1950, pp. 107-17.

HARRISON, N. K. Photographing pathological specimens. *Functional Photography*, 1, July, 1950, pp. 22-3.

*HORDER, Lord. Favourite prescriptions. *Practitioner*, 165, July, 1950, pp. 5-9.

HOWELL, T. H. Subluxation of the shoulder joint in chronic rheumatoid arthritis. *Med. Illus.*, 4, Aug., 1950, pp. 385-8.

JOHNSON, D. McI. A. G.P. on his clinical training. *Brit. Med. J.*, Aug. 26, 1950, pp. 493-6.

KERSLEY, G. D. Impressions of American rheumatology and recent advances in "rheumocrinology." *Bristol Med.-Chir. J.*, 67, July, 1950, pp. 82-7.

LOXTON, G. E. Recent advances in the treatment of rheumatoid arthritis. *Post-Grad. Med. J.*, 26, Aug., 1950, pp. 447-51.

*MACKENNA, R. M. B. The problem of psoriasis. *Brit. Med. J.*, July 22, 1950, pp. 207-10.

—— and COHEN, E. Lipman. Case for diagnosis: recurrent painful nodules of the limbs. *Brit. J. Derm. & Syphilis*, 62, June, 1950, p. 273.

NICHOLSON B. C., (and GASKING, C. T.). Low back pain associated with abnormal alignment of the posterior lumbo-sacral articulations. *Med. Press*, 5792, May 10, 1950, pp. 450-51.

O'SULLIVAN, J. J. Gynæcological problems of old age. *Practitioner*, 165, Aug., 1950, pp. 141-7.

OSWALD, N. Artificial pneumothorax. *Practitioner*, 164, March, 1950, pp. 249-53.

*PARAMORE, R. H. Vesalius: anatomist (1514-1564). *Brit. Med. Bull.*, 6, no. 3, 1949, pp. 230-231.

*ROUALLE, H. L. M. Malignant disease of the thyroid gland. *Ann. Roy. Coll. Surg.*, 7, July, 1950, pp. 67-86.

RUSSELL, Brian, (and ANDERSON, D.). Protection of the skin from sunburn. *Lancet*, Aug. 12, 1950, pp. 247-50.

SCOTT, R. Bodley. Diagnosis and treatment of pernicious anæmia. *Brit. Med. J.*, July 15, 1950, pp. 157-9.

——. Current therapeutics, 32: Vitamin K and its analogues. *Practitioner*, 165, Aug., 1950, pp. 182-8.

*SHELLSHEAR, K. F. (LAMBIE, C. G., ——, and SHELLSHEAR, J. L.). Arachnodactyly, or Marfan's syndrome. *Med. J. Australia*, Feb. 18, 1950, p. 213.

STALLARD, H. B. A head clamp for orbital operations. *Brit. J. Ophthalmology*, 34, July, 1950, pp. 449-50.

——. Plastic disc for retention of a corneal graft. *Brit. J. Ophthalmology*, 34, July, 1950, p. 450.

*TATLOW, W. F. T., (and others). Lead in relation to disseminated sclerosis. *Brain*, 73, 1950, pp. 52-71.

*THOMAS, B. A. The so-called Stevens-Johnson syndrome. *Brit. Med. J.*, June 17, 1950, p. 1393.

*WHITE, J. S. Clinical aspects of chloromycetin. *Irish J. Med. Sci.*, July, 1950, pp. 326-32.

*WILLS, E. D., and WORMALL, A. Isoelectric points of enzymes as determined by inhibition with suramin. *Nature*, 165, May 20, 1950, p. 813.

*WORMALL, A. *See* WILLS, E. D., and ——.

*YOUNG, F. H. The management of pulmonary tuberculosis. *Brit. Med. J.*, July 8, 1950, pp. 97-99.

* Reprints received and herewith gratefully acknowledged. Please address this material to the Librarian.

SPORT

CRICKET CLUB

SUMMARY OF 1950 SEASON

RESULTS:

Played 29, Won 12, Lost 6, Drawn 11

BATTING AVERAGES

Qualification ten innings

	In.	n.o.	Total	Gr't'st Score	Av.
J. D. W. Tomlinson	14	2	410	74	34.2
M. Braimbridge ...	12	1	282	74	25.6
J. A. Clappen ...	22	2	493	73	24.5
J. P. Waterhouse ...	14	3	228	55	20.7
H. B. Ross	25	1	496	54	20.7
D. G. Hodgson ...	19	0	316	64	16.6
A. G. May	17	3	219	80*	15.6
D. F. A. Aubin ...	19	5	205	34*	14.6
P. G. Haigh	20	3	213	40	12.5
P. B. Biddell	20	1	221	43	11.6

*Not out

BOWLING AVERAGES

Qualification 100 overs

	O.	M.	Runs	W'kts.	Av.
B. N. Foy ...	110.2	31	286	33	8.7
H. B. Ross ...	100	13	293	23	12.7
P. G. Haigh ...	228	30	677	52	13.0
J. A. Clappen	135.2	20	624	45	13.8
B. K. Arthur	178.1	25	514	36	14.2
D. F. A. Aubin	183	35	478	22	21.5

To a loyal supporter these results could only be interpreted in one way: the weather must have been bad.

Many of the draws were due entirely to rain and we like to think that our unimpressive batting figures can be put down to the same cause. As might be expected, our bowling analyses have shown a corresponding improvement. In 1949 the best bowling average was 15.3, whereas this year five accepted bowlers and Tomlison have done better than this.

We were defeated in the Hospitals cup at the second attempt by St. Thomas's at the end of June. After this game our consistent and hitherto unbeaten side became very depleted and for the rest of the season the strength of the team was very uncertain. Work of one kind or another deprived us of the services of Tomlinson, Braimbridge and Foy for the majority of the remaining matches including the Sussex Tour.

The small number of defeats, therefore, does great credit to the captaincy of Clappen in his ability to make the best use of the material at his disposal. Once again he showed himself to be the best all-rounder in the team.

The tour was largely a reflection of the previous year. We won four matches out of six and avenged our former defeat at the hands of Littlehampton.

Most of the successes we gained were due to little and often unexpected contributions from all the members of the team. It would, therefore, seem invidious to pick out any players for special mention but surely two exceptions immediately spring to mind.

First, P. D. Moyes. He has always been one of the stalwarts, and this year he has distinguished himself by being the only person to play in every match in spite of pressing engagements with the examiners. During the season he has conceded only 40 byes compared with 169 let through by our opponents, and has had 39 victims of whom 24 were stumped. Nevertheless, examinations leave their mark on the very best of us and as the season advanced we noticed with deep regret that there was a marked deterioration in the pitch, duration and volume of his appeals.

Secondly, B. K. Arthur, one of our best left arm bowlers. His scores for the season will demonstrate that he was easily our most consistent batsman: 0*, 0, 0*, 0, 5*, 0*, 1*, 0, 2, 0*, 0*. It is on occasions such as these that one fully appreciates the hopeless inadequancy of mere figures. Cold print cannot convey the gratitude we all felt to Arthur as time and again he carried his bat to the wicket to play out the last two or three balls of the match and then carried it back again—having apparently staved off defeat purely by his presence at the receiving end.

The Second Eleven were of a higher standard than at any time since the war and they enjoyed a good season under the able leadership of S. W. Mellows. Their results were: Won 3, Drawn 2, Tied 1, Lost 2.

The Club has been ably served by its hard working Secretary, Harvey Ross, who has at times had to combine the jobs of captain, secretary and treasurer, and done them all very efficiently.

RUGBY CLUB

v. WOODFORD. Sat. Sept. 30th. 1950.

Result—Lost 8—3.

The Hospital played the first game of the season away from home under conditions which were a welcome change from those normally experienced in September.

The team played hard from the kick-off, admirably led by the captain and pack-leader. Bart.'s came very near to scoring in the first few minutes, when a Bart.'s centre exploited an opponent's error and carried the attack to the home side's goal-line.

Territorially, the advantage lay with Bart.'s for most of the first half. The score was opened with a penalty goal by A. J. Third.

Woodford, pressing hard, forced Bart.'s back by some very accurate kicking. They were rewarded by a try scored by their scrum-half, who slipped round the open side of the scrum and scored between the posts. The try was converted by P. D. Hepburn.

The second half was a very equal battle, each side saving difficult situations by good tackling. The pack played vigorously and well. P. D. Moyes hooked the ball in over sixty per cent. of the set scrums, and both wing forwards did grand work in worrying the opposing stand-off half. In spite of very wet, slippery conditions, the handling was good.

During the last ten minutes Woodford gained the advantage due to superior weight, and game experience this season.

An individual forward dribble resulted in a further try for Woodford, immediately before the final whistle. This was not converted.

The team wishes to thank those supporters who encouraged them on a wet afternoon, away from home, so early in the season.

Team:—V. G. Caiger, R. F. M. Jones, J. M. Kneebone, M. J. A. Davies, G. Picthall, K. A. Clare, L. Cohen, J. F. N. Maskell, P. D. Moyse, C. W. H. Havard, A. J. Third, W. Castle, M. V. Fitzgerald, D. G. Dick, R. A. Anderson.

The "A" XV beat Woodford "A" at home by 9—8.

GOLF CLUB

VERSUS ST. MARY'S. Won 3½—2½.

In this match played at Ilford on September 6, the team took revenge for their defeat at Moor Park in the beginning of the year.

Both teams were playing at half strength and the outcome was a question of whose tail would wag the more buoyantly. Whether the result was to be a draw or a win for Bart.'s remained uncertain until the end—J. S. Dodge and his opponent having disappeared somewhere in the gloaming and it was feared that some mishap had overtaken them. However, they did return eventually. Having been all square at the 18th they had proceeded to cut each others throats on the 19th and 20th holes, forgetting in their zeal, that the 18th represents the last hole!

RESULTS: D. H. Rushton lost to P. O. P. Newell 4 and 2; M. Braimbridge lost to A. G. Wells 1 up; C. J. R. Elliott bt. P. M. Forster 1 up; R. E. Dreaper bt. C. K. Hudson 2 and 1; J. S. Dodge halved with T. Gibson; J. P. Waterhouse bt. H. Montgomery 3 and 1.

SIR GIRLING BALL CUP

This competition was played, off handicap, on September 20th, at Sundridge Park golf course. Scores were high, due in the main to a north-westerly wind and the appalling condition of some of the greens in the new course. The cup was won by C. J. R. Elliott, who played very steadily and returned a card of two down on bogey.

Scores were as follows: 2 down, C. J. R. Elliott; 4 down, B. St. John Brown; 5 down, R. V. Fiddian, L. R. Gracey; 7 down, D. H. Rushton; 8 down, J. P. Waterhouse; 10 down, J. Montagnon; No returns—A. B. Lodge, J. S. Dodge, G. Greenhalgh, Blake.

BEVERIDGE INTER-HOSPITALS CUP

The result of the quarter-finals meant that D. H. Rushton and M. Braimbridge would meet L. R. Gracey and R. V. Fiddian in the semi-finals. This match was played at Sundridge Park G.C. on September 26th, and resulted in a 5 and 4 win for the latter. The final will be played at some future date.

FENCING CLUB

During the past season various members of the club put in a great deal of time and energy in practice with the result that though we only had two matches of which we won one and lost the other, we now have the nucleus of a very sound team with which we hope to fight a fair number of matches during the coming season.

One of our members, W. M. Beatley, also brought distinction to the hospital and the university by coming second in foil and third in the sabre in the U.A.U. championships and being thus largely responsible for London's winning of the cup.

During the coming season we hope to see a lot more new faces in the gym during our weekly sessions, especially from Charterhouse, as it is from those members that our future teams must inevitably be drawn.

It is hoped that the London University trials will be held in the Bart.'s gym in October for which some members of the team will doubtless be entering and there should be both hospital and university matches taking place which will be of interest to members of the club.

Later in the season we hope that we will again be fortunate enough to secure the services of our instructor, Prof. Delzi.

ACCOMMODATION WANTED

Bart.'s student and wife (no children) urgently require unfurnished accommodation, preferably in N.W. London area.

Please reply to the Manager of this JOURNAL.

N.A.P.T.

Fifty million Christmas Seals—the largest number ever issued—will decorate letters and parcels this Christmas and, more important still, will be the means of preventing the spread of tuberculosis and of helping those unfortunate enough to suffer from the disease.

The Seals are the gift of the Canadian Tuberculosis Association to the National Association for the Prevention of Tuberculosis in this country for the tenth year in succession. Attractive Christmas cards in similar colours are also available, and a new departure this year—though not especially linked with the Christmas Seal Sale—is the publication of brightly coloured Whist score cards, which may be of interest to social clubs, promoters of whist drives and others. The cost of the Christmas Seals is 4s. per 100, of the Christmas cards, including envelopes, 6d. each, and of the Whist score cards, 10s. per 100, and all can be obtained from the Duchess of Portland, Chairman, N.A.P.T., Tavistock House North, London, W.C.1.

BIRTH

COOPER, on October 2, 1950, at Queen Charlottes Hospital, Hammersmith, to Frieda (née Bell), wife of Dr. J. R. Cooper, a daughter—Monica Frieda.

EXAMINATION RESULTS

UNIVERSITY OF OXFORD

2nd B.M. Examination

Long Vacation, 1950

General Pathology & Bacteriology
Carlisle, I. O.
Special & Clinical Pathology
Hadley, D. L.

UNIVERSITY OF LONDON

General Second Examination for Medical Degrees

September, 1950

Cochrane, J. G.

Ph.D. Examination for Internal Students Faculty of Science

July, 1950

Mulligan, W.

Examination for the Academic Postgraduate Diploma in Clinical Pathology

October, 1950

Ratnavale, W. D. Vogel, L.

SOCIETY OF APOTHECARIES

Final Examination

August, 1950

Medicine
Gould, G. T.
Surgery
Bexon, W. H.

The following candidates, having completed the Final examination, are entitled to the Diploma of the Society:—

Bexon, W. H. Gould, G. T.

CONJOINT BOARD

First Examination

September, 1950

Anatomy			
Carrick, D. J. E. L.	Fletcher, L. O. A.	Jones, A. R.	
Physiology			
Carrick, D. J. E. L.	Fletcher, L. O. A.	Jones, A. R.	Walker, L.
Cuthbert, E. R.			
Pharmacology			
Batey, I. S.	Dreaper, R. E.	Khurshid, M. N.	Page, A. R. W.
Cave, J. D. H.	Gaskell, F.	Lascelles, B. D.	Penty, P. R.
Chia, A. K.	Gompertz, R. M. H.	Leigh, J. G. G.	Poole, G. H. G.
Clappen, J. A.	Hill, A. N.	Lewis, B.	Price, M. G.
Corbet, J. L. M.	Hill, F. A.	Lodge, A. B.	Randall, J.
Cretney, P. N.	Hill, J. J. McL.	Mears, G. W. E.	Stanford, R. M.
Davies, H. T.	Hughes, K. R.	Mules, R. J.	Train, P.

Final Examination

October, 1950

Pathology			
Albright, S. W.	Courtenay, P. H. E.	Jones, K.	Shah, M. C.
Apthorp, G. H.	Cox, W. H. A. C.	Jones, R. F.	Sims, A. J.
Bapty, A. A.	Drysdale-Anderson, R. J.	Leigh, J. G. G.	Smith, D. P. Q.
Barnes, J.	Farley, J. D.	Lumley, P. W.	Taylor, J.
Beattie, A. O. C.	Fildes, P. G.	Montagnon, J. L.	Taylor, W. N. A.
Birch, G.	Fuller, A. P.	O'Sullivan, D.	Thomas, G. E. M.
Bowers, K. E. I.	Hirst, G.	Parrish, J. A.	Trevan, A. C.
Carroll, D. S.	Hodgson, D. C.	Power, G. H. D'A.	Wilkinson, B. R.
Clarke-Williams, M. J.	Holbrook, B. W.	Reading, J. H.	Wilkinson, W. H.
Coldrey, P. A.	John, A. H.	Rosser, E. M.	Williams, D. J.
Connell, P. H.		Scott, A. E. R.	
Medicine			
Corbet, J. L. M.	Horwitz, H.	Richards, R. B. O.	Vickers, R.
Surgery			
Aubin, D. F. A.	Hirst, G.	Montgomery, B. K.	Vickers, R.
Blakeway, I.	Horwitz, H.	Pedersen, D. L.	
Midwifery			
Clulow, G. E.	Hambling, M. H.	Reading, J. H.	Wise, M.
Fildes, P. G.	Power, G. H. D'A.	Wilkinson, W. H.	

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

✓Aubin, D. F. A.	✓Horwitz, H.	✓Pedersen, D. L.	✓Richards, R. B. O.
Blakeway, I.	✓Montgomery, B. K.	✓Reading, J. H.	✓Vickers, R.

APPOINTMENTS

The following appointments to the Medical Staff have been made with effect from the dates indicated:—

Casualty Physician (vice Dr. Bunje)	Dr. M. B. McIlroy	From 1.10.50
Dr. Spence's firm		
Registrar (vice Dr. O. Garrod)	Dr. H. J. B. Galbraith	From 1.11.50
Junior Registrar (vice Dr. Galbraith)	Dr. J. L. G. Thomson	From 1.11.50
Dr. Bourne's firm		
Junior Registrar (vice Dr. Hogben)	Dr. M. Wilkinson	From 1.11.50
Dr. Scowen's firm		
Junior Registrar (vice Dr. Mail)	Dr. H. Lloyd	From 1.11.50
Medical Professorial Unit		
Registrar (vice Dr. Rees)	Dr. R. Marshall	From 1.10.50
Mr. Corbett's firm		
Junior Registrar (vice Mr. Farrar)	Mr. J. G. Jamieson	From 1.11.50
Mr. Hosford's firm		
Junior Registrar (vice Mr. Hurt)	Mr. R. Youngman	From 1.11.50
Surgical Professorial Unit		
Registrar (vice Mr. Robertson)	Mr. R. M. T. Walker-Brash	From 1.10.50
Junior Registrar (vice Mr. Walker-Brash) ...	Mr. J. M. Potter	From 1.10.50
Dental House Surgeon	Mr. J. M. Leitch	From 1.10.50
Anaesthetic Department		
Resident Junior Registrar	Mr. W. J. Wright	From 1.10.50

BOOK REVIEWS

INDEX OF MODERN REMEDIES, 5th Series. 1950. The Scottish Chemist. pp. 86. Price 5s.

This very comprehensive and up-to-date index is an extremely useful reference book, and is meant essentially as a guide to the prescriber and the pharmacist. It supplies the information which the prescriber needs regarding new preparations, pharmaceutical specialities and their manufacturers.

As the range of preparations, which may be prescribed, becomes more extensive, keeping up-to-date entails considerable effort and time, and the conveniently classified information in this index should be of much practical value.

It is not intended as a text-book, but as an aid for quick reference; nevertheless, it is to be commended, and one could only wish that the author had expanded his material more fully.

B. Edwards, M.P.S.

FLORENCE NIGHTINGALE, by Lucy Seymer. Faber & Faber, 1950, pp. xiv+154, Illus. 5. Price 8s. 6d.

Until this year there has been no biography of Miss Nightingale in print, and we needed one badly. How much better than that dimly seen figure of the Lady with the Lamp is the real Florence, a born leader with selfless determination, ruthless efficiency, keen intellect and indomitable shrewdness in handling people. The most intriguing point about her is the "illness" that made her a recluse for fifty years, "often so severely prostrated with illness that her doctors despaired of her life," and yet allowed her to do a staggering amount of work and to die in her sleep at the age of ninety.

Mrs. Seymer throws no light on it, but the dust jacket indicates that the book is primarily for young readers. She has an easy and attractive style, and everyone who heard her give the Florence Nightingale Oration in Atlantic City knows of her sympathy with her subject. Your reviewer regrets that there is no mention of Florence's owl, that used to travel in her muff.

WORTH AND CHAVASSE'S SQUINT, Edited by T. Keith Lyle, 8th Edition, 1950, Baillière, Tindall & Cox, pp. x+319, Illus. 206. Price 35s.

Chavasse's edition of Worth's Squint laid the foundation of our understanding of the physiology of binocular vision, and enabled the treatment of squint to be put on a rational basis.

The book has now been largely rewritten by Keith Lyle and while retaining the fundamental concepts of Worth, the simpler terminology and lucid explanation greatly increase the value of the book to the less advanced reader.

The author's technique of surgical treatment is described and an appendix illustrates the investigation and treatment of eight cases of ocular palsy.

The printing and layout of the book are excellent, and there are a large number of new illustrations.

E. S. P.

THE SULPHONAMIDES, by F. Hawking and J. Stewart Lawrence. Lewis, 1950, pp. viii+390. Illus. 46. Price 42s.

It is fourteen years since the Sulphonamide drugs were introduced into medicine and although they have now been displaced from many of their original therapeutic uses by penicillin and by other antibiotics, it is of great interest to review the changes in the treatment of diseases due to bacteria which were initiated by the discovery of these therapeutic agents. A very considerable improvement in therapy has taken place, and this is now being reflected by a continuous extension of the expected period of life of the whole population.

Drs. Hawking and Lawrence have prepared an interesting little book which gives a good summary of the development of sulphanilamide therapy from both the experimental and clinical standpoints. The book contains an account of the pharmocology and bacteriology as well as of the clinical applications of the sulphonamide drugs. The drugs are compared with penicillin and the present position as to the relative usefulness of these agents is discussed, and a list of references to most of the more important papers is included.

G. A. H. B.

THE PHYSIOLOGICAL BASIS OF MEDICAL PRACTICE, by C. H. Best and N. B. Taylor. 5th Edition, 1950, Baillière, Tindall & Cox, pp. xiv+1,330, Figs. 601. Price 84s.

This book quickly found favour in this country, and now, thirteen years after the appearance of the first edition, it is a standard text-book widely used by students of physiology.

In the new edition an attempt has been made to keep pace with the productive research of the past five years. Much new material has been added, mainly accounts of new work, and some old matter has been removed. In addition, more than 100 new illustrations have been included. These changes have resulted in an increase in the size of the book by 160 pages. The book has now overcome most of the small blemishes that attended the first use of the two-column format in the last edition. The misprints of that edition have been corrected; the illustrations have been better adapted to the new format and, by the use of finer paper, their reproduction has been improved.

One of the virtues of this book has always been the attempt it makes to bridge the gulf between physiology and the clinical practice of medicine. It lays emphasis on the medical applications of the study of physiology, and it is therefore a book which the student will still wish to consult when his days in the physiology department are over. It cannot, however, be recommended as a sole text-book to all students at the commencement of their physiology course. Some would be able to select from it the essentials they then require; others would find themselves adrift in a sea of detail. But if used in conjunction with a smaller text even the junior student should find it useful and stimulating, while to his senior colleague, who already has a grasp of general principles, it should prove of the greatest value.

A SHORT TEXT-BOOK OF SURGERY, by C. F. W. Illingworth. 5th Edition, 1950. Churchill, pp. viii+676, 13 Plates, 233 Figs. Price 30s.

Three years have passed since the last edition of this popular text-book was produced. The surgical advances of these years have necessitated revision of the sections on the surgery of the Blood Vessels and Infections of the Fingers and Hand, and new sections have been added on Pulmonary Stenosis and Portal Hypertension. In addition numerous small alterations have been made. In its overall size the book is little changed and it still provides in a compass of less than 700 pages a well-balanced lucid account of the essentials of surgery.

The preparation single-handed of a book covering so wide a field is no small feat in the present days of specialism. But Professor Illingworth has shown that such a feat is still possible, and that in a short text-book unity of approach to the whole subject can more than compensate for lack of detail in certain parts of it. It is the junior student who will benefit most from this unity of approach, and to him the book can be recommended wholeheartedly.

The illustrations in this edition are for the most part unchanged and include, in addition to many photographs, a number of excellent drawings and diagrams.

MODERN TRENDS IN ORTHOPÆDICS, Edited by Sir Harry Platt. Butterworth, 1950, pp. viii+497, Illus. 222. Price 45s.

This is a book of considerable merit and interest. No attempt has been made to cover the whole field of orthopædics, but in the various sections the authors have concentrated on reviewing the more recent advances in methods of treatment and technique, and have also discussed some of the problems, both new and old, that have still to be solved.

The introduction by Sir Harry Platt reviews the scope of modern orthopædics, the place of orthopædics in the curriculum of the medical student, and the importance of the teaching of this subject being in the hands of experienced orthopædic surgeons. Definite views are expressed on the training of the orthopædic surgeon. Experience in general medicine and surgery is considered essential before he undertakes specialisation in orthopædics. These opinions must receive serious consideration coming as they do from so distinguished and respected a surgeon and teacher. They also fall into line with the present practice in America and various European countries.

In the section dealing with fractures, a brief survey is made of past methods and principles. The present-day view on the process of fracture healing is discussed and a detailed exposition given of the author's method of treatment of "short and oblique fractures with only potential stability" by the three-point action of splints. Finally there is an assessment of various operative methods of internal fixation of fractures, and here an interesting clinical impression is made regarding the undesirability of combining internal fixation with plaster fixation.

Acute and chronic osteomyelitis and tuberculosis of bones and joints is dealt with very completely. Recent views on the indications and technique for the operation of costo-transversectomy and laminectomy in the treatment of Pott's paraplegia are given clearly and concisely.

There are good sections dealing with scoliosis, certain vascular lesions, injuries to muscles and tendons, and paralysis.

The author dealing with injuries and derangement of the spine includes an interesting historical introduction. The relation of degenerative spinal changes and trauma in the causation of chronic backache is also emphasised.

The section on bone dystrophies is excellent and throws new light on the causation and pathology of these puzzling bone conditions. Endocrine disturbances and rare diseases of unknown etiology are discussed and are of primary interest in view of the current importance of all phases of endocrinology.

This book, primarily for those interested in orthopædic surgery, signposts new avenues along which the trend of modern orthopædic thought is proceeding and should stimulate fresh enthusiasm in those reading it.

A TEXT-BOOK OF VENEREAL DISEASES, by R. R. Willcox. Heinemann Medical Books, 1950, pp. 439. Price 32s. 6d.

The publishers claim that this new book "differs from all others in its wide global outlook." It is true that the author has included some account of a number of venereal and allied diseases occurring in the tropics. This section, however, is of little use to students in this country, while doctors working abroad will find fuller accounts of these diseases in text-books of tropical medicine.

A lot of hard work has been done in collecting and arranging all the current medical information, but unfortunately, the style of writing is poor. The book abounds in errors of grammar and construction and many phrases have a journalistic bias, e.g., "upper reaches of the uretha" (p. 12) "venereological armoury" (p. 44) "a new diagnostic test is born" (p.117). Sentences are long (there is one of 89 words) and the meaning of the text is sometimes obscure.

The author has tried to include too many medical details. For instance, mention of gonococcal tonsillitis (p. 56) and syphilitic epididymitis (p. 150) only tends to confuse the reader, if we accept that these conditions exist at all.

All the latest advances in the subject get a mention and the author even makes some predictions for the future, concerning the electron microscope, the Nelson test, and the uses of new antibiotics.

There are a number of incorrect or controversial statements and a few omissions, in the medical text. For example, the reviewer does not agree with the statement that female patients with acute gonorrhœa usually complain of a vaginal discharge (p. 63). There is no mention of fever therapy in the treatment of gonococcal salpingitis.

Too many of the patients photographed as having skin lesions of secondary syphilis are negroes.

This text-book will not prove as useful to practitioners and students as several others published in the last few years.

AIDS TO HYGIENE FOR NURSES, by Edith M. Funnell, 4th Edition. Baillière, Tyndall & Cox. 1950. pp. xii+252. Illus. 14. Price 5s.

This is an enlarged new edition of a useful little book.

STUDIES ON TUMOUR FORMATION, by G. W. de P. Nicholson. Butterworth. 1950. pp. xi+637. Illus. 184. Price 63s.

All pathologists will welcome the appearance of this series of articles published in the Guy's Hospital Reports between 1922 and 1938. The late Professor Nicholson had almost been persuaded to revise these articles for publication in 1948, but death unfortunately overtook him before the revision could be started. It has, therefore, been wisely decided to submit them in their original form.

The rather unusual approach to the subject is the result of much human pathological experience being blended with an outlook which was essentially biological. Certain specific problems in tumour formation are dealt with in the earlier chapters, where theories such as Cohnheim's on cell-rests, Wilms on teratomas, and Grawitz on hypernephroma are severely criticised and finally rejected. The chapter on hypernephroma will prove particularly interesting to a wide public as it gives an excellent history of the views on the nature of this common tumour. The later parts of the book discuss biological principles in relation to neoplasia. Although the final chapter was written about 12 years ago, the fact that Nicholson's opinions have not been invalidated by further discoveries is adequate testimony to his advance in ideas. That the author was also no mean artist is shown by the illustrations, many of which were drawn by him. Although much of the reading is rather closely reasoned and requires concentration, the philosophical approach to the subject is greatly lightened by the frequent references to specimens examined personally. Indeed, in reading some of these accounts one detects a sense of affection existing between the author and his tumours.

This work will be appreciated by all interested in neoplasia, and will serve as a source of information and as a stimulus to pathologists dealing extensively with tumours.

FIFTY YEARS IN MIDWIFERY, The Story of Annie McCall, M.D., by Patricia Barrass. Health for All Publishing Co., 1950, pp. 122. Price 6s.

Dr. Annie McCall was a real pioneer. After studying in London, Berne and Vienna she became medical officer to a Clapham mission founded by "the Prisoner's Friend," Mrs. Susannah Meredeth. A disagreement with Mrs. Meredeth led to the founding of her own clinic and eventually of the Clapham Maternity Hospital and its School of Midwifery. The story of this and of Dr. McCall's work in the fields of antenatal care, especially of the tuberculous patient, of midwives' and post-graduate training, is admirably told in this little book. It suffers a little from being written in the first person by an obvious *devotee*. The publishers have performed a worthy service in its production.

POST-GRADUATE OBSTETRICS AND GYNÆCOLOGY, by F. J. Browne. Butterworth, 1950, pp. vi+544, Illus. 107. Price 50s.

At its title implies this is essentially a book for the trainee specialist. Because this is so, and because the material is derived from lectures, the book has not the continuity which is characteristic (or should be) of the undergraduate text. This lack of continuity is furthered by the omission of subjects discussed in the author's **Antenatal and Postnatal Care.** This means that each chapter is an isolated unit which can be read without reference to the rest of the book; cross references being only to the chapter under consideration. In some cases this means that a thorough knowledge of the subject is presupposed; in others the elementary facts are included. Professor Browne's selection of the topics to be dealt with in each manner is admirable.

The text, as a whole, is a noteworthy example of lucid writing and, whilst the references are by no means complete, the essential ones are present. The author draws his own conclusions from the material set down and although not all of these are acceptable, they are the carefully considered opinions of a master of his art, and as such should be respected.

The format is in the usual Butterworth style—a medium admirably suited to this type of book—and the quality of production is of their usual high standard.

GERMAN-ENGLISH MEDICAL DICTIONARY by Waller and Kaatz. 7th Edition. Allen & Unwin, 1950, pp. 224. Price 10s.

This "handy" little dictionary has been the standby of readers of papers in the original German for some years. It is essentially a specialised medical dictionary, and unless a first-rate command of basic German is possessed there must be few papers which could be mastered without the further aid of a standard dictionary. Nevertheless, it serves its purpose admirably. No more comprehensive and carefully picked selection exists in such small compass. The type is very suitable and the general production and format good.

EYE SURGERY, by H. B. Stallard. 2nd Edition. Bristol, John Wright, 1950, pp. xiii+667, Illus. 550. Price 52s. 6d.

To those who have seen the first edition of this book no introduction or recommendation is needed. Suffice it to say that recent advances in technique have been included; that two hundred and twelve new illustrations (of uniformly high standard—the author's apology is unnecessary) and that certain illustrations, more applicable to war surgery, have been replaced. In all, a better edition than the first—this is high praise.

To those who have not seen the book it should be explained that it is something much more valuable than an encyclopædic compilation of the technique of eye surgery. Rather is it an account of the author's experience which has an individualistic flavour which one rarely finds in modern texts. It includes all the essentials of the subject and is written in much greater detail than is usual.

Messrs. John Wright are to be congratulated on the production.

ST. BARTHOLOMEW'S

HOSPITAL JOURNAL

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STUDENTS SURVEYED

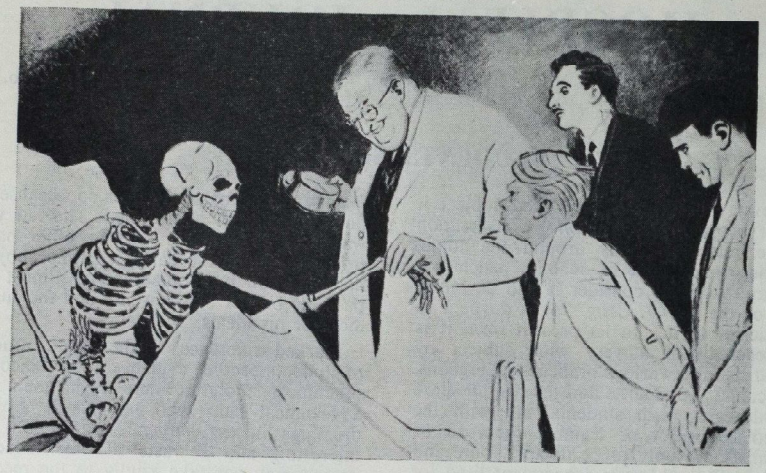
If ever there was a hackneyed subject it is that of *medical education.* Conversation in the refectory hums around the topic, editorials undermine it, leading articles in the national press consider it and an entire issue of the *B.M.J.* (*Aug.* 26) is devoted to a criticism of it. In its present form it is the teaching of a very wide subject by specialists of its various branches. Surgeons, physicians, pathologists and the rest all share their learning with students, not with the immediate object of training them to be specialists but only to be doctors, pure and simple. The subject is departmentalised for teaching and examination purposes and so it must be for organised learning, but before the student can become a good doctor he must integrate what he has learnt and study the amassed knowledge in perspective. Then, if he likes, he can turn his attention again to one or more specialised departments. Such a complicated educational system will always have its knotty problems.

The seed of medical learning presents problems enough, but what of the soil? Medicine is a wide subject and it collects a variegated band of followers. There are the clever and the dull, the keen and the disinterested, the latter usually having been launched on medical careers by over-enthusiastic parents. It is perhaps a pity that some of these still slip through the selectors' nets, though frequently the test of time will either foster in them an interest in medicine or, by killing any vestige of the same, cause them to seek fresh pastures of learning. The would-be doctor is by no means always a scientist at heart. The schoolboy who chooses, say, engineering or languages as his fancied course of study does so because he finds the subject interesting. The lad who wants to be a doctor, on the other hand, frequently finds the early scientific subjects not only dull but sometimes an almost impassable barrier between him and the fulfillment of his ideals.

Marked differences in the mental attitude of students become evident during the course of clinical studies. There is the man with a technical bent who finds such jobs as dressings in the surgical wards both uninteresting and a waste of time. Such a person may not take kindly to the recently instituted practice of bed-making in the Introductory Course. His opposite number is attracted by the possibilities of service to his patients but stumbles heavily over medicine as a science. To one the sympathetic understanding of his patients is a natural gift whereas to another it is a difficult task, slowly mastered. Methods of learning, too, are variable and every student has his own. There are the logicians and those who learn by rote, the clinicians and the "book-boys," the assiduous note-takers in the lecture theatre and their colleagues who merely listen.

From such vastly different material our teachers are endeavouring to turn out one end-product—doctors. New and better methods of medical education will forever be appearing, but though the farming changes, the seed and the soil remain the same. Both are highly complicated in their constitution. The task of training doctors, despite its problems has been and will always be surmountable. It is a gratifying thought that men and women of such different dispositions

and intellectual abilities can master so many varied subjects and take up useful places in our great profession. May the time never come when the competition for students entering our teaching hospitals will be so great as to compel the selectors to demand to see in their applicants a rigid and stereotyped standard of academic or other achievements.



"Look—he's smiling! Wonderful stuff, this streptomycin."
(*Drawn by a patient in Bowlby*)

ABERNETHIAN SOCIETY

The following meetings of the Abernethian Society will be held next term at 5.35 p.m. in the Clinical Lecture Theatre:—

Jan. 18.—Mr. John P. Hosford, M.S., F.R.C.S. (Surgeon to St. Bartholomew's Hospital).

Feb. 1.—Sir Theobald Mathew, K.B.E., M.C. (Director of Public Prosecutions).

Feb. 8.—Sir Allen Daley, M.D., F.R.C.P. (M.O.H. to the L.C.C.).

Feb. 22.—Dr. Martyn Lloyd Jones, M.D. (one time chief assistant on the Medical Unit, St. Bartholomew's Hospital).

The subjects of the addresses and film will be announced later.

ROUND THE FOUNTAIN

The fifth edition of this anthology of verse and prose from the JOURNAL, 1893-1949, was published in December of last year and is still on sale.
Order your copy now. The price is four and ninepence (post free).

THE COMMON COLD AND THE BEACHCOMBER

by C. H. ANDREWES

He had an unkempt white beard and a glassy eye, and altogether he looked decidedly shaky as he hunted for goodness knows what amongst the jetsam on the beach at Pago-pago. He looked as if he'd known better days, so I offered him one of my Liquorice Allsorts in hopes of eliciting his story. I succeeded. "Many, many years ago," he began, "I thought I would solve the problem of the Common Cold. I like a gamble and I knew from the start that it would be either an Earldom or"—he stooped to pick up an over-ripe banana—"this! Well, it wasn't the Earldom. I'm not complaining. My colleagues and I had every chance, including a lovely Common Cold Research Institute down at Salisbury. But the Common Cold was too much for us.

"The trouble from the start was that too much was known about the Common Cold—and yet nothing. Everybody knew that colds could be brought about by sitting in draughts or getting your feet wet. So we tried to put this 'fact' on a scientific basis. We were working with volunteers—human guinea pigs—kept under conditions of strict isolation. We tried to give them colds, or to increase their susceptibility to cold virus by chilling them. We gave them baths and made them stand about in wet passages without drying themselves, till they shivered. We sent them for walks in the rain and made them sit about afterwards, undried. We made them wear wet socks. Did they get colds? They did not. When subjected to these various treatments and in addition given a small dose of cold virus, were their colds any worse or more frequent than those in the controls who were not chilled? They were not.

"It was well-known that colds were 'catching.' So we exposed normal people in a small room to others with colds, to study how the virus got across from one to the other. But did the colds 'jump!' They did not, or only in such small numbers that we could not adequately study the phenomenon.

"People wrote to us and told us what made them catch colds. Still more often they wrote and told us how they could infallibly prevent or cure colds. Sometimes they offered to tell us their secret for cash in advance, but more often their secrets were freely revealed for the benefit of humanity. Unfortunately, all the infallible methods were different. One could, we learnt, avoid colds by eating no meat—or by eating only meat; by nasal douching—or by letting the nose well alone; by sleeping with the windows wide open—or by rigorously avoiding the slightest draught. It appeared that there was almost nothing one could do, or not do, which would not irrevocably keep the Common Cold away. In these circumstances we were puzzled that Common Colds were as common as ever and we were reluctantly compelled to believe that our 200 and more correspondents had not adequately controlled their investigations.

"In some few instances there seemed a *prima facie* case for following up the clues provided. For instance, there were the antihistaminic drugs, hailed in several articles in the American Press as reliable aborting agents for colds when taken within a few hours of onset. It was stated that experiments proving this had been fully controlled. But we, who knew the difficulties, were not happy about those controls, and when we tested two of the most potent drugs for ourselves, the effects on colds were found to be nil. Several other groups of workers reached the same conclusions as ourselves concerning the futility of antihistamines against colds, and we all said so. But did the American public cease to buy the substances from drug-stores in millions of dollars' worth? They did not.

"It wasn't only the untrained man-in-the-street who thought he knew how to avoid colds. The most eminent scientific men told us their personal experiences and were upset when we were not impressed. One day I went rather too far. After listening to such an one, I told him just what I thought. 'Do you realise' I said, 'that in your daily work you try to use scientific methods to reach correct conclusions, but that you are now laying down the law to me about your own snivelling colds on the basis of a few unchecked facts which would make a statistician groan in agony? Do you appreciate . . .?' But I had said enough. This parti-

cular eminent man was really hurt. Unfortunately, he could pull a string or two. He was able to point out in certain quarters that I'd spent a lot of other people's money, one way and another, without solving the Common Cold problem. I lost my job.

"At first I wasn't worried. I confidently advertised my qualifications: 'Knows more than any man living about the futility of current beliefs concerning the etiology of the Common Cold!' Unfortunately this got me nowhere, and gradually I got desperate. One day, in my black despair, I was tempted: I drank a Coca-cola. From there to the beach at Pago-pago the downward drift was inevitable."

He staggered. I saw he couldn't last long. "Quickly" I said, "Give me a message to take to the world about the causation of colds. You may without knowing it hold some important key." "Very well," said the old man, "Here is my creed. I believe that the Common Cold is caused by a virus or group of related viruses. In a civilised community it gets about very freely from one person to another. But we've all met it so often that our immunity to it is pretty high, and we only catch a cold if we either meet an enormous dose of virus or meet it at a time when we are temporarily vulnerable. Because our immunity, in the ordinary sense, is good anyway, I don't believe that vaccines of the ordinary sort will make it any better. In our experiments at Salisbury, we could get about 50% of 'takes' by dropping nasal washings from people with colds up the noses of normal people. These washings must have contained thousands of times the dose of virus which anyone could expect to receive in his nose in real life; yet, nevertheless, the takes were only about 50%. Moreover, the 50% who resisted our efforts were mostly liable, like other people, to get colds every so often; they were just very highly resistant at the time we were testing them.

"Yet in real life people do catch colds after contact with what must be a tiny dose of virus. It seems to follow that at times our immunity temporarily fails and the virus gets behind our guard. What allows this to happen is, in my view, the kernel of the Common Cold problem. My bet is that it's a local breakdown of defence, not a general one, for the debilitated are not necessarily more liable to colds than the healthy. It could be, first, that our chilling experiments gave a fallacious result and that reflex vascular changes in the nasal mucosa, induced by cold feet and so on, cause an upset to our defences. Second, we know that normally a moving carpet of mucus is sweeping backwards all over the nasal epithelium; I suppose cold virus must somehow get through this to start infection. Local drying can temporarily arrest this flow of mucus; perhaps that could give the virus its chance (but I must confess that the few experiments we did to test that hypothesis weren't encouraging). Third, we got some evidence that human serum may contain neutralising activity against the cold virus. The amount of antibody which can get through the epithelium from the blood into the mucus is not great: variation in the amount getting through may determine susceptibility or resistance. There is a hope here that one might increase resistance by some non-specific stimulus which would help the antibody to get out to the place where it is really wanted. Fourth, it may be that so long as, after an infection, virus persists in the nose, one can withstand reinfection, and that when it has gone one is vulnerable again. There is evidence that apparently normal people may carry virus for a time. Probably, however, they can't do so for long, for colds seem always to die out quickly in small isolated communities. Resistance certainly seems tied up with regular contact with virus; else, why should those isolated communities acquire such high susceptibility? Here again is a ray of hope. An attenuated virus, if it could be obtained, might be given regularly, say as a snuff, and keep one's resistance steadily at a high level. Fifth, there may be some explanation we've never even thought of. I wonder now . . .! Could it be? I suppose, Sir, you wouldn't like to volunteer as a subject for a little experiment? No? Ah, well!'

Suddenly he was gone, tottering away from me along the beach. Whether he was looking for coconuts or the cause of the Common Cold, I couldn't tell.

(*Editor's note*: Despite the author's odd and unorthodox presentation of his subject we fancy he means his discussion of the Common Cold problem to be taken with a certain amount of seriousness.)

VIEWPOINT ON MEDICAL EDUCATION

By F. GASKELL

"Stuffing birds or playing stringed instruments is an elegant pastime, and a resource to the idle, but it is not education; it does not form nor cultivate the intellect."
—*Cardinal Newman*, "Idea of a University," 1852.

It has been suggested, rightly or wrongly, that University teachers might learn something from their more humble brethren who teach in schools. Emboldened by this, and fortified by carefully chosen quotations, I venture to express some opinions on a number of educational questions.

One principle which appears to be universally accepted is that the learning process should be pleasurable. Thus Shakespeare wrote:

"No profit grows where is no pleasure ta'en;
In brief, Sir, study what you most affect."

And Wordsworth: "We have no knowledge, that is, no general principles drawn from the contemplation of particular facts, but what has been built up by pleasure, and exists in us by pleasure alone." This would appear to justify attempts to make lectures, for example, more interesting by the use of pictorial aids. It is possible, however, to place too narrow an interpretation on the word "interest." As Quick points out, an occupation may be interesting "either in itself or from some object that is to be obtained by means of it." Hence learning a list of dosages of drugs, although not interesting of itself, becomes interesting if knowledge of the list will ensure success in an examination. The degree of interest, I have found, increases more than proportionately as the day of the examination draws nearer! It is no longer fashionable to regard examinations in this light as a stimulus to promote the student's interest. Yet it appears to be accepted that we should be encouraged to remember facts by saying, "You will find this or that useful when you go out into general practice." These appear to me to be essentially the same motive with the important difference that the examination produces greater exertion.

It is hardly necessary to emphasise that interest does not imply absence of effort. Pestalozzi maintained that "a child must very early in life be taught the lesson that exertion is indispensable for the attainment of knowledge." Newman, writing in terms of university education, put it: "enlargement of the mind consists not merely in the passive reception into the mind of a number of ideas hitherto unknown to it, but in the mind's energetic and simultaneous action upon and towards and among those new ideas which are rushing in upon it." Such healthy exertion of the mind, as of the body, should be attended with a feeling of satisfaction amounting to pleasure.

Similarly, it is widely agreed that there is no true teaching but self teaching. For example, the general aim of the elementary schools is stated to be "to develop (in the children) such a taste for good reading and thoughtful study as will enable them to increase that knowledge in after years by their own efforts." Professor Lauwerys implies in a recent article that a student at the outset of his university training should already be capable of self-directed study. He suggests that this may not always be true. Rousseau, with his usual exaggeration, went so far as to lay down that Emile should not learn science and geometry but should invent them. In that way he would make use of his reasoning powers and would advance only in proportion to his own strength. Whatever reforms may be desirable in medical education, it is unlikely, therefore, that an increase in didactic teaching is required. "Past a doubt the besetting weakness of teachers is 'telling.' They have the knowledge which they desire to find in their pupils, and they cannot help expressing it and endeavouring to pass it on to those who need it 'like wealthy men who care not how they give.' But true 'teaching,' as Jacotot and his disciple Joseph Payne were never tired of testifying, is 'causing to learn,' and it is seldom that didactic teaching has this effect."

Such unanimity does not exist in regard to the details of what should be taught although the general principles are widely accepted. The Goodenough Committee, 1944, stated the broad aim of medical education—"to secure that the main emphasis during the training is on basic principles and methods . . . rather than on the implanting of a mass

of purely factual knowledge." While factual knowledge is admittedly less important than understanding of principles, a background of facts is essential before the student can begin to understand the principles. To serve this purpose the facts must be such as the mind can thoroughly grasp and handle, and such as can be connected together. In view of the recent criticisms of medical education which stressed utility, it should be stressed that the aim is not to give "useful knowledge." It may be that the two aims can be reconciled but they are essentially different.

The Goodenough Committee also recommended that medical education should be related more closely to the practical work which most of the students will ultimately have to do. One of the suggestions which has been made is that part of the student's training should be spent working with an experienced G.P. This would be analogous to the training of a teacher, part of the time being spent working in schools under the direction of members of the staff of the school. But the student is not on that account considered to be competent as soon as he has passed a qualifying examination. In fact, the usual arrangement is that the newly-qualified works for one year "on probation." Only if this probationary period is satisfactory, is he appointed to a permanent post. It is still less to be expected that a medical student should be a competent general practitioner immediately after he has passed his qualifying examinations.

There is a danger in paying too much attention to what is useful knowledge and what is not, that we should forget that, ideally, university education influences the mind in ways which are not at first obvious. Newman described this concept of liberal education nearly 100 years ago. "This then I would assign as the special fruit of the education at a University, as contrasted with other places of teaching or modes of teaching . . . A habit of mind is formed which lasts through life, of which the attributes are freedom, equitableness, calmness, moderation, and wisdom." Dr. Geoffrey Evans must have had something like this in mind when he wrote of "the tradition and atmosphere of St. Bartholomew's Hospital with its teachers, nurses, porters and students." And to this may we add, "an Alma Mater knowing her children one by one, not a foundry, or a mint, or a treadmill"?

THE SMILE

My heart was sad, my spirits low, the day seemed all too long.
A stranger, and alone, I sat, unheeded by the throng
That laughed and sang so merrily, so joyful and so gay.
When all at once my mood was changed—my night turned into day!
A face was turned towards me—she stared, then (this I swear),
She smiled so warm a welcome that my heart lept in the air!
And in a brief five seconds' time the thoughts that filled my brain
Were countless as the rings that form on water in the rain.
"She *welcomes* me! But not because I'm all alone and sad—
There's *recognition* in her glance—she *knows* me and she's glad
That after all we've met again. But who is she? I'll vow
That I have never seen such utter loveliness till now!"
She reaches out a slender hand—I answer with my eyes
And rise to greet this angel that has flown down from the skies.
But even as I stretch my arms to draw her to my side
Stark disillusion freezes me immobile in my stride.
But the thrill of that encounter will still haunt me all the while
For I came so near to Heaven in that *intercepted* smile.

R. C. H. L.

DISCONNECTED JOTTINGS OF A BACHELOR

by ANDREW G. BUTTERS

As I grow older, I find myself wondering if I am missing, or indeed have already missed, the matrimonial boat. The choosing of a wife, if choose is the word to use, can well be likened I always think, to the choice of the ideal picnic spot—you know the sort of thing I mean—you decide to take lunch out with you in the car, you start looking for a beauty spot before it is really time to eat, and although you pass some very pretty ones, as it's rather too early you drive on, and driving on you come to other pleasant places, but you still feel there must be even nicer ones a little further ahead; after all you haven't as yet found the ideal picnic spot, so why not see what's beyond the next bend, and perhaps even the bend after that? And in so doing you drive on past the normal lunch time, but by now having passed so many desirable spots you are determined to wait until your ideal turns up, surely but just around the next corner—the end result of all this is that you find yourself running out of the green and pleasant countryside, and into the dark and dreary city. Alas! you realise all too late that now you cannot possibly find your picnic spot, so your lunch goes uneaten, and you remain hungry and sadly disillusioned. True, you would gladly have stopped at several of the more lovely places way back in the country, but they were already taken, and another car in the same parking ground would not have been welcome.

I think a bachelor can well be likened to a man who has ready access to the public libraries. He is free to enter such libraries, can spend as much or as little time as he likes in looking through the books (most of which, though by no means all, he can take down from the shelves), he can turn the pages over, stopping to read a chapter here, or a sentence there, to admire a picture, or to criticise an etching, and when he becomes bored with one type of book he can replace it with another. As he grows older, however, he cannot command so wide a choice—as his years advance so do the books on their shelves retreat from his groping hand. Then one day he is asked by the Librarian if he would not like to select a book to take home with him, and to keep as his very own for all time, as obviously he is so very keen on reading, having spent so many hours in going over and looking through so many of the volumes on so many of the shelves. How nice it would be, the Librarian goes on to say, to possess your own book of your own choosing, to be your constant companion—a book to have at home by the fireside or upstairs in bed at night—one which you would never tire of reading—how much nicer, and how much more satisfactory, than having to come into the public library every time? But of course, the Librarian adds, once you have taken a book for your very own, you will not be able to come any more into the libraries, and never again will you be allowed to remove, even for a minute, any of the books still remaining on the shelves.

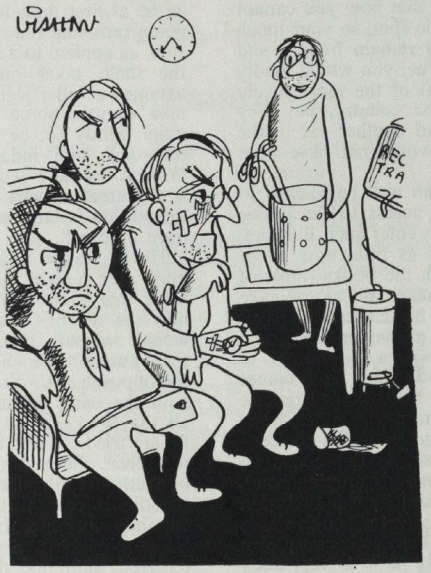
Now I, in common with many a single man, would very much like his own book, but am undecided as to which one to take—it is truly a big decision to make — once made there is no chance of changing first from one book, then to another, as is the case of the bachelor, who finds that after all the story is not turning out so enthralling as he at first thought. In view of the foregoing rambling remarks, the age old expression, as applied to a spinster, of being left on the shelf, takes on a new meaning and assumes a fuller significance; make no mistake though, some volumes will not, and quite rightly so, be taken down from their respective and indeed respectable shelves. What is woman? The saying goes, "Woman is the greatest work of the greatest author, the edition is large and every man ought to have a copy."

Having taken unto oneself a wife, there must ever remain the danger of discovering some one even more desirable, though by now the die has been irretrievably cast. I would compare this to the once in a lifetime purchase of an expensive fur coat by the opposite sex. You are doubtless familiar with the usual technique—for long enough all the fur coats at all suitable are looked at, are tried on, and are weighed one against the other. Several are suitable, but none is perfect. At long last the decision is made, the die is cast, the coat is bought. It is certainly very nice, but does not quite fulfil all requirements, nevertheless it is warmly received until one day in a shop window appears a fur coat which exactly fulfills (or

so it seems) the ideal which had always been in mind, but which up to now had, despite many an effort, remained unseen and thus undiscovered. But now, alas, it is too late, this coat of perfection cannot be purchased. The tragedy is that the coat which has already been bought is no longer worn with so much pleasure and delight, and thoughts of that other and more attractive coat (chiefly perhaps because it is unobtainable), are ever present.

I find there are married men, I suspect somewhat "henpecked," who tend to overemphasise the unhappy lot of a single man, saying what a miserably lonely life we lead and that we really must knuckle down and get on with things. They add how very much they would like to see all bachelors married. I usually reply by saying that as married men they are possibly a little jealous of our freedom and so desire to apply the matrimonial brake. Perhaps tho', bachelors would feel the same if, for example, they were to contract a long-standing and unpleasant infectious disease which necessitated irksome restrictions as well as partial isolation from their fellow creatures. After a time how galling it would be to know that those more fortunate were free to do as they pleased and to go where they wished, regardless of restrictions—would it not be only too human to envy the latter and possibly even play with the idea of passing the disease on to virgin soil?

Now from the above you must not think I am a confirmed bachelor, far indeed from it, and I am still hoping one day to have my own library book in my own home, though I must freely admit I am long in choosing my picnic spot, and the hour grows dangerously late, and the town gets dangerously near at hand. I am also fully aware that for me many of the books have always been beyond my grasp, and now in the twilight of my bachelor days, on looking up at the shelves, I see that most of the volumes have their backs turned to me.



"He should be here any moment now."

FRIEND OF THE BOSOM

by E. A. BOYSE

Long ago my mother said that one day my taste for eccentric companions would get me into trouble, and so it did indeed. And yet if the little dark man had not possessed the peculiar habit of resting his saucer on the out-spread periphery of his beard I dare say I should not even have noticed him.

"Don't you find you tend to collect the crumbs from the table by doing that?" I enquired, placing my own cup of tea on the remaining exposed portion of table and drawing up a chair.

"When THE DAY comes" was his gambit, "table-cloths will all be swept away together with all the other class-symbols of the bourgeoisie."

And so our friendship began—one I may say which became closer each time we met. Until that awful day (I can hardly bear to write of it), when *it* happened. We had been meeting daily at the tea-shop for some time and our mutual attraction had greatly increased. I was tired on this particular day and therefore was not unduly surprised to find some awkwardness in rising from my chair when the time came for me to take my leave. He evidently experienced much the same sensation for he lurched rather clumsily after me as we went to settle the bill. We bade each other good evening at the door but when we turned to walk off we found ourselves unable to move from the spot! Tentatively at first, and then with rising panic we tugged this way and that when, happening to pull in the same direction, we were suddenly precipitated into the street. We stumbled a few paces and walked on with a common heading.

Slowly the truth was dawning upon me. "Comrade," I said (for he had converted me to the Faith), "I fear we have become *inseparable*!" His reaction to this was alarmingly favourable and he began to dwell at length upon the virtues of communal ownership of both the necessities and the luxuries of life. My misgivings grew as we approached my somewhat richly appointed house. (I contrived to drop the key of the wine cellar into the long grass as we walked up the drive.)

Now I shall always maintain that my wife behaved most unsympathetically over the whole affair. "But my dear" I tried to explain, "I can't get *away* from the man." She was not consoled: it was all *my* fault. Without waiting for a dissertation by my companion on citizens' relationships in the New State she packed a depressingly adequate trunk and went home to Mother.

In the week which followed my hopes for an early release from this entanglement faded into despair. The more repelled I became by his now loathsome proximity the more he insisted that he was becoming increasingly drawn to me. Then the gardener returned the key of the wine cellar to me and I resolved to have it out with Smith. (I had dropped all that "Comrade" nonsense by this time.)

"Smith," I told him, "this is the end, we must part."

"Ah, but Comrade!" he mouthed through that scurf-ridden beard of his, "we can't break it off just like that."

"Oh yes we can" I replied, hotly and very firmly. "Fiddlesticks to Stalin and all his works;—all those frightful meetings you force me to attend, with everyone blathering about moiling and toiling when they've never *seen* an honest day's work let alone *done* one,—ugh! Besides, it's ruining my health; with your disgusting fitness, I get positively winded every time you run up the stairs. And moreover our bath isn't big enough for two."

Well the upshot of it was that we went to see my doctor. He produced a second form when I told him the object of our visit and announced that his fee was two guineas,—(each). He asked a lot of tom-fool questions:—was it congenital?—had I noticed anything amiss with our water?—and so on. Then he performed a long examination. "With the exception of the nits in your friend's beard I can find nothing organically wrong," was his finding, "nor can I hold out the slightest hope that your relationship can be severed surgically. It's undoubtedly functional. You had better see a psychiatrist."

The psychiatrist we visited grasped the situation at once. Vainly I tried to explain that it was only *I* who wanted a consultation. In that case, he insisted, my partner must leave the room. So I had reluctantly to pay a double fee once more. As he opened the

door for us on my way out he whispered into my ear "Your only hope is to insult him deeply."

But the insulting of Smith proved no easy matter. To all conventional approaches,—physical, mental, spiritual, sexual and antecedent he seemed quite unresponsive. In vain I showered upon him hailstorms of eloquent invective. At last, when I had all but given up hope I hit upon the right formula quite by chance. It was while he was "sharing" the last bottle of my finest Bordeaux that I flung at him bitterly, "Comrade, my foot, why you're nothing but a,— a,— social parasite."

I could see he was hurt. He remained silent the whole evening and even forgot to grease his beard that night. Next morning he was noticeably distant;—I checked it with the tape-measure. After that it was plain sailing. We drifted further and further apart. As soon as we could inhabit separate rooms I made careful calculations based on Animal Magnetism and the Inverse Square Law and gave the butler instructions to have him thrown down the steps into the area.

I still feel distinctly uncomfortable when I hear that wretched tune "I'll Walk Beside You," and I continue to receive pestering postcards from Smith suggesting a reunion, but on the whole I consider myself quite recovered. But, believe me, it will be a long time before I form another attachment of that nature.

SO TO SPEAK . . .

From a "General Interest" Film

. . . further research in electronics disclosed a method of converting sound into audible impulses.

Starting Early

. . . What did the doctor mean when he said to the nurse that my baby had a fickle heart and that his head was engaged? He isn't the sort to make jokes or I'd have thought he was just being funny.

From the correspondence column of a women's journal.

On Examination

Heard towards the end of a long sequence of irrelevant negative findings in a man aged 50.

1st time clerk: ". . ., and I thought the umbilicus was rather low, sir."

Chief Assistant: "I suppose that precludes a pregnancy or an ovarian cyst."

Differential Diagnosis

"You can always mention syphilis. It causes everything except nystagmus."

Medical Out-Patients.

BART'S REVISITED

JUNE 1976

by VISHNU

I hadn't long to stay in London and I decided to revisit my old hospital of which I had such happy memories. I hoped to meet the Dean and those others among my teachers who were still there. My days at Bart.'s were what would strike the modern man as being anarchic and archaic in the extreme. Human assets like common sense were valued. The Dean admitted students when he liked the look of them. He thought that if they were not totally lacking in brains and were reasonably interested in medicine and in their fellow men they might make good doctors. Some did, others didn't. However he never relied completely on scientific investigations.

On reaching there I discovered that there was a new Dean and that he was very busy that morning engaged in interviewing applicants for admission to the medical school. I was trying to decide whether it would be worthwhile bothering him when he opened the door and said,

"Next please . . ."

I was about to explain who I was but he interrupted me, saying,

"Don't tell me your name. For our purposes you will be 10237 until you leave us at the end of your medical studies, that is of course if our scientific investigations prove that you are a suitable chap on whom the state can risk wasting its resources . . ."

I realised the awful predicament in which I found myself but he wouldn't let me explain. He went on,

"You mustn't talk to me except to answer the questions I put to you. Otherwise it may prejudice me one way or the other about your personality. That factor we would prefer our psychologists to assess. We endeavour to consider you as a unit. You look a bit above average age for the course which as you know now extends over 25 years. The last three years as an intern are frightfully important. Why do you want to come to Bart.'s?"

I thought I would try and humour him and said that I thought Bart.'s was the best hospital in London. Contrary to what I expected this remark seemed to displease him and he said,

"You hold imperialist bourgeois ideas about the standards of our state medical education. If you read the Ministry publications you will know that the standards of teaching at the different medical schools are high and maintained at an equal level. No one hospital is better than another. Our ministry has seen to that." He looked up admiringly at a life size portrait of a past Minister of Health. Having done this he took another look at me and said,

"You look reasonably fit. Now off with your clothes and let our Registrar of admissions examine you."

He had hardly said this when a bespectacled registrar walked in, percussed my chest and while he smartly performed a liver biopsy said,

"You will have to undergo a short series of special investigations."

I had to submit to these during the course of the next three days. They included:

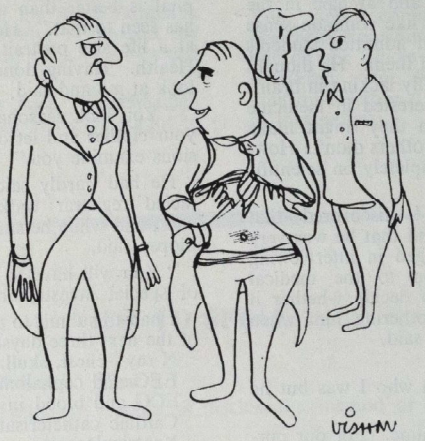
X-ray—chest, skull, abdomen and joints,
EEG and cephalometry,
ECG and blood investigations.
Cardiac catheterisation,
Ventriculogram,
Bronchogram and bronchoscopy,
Gastroscopy and occult blood in stools,
Throat swab, blood culture and blood tests.

After this I was interviewed by a panel of psychodiagnosticians who extracted my secrets under thiopentone and made me submit to an I.Q. determination. They studied my cephalometry results and EEG's. At the end of these investigations I was summoned before the selection committee presided over by the Dean. Apparently they had already studied the results of my investigations, for the long table at which they sat was cluttered up with them. The Dean rose and said,

"I am sorry 10237 that we had to perform so many investigations on you. We do that as a routine on all applicants. Our admission registrar has shown your results to the statisticians who believe that you will not outlive the course of medical studies here but that is not the point on which we are forced to reject you. It is far more serious

one. The psychodiagnosticians assure us that the study of your EEG's and cephalometry recordings show that you are predisposed to a psychosis and it would therefore be a waste of our state's resources to attempt to teach you. Have you anything to say?"

"Yes," I said, my cheeks colouring. "Bart.'s isn't the same cheerful and happy place that I knew when I left after qualifying in 1951." My remarks shocked the members of the Committee who shifted about uneasily beneath the portrait of the Minister of Health.



"The pain is worst over here, Mr. Cutter."

ERUCTO AD ABSURDUM

Coriander, caraway, betel, fennel, dill,
Peppermint and ginger, and aqua camph. destill,
Cinnamon and cajuput, rosemary and myrrh,
Bachu, chalk and nutmeg, and oil of lavender.

Oils of eucalyptus, of sassafrax as well,
Lemon, pepper, juniper (hear the dinner bell),
Cardamoms and spearmint, pimenta, aniseed,
Balm and cloves and orange are very nice indeed.

Many are the simples we have mentioned here by name.
Are the ailments many that are remedied by same?
Sad to say they're not, sir! Tho' pick of nature's garden,
The only action of these drugs is "hup b-r-r-r-p, pardon!"

R. V. F.

QUESTIONS ANSWERED

What is the present treatment for pernicious anaemia?

The aim of treatment in pernicious anaemia is to restore and preserve a normal blood picture. For this purpose normality may be defined as an erythrocyte count above 4,500,000 per cu. mm., a haemoglobin level above 95% (Haldane), and a mean corpuscular volume below 100 cu. micra.

The patient should remain in bed during the initial treatment until the haemoglobin level has risen above 65% (Haldane). Specific treatment consists of the administration of the anti-anaemic principle: this is best given by parenteral injection and the most satisfactory results are obtained with either refined liver extract or vitamin B_{12}. The dosage of the former depends on the preparation; but one or two c.c. is the usual amount required weekly in the initial stage; the weekly dose of vitamin B_{12} should be 20-40 micrograms.

When normal blood levels have been reached, a maintenance dose must be given. This varies between 2 and 4 c.c for refined liver extracts and 40-80 micrograms for vitamin B_{12}. Regular examinations of the blood are an essential method of controlling treatment. If there is evidence of neural degeneration at least double the doses recommended must be used.

R. B. S.

What are the present views on the aetiology and classification of cystic conditions of the lungs?

Cysts of the lung may be single or multiple, unilateral or bilateral and may contain air or fluid or both. Those arising by distention of fluid are unusual, but hydatid disease provides an obvious example; much more frequently they contain air. Pathological examination reveals that almost all are regular and circular in outline and contain no fluid or solid; their walls are smooth and incompletely lined with bronchial epithelium which may derive from their bronchi of origin or represent an overgrowth from neighbouring bronchi. One or more bronchi may be seen entering each cyst and these are usually diseased and often enter the cyst at an acute angle. Many theories have been put forward to account for such cysts and there now seems no longer to be any doubt that they arise mainly as a result of differences in calibre of the bronchi during respiration. The bronchi actively dilate during inspiration and passively relax during expiration so that, in the presence of partial bronchial obstruction, air can pass more freely along them in inspiration than expiration. Hence, air will always tend to accumulate beyond a narrowed bronchus; this is classically seen in asthma where a cushion of air forms in the alveolar bed. If such distension is sustained, atrophic changes are likely to occur with loss of pulmonary substance and the formation of an air space or cyst. The walls of the terminal bronchi, bronchioles and alveolar ducts are fragile and readily succumb to such pressure, giving rise to the commonest variety of pulmonary cyst, the emphysematous bulla; these occasionally become enormous and may occupy the greater part or the whole of the hemithorax. Larger bronchi distend less readily, but occasionally segmental or lobar bronchi are distorted by a long-standing lesion such as a tuberculous stenosis or bronchial adenoma leading to the replacement of the segment or lobe distal to it by a cyst or cysts.

Local distension or ballooning of the lung occurs in a variety of clinical conditions. If radiographs are taken during the stage of resolution of ordinary lobar pneumonia in childhood, a thin-walled cyst is often seen which may persist for several months and then suddenly disappear. In staphylococcal pneumonia there may be several cysts, possibly representing inflated lung abscesses. Tuberculous cavities may suddenly distend, the so-called tension cavities, which occasionally rupture into the pleural cavity.

A term which is commonly used, with singularly little justification, is "congenital cystic disease": it denotes one or more thin walled cysts for which no obvious cause can be found. Pulmonary cysts are extremely rare at birth and there is good reason to suppose that the vast majority of this sort are acquired: to say that a cyst is develop-

mental in type is occasionally permissible but to infer that it was present at birth is unreasonable. The word "congenital" in this connection should be abandoned.

Cysts may develop as part of a bronchiectasis, usually towards the periphery of the bronchial tree. The mechanism of their production is by no means certain, but it is probably related in part to bronchial obstruction and atelectasis; there is probably also an individual factor or weak point in the bronchial tree of many people which, in response to stress, may lead to cylindrical bronchiectasis, saccular bronchiectasis or cystic bronchiectasis. As Tudor Edwards said, bronchiectasis is rather like varicose veins, some people get it and some don't.

N. C. O.

CLINICAL CASE-BOOK

CARDIAC RHEUMATISM

Mackenzie has said "the purpose of a patient in consulting his doctor is to find out what bearing his complaint has on his future. The patient may not be able to express it and his ideas may be confused, but what he is in fact afraid of is that his heart may fail. He demands of his physician that he shall tell him whether or not his present symptoms indicate heart failure or foreshadow its occurrence. This then clearly is the imperative question you have to answer as regards every case with an affection of the heart."

Miss K., aged 14, at school.

PRESENTING SYMPTOMS in March, 1949.

For one month, dyspnœa and palpitations on climbing one flight of stairs.

For three weeks, pain in left chest aggravated by coughing, night sweats on two occasions and vomitting on two occasions.

For one week, cough.

H.P.C.

5 years ago, in bed for 1 month with "growing pains" in chest and loin.

6 months ago, rash, hair falling out, loss of weight and poor appetite.

F.H. No rheumatism.

O.E. General appearance of lassitude.

HEAD and NECK. Fauces injected, mucous membranes pale, trachea central, no venous engorgement.

CHEST. Incipient clubbing of fingers. Few râles at both lung bases.

A.B. 4 inches from midline, ¼ inch outside M.C.L.

Apical presystolic crescendo, diastolic rumble and a blowing systolic murmur conducted to axilla.

Aortic systolic murmur.

Pulmonary second sound accentuated.

Pulse regular. 80. B.P. 90/50

ABDOMEN. N.A.D.

LIMBS. N.A.D.

Patient was afebrile. Weight 5 st. 10 lbs.

SPECIAL INVESTIGATIONS.

Hb. 64%, E.S.R. 38 m.m. Throat swab gave a growth of streptococcus viridans.

E.C.G. showed right ventricular preponderance and/or carditis.

Screening showed left ventricular enlargement with apex in the mid axillary line. Prominent pulmonary conus.

Barium swallow showed enlarged left auricle.

DISCHARGED May, 1950. Hb. was 86%. E.S.R. 4 m.m. Hb. within M.C.L. No sign of failure. Patient looked cheerful and well. The prognosis appeared fair.

SUBSEQUENT COURSE.

At convalescent home there was a gradual improvement in exercise tolerance but she continued to cough and did not gain weight. In August she was allowed to play tennis for 4 days. She could serve one ball and return it, then had to rest for 5 minutes. She became increasingly dyspnoeic especially after coughing and she was returned to bed. Cough became productive and the sputum was occasionally streaked with blood. She had a dull ache in the knees and elbows.

X-RAY showed an enlarged cardiac shadow and pulmonary congestion. The pulmonary congestion subsequently diminished; the heart, however, continued to enlarge.

READMITTED TO BART.'S in September, 1950. She had cough, dyspnoea on walking on the flat, orthopnoea and poor appetite.

O.E. Mitral facies; appeared tired and depressed.

HEAD AND NECK. Mucous membranes good colour, fauces not injected, no venous engorgement, trachea central.

Slight clubbing of fingers.

CHEST. Movements = poor. At both lung bases the P.N. was impaired, T.V.F. absent, breath sounds diminished, and moist râles present.

C.I. 4½ inches from midline 1 inch outside M.C.L. in 5th space.

Apical systolic crescendo and faint diastolic rumble, systolic blowing murmer.

Aortic systolic murmur.

Pulmonary second sound accentuated.

Pulse regular 120.

Afebrile.

SPECIAL INVESTIGATIONS.

Hb. 88%, E.S.R. 27 mm., throat swab showed the presence of streptococcus viridans and Lancefield Group A streptococcus.

E.C.G. showed right ventricular hypertrophy and/or carditis.

X-RAY showed enlarged heart with pulmonary congestion of both lower lobes.

Points of Special Interest

1. The prognosis has become poor. Is the marked increase in heart size due only to progressive mitral valvulitis or is there also active myocardial rheumatism? The pulmonary symptoms and signs suggest mitral stenosis and the left ventricular enlargement myocarditis. In addition the recent pains indicate still active rheumatism.

2. Action of digitalis on the rapid regular heart. Digitalis is useful to reduce tachycardia and to increase cardiac output in patients with tachycardia with normal regular rhythm who also have active rheumatism. Two weeks before digitalis was given (0.5 mg. daily) the average heart rate was 120. 2-3 weeks after this the average rate was 80.

I wish to thank Dr. Geoffrey Bourne for permission to publish this case and for his helpful criticism—L.F.

This Clinical Note is the first of a new series to which students are invited to contribute. Persons wishing to present cases in this way should see MISS LORE FELDBERG.

STUDENTS UNION BALL

The Annual Students' Union Ball will take place at the Dorchester Hotel, Park Lane, on Friday, January 26, 1951, from 8.30 p.m. until 2 a.m.

Double tickets are £2 10s. and can be obtained from the Hon. Sec. Students Union.

NOSOPHOBIA ?

Following some correspondence in the *B.M.J.* about smoking as a cause of carcinoma of the lung the cash realised from cigarette sales in the Refectory fell from £8 in a week to £2.

CORRESPONDENCE

AUTHOR UNKNOWN

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

Dear Sir,

During the summer we had the pleasure of showing Dr. L. P. Ereaux, a distinguished dermatologist from Montreal, some of the work being done in this department.

He left behind for our edification the following poem, but could not tell us who was the author or where the poem was originally published.

I would be very grateful if any of your readers could tell me where I can find the original.

Yours sincerely,

R. M. B. MACKENNA.

Dermatological Department,
St. Bartholomew's Hospital.
October 10, 1950.

THE SKIN MAN

Some may sing the Surgeon's skill—he wields a wicked blade,
While not a few prefer G.U.—('tis not a tidy trade);
Pure science has her accolytes—a brave, devoted band;
But I'd rather be a Skin Man, and with the Skin Man stand.

Outside the Throat Room's dreadful door the knitting women wait,
While still unseen the Guillotine keeps up its ghastly gait;
Like plums upon the dewey grass the tender tonsils fall—
But neither they nor adenoids intrigue my thought at all.

The Skin Man never is aroused as breaks the morning pale,
By vehement parturient or ailing infant's wail;
Nor is he snatched from Morpheus' arms, from some delicious dream
To aid some old prostatic case who cannot start his stream.

Behind his broad expanse of desk—mayhap of tropic teak—
He views the rash and takes the cash—and does it week on week.
His mind is calm, his spirit blythe, his future is assured,
For though his patients oft come back, they're never quickly cured.

With ointments bland he tries his hand to soothe—but ere too late,
If soothing makes them worse again, then he can stimulate;
If stimulation aggravates, his course runs ever smooth,
For he can cease to stimulate, and start once more to soothe.

No paladin of Arthur's age, no gleaming dressed knight
Of old romance had such a chance his lady to delight;
For him that blush of damask rose, for him that downcast eye,
Who drives the ringworm from her cheek, the itch-mite from her thigh.

The lady fine, the concubine, the virgin and the priest
Discard their pants in Bacchic dance—from lues now released.
Tabetic and paretic in Corybantic maze
Surround the guy that got them by, and raise their songs of praise.

So farewell dermatitis, from you forever free;
Goodbye the bugs that bite us—the louse, the tick, the flea;
Oedema, erythema, and pruritus ani too;
Like driven snow from head to toe—we bid you all adieu.

LECTURES

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

Dear Sir,

We have recently been regaled with an editorial on the standard of lectures at Bart.'s, and two letters on seating accommodation. Like others, I have wondered whether a good part of the criticism was surely, unfair and dishonest, and the rest grossly exaggerated. I felt certain that in the intervening period others would have taken up the cudgels, and so I trust Mr. Editor you have not been abusing your prerogative by prohibiting opinions opposed to your own!

On the subject of lectures it has *not* been the case of an odd lecture or so being interesting or useful, but, rather that the very great majority have been well worth attending. Only the occasional has been of sufficient note to deserve your laboured censure. The only lectures I can recall in the terms you describe were on such subjects as Pharmacy and Public Health, dull subjects to most of us. It is hardly what your editorial implied. Who, searching his conscience, would not admit that lectures given at Bart.'s are well worth the trouble we take to attend them; witness the huge attendances amidst the much vaunted seating discomfort at the lectures of any, aye, any of the heads of firms, assistant chiefs, Professors and their minions. I think our teachers may justly regard your editorial as impertinent, but I hope will think of it in the light of your youth, inexperience, and status pupillaris.

As for the remarks on seating accommodation in the Practical Surgery Room, they are unfair, because, obviously the architect must have been severely limited by building restrictions, plus the need to accommodate the largest number of students in the smallest possible space IN THE QUICKEST POSSIBLE TIME. Would your correspondents dispute this! Whether notes should be taken or not at a lecture is quite arbitrary and varies with each student, lecture and lecturer. Your correspondents Messrs. Fitt and Winston certainly ascribe high motives to the architect. Perpetuation of mediocrity my foot! Not wishing to ingratiate myself with either our teachers or you Mr. Editor, I take the liberty of signing myself,

Yours faithfully,

HUMANUM EST ERRARE.

Abernethian Room.
October 6, 1950.

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

Dear Sir,

Those who have followed the recent correspondence on Lecture Accommodation may be interested in this excerpt from the *Memorials of John Flint South.*[1] The year referred to is 1814 and the lecturer, John Abernethy.

"When I attended the surgical lectures at St. Bartholomew's they were given in a small amphitheatre, most inconvenient for comfort—or rather, comfortless—as the seats were without rails, and therefore each ascending row of students received the knees of those above into their backs, whilst they thrust theirs into those of the sitters below. Here also the theatre was crowded before the lecture began, . . ."

Plus ça change?

Yours etc.,

C. P. WENDELL-SMITH.

The Abernethian Room,
St. Bartholomew's Hospital.
October 27, 1950.

[1]Feltoe, Charles Lett. *Memorials of John Flint South* [etc.], 1884.

EXAMINATIONS

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

Dear Sir,

As a former teacher of Physiology, I should like to suggest that a reprint of the admirable paper under this title in the October number be given once, preferably twice, to all students during their years at the Hospital.

One cannot over-emphasise the importance of reading the questions before answering them. In every examination room one sees some candidates scribbling frantically before they have had time to read even one question carefully. The most unpleasant viva I ever had came from an enraged anatomist to whose question on the third ventricle I had replied with an elaborate description of the fourth.

If one reads through all the questions first, as one should do, and then begins to answer one of them, points about the other answers will keep bobbing up in one's mind. I have always advised students to have a spare sheet of paper at hand and to note these points down; they come in usefully especially towards the end, when one is getting tired.

The over-self-possessed candidate must be an even greater trial to the examiner than the over-nervous one. At a Primary F.R.C.S. viva a candidate misunderstood, either actually or intentionally, a question put by the examiner, who thereupon worded it differently. The candidate replied, in a most irritating drawl, "Ah, *now* I see what you're trying to ask me." This kind of thing is enough to try the patience of any examiner.

Candidates should remember that examining is very exhausting work for the examiners. At my own Conjoint Surgery viva, rather late at night, one of the two examiners was fast asleep, and the other (a famous mountaineer, and a man not easily tired) was, with his head only a few inches above the table, almost in the same happy condition.

If one is asked, at a viva in what used to be called "Chemical Physiology", to identify a spectrum, one must not, as did a friend of mine, hold the pocket spectroscope vertically and pour the contents of the test-tube into one's eye.

One must not be alarmed if, especially in the more theoretical subjects, an examiner at the viva asks rather queer questions; this may mean only that one's paper is all right, and he is just filling in the time pleasantly, as a good host should do. At a viva in Public Health and Medical Jurisprudence I was asked only two questions, and could only reply "I don't know" to both; they were "Is there any known case of typhoid in a cow?" and "If you want to take a patient to a fever hospital in a cab, can the cabman refuse?"

Some caution may be necessary in discussing their experiences with students after the exam. One of my men complained to me of hostile treatment in the Primary F.R.C.S. viva by an examiner whose name he did not know. I said "That sounds like S. Was he a villainous-looking man, like a parrot?" "No," the man replied, "it wasn't S. I know S. He's my uncle."

Candidates should always remember that the great majority of examiners want to help them, and that all examiners have been examinees themselves, and that the chief object of the viva is, not to trip up those who have done a satisfactory paper, but to give another chance to those who have not done so.

E. L. KENNAWAY.

October 21, 1950.

THE ANATOMY OF MIDWIFERY

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

Dear Sir,

The charming article by Mr. Reginald Vick reminds me that when I faced the Examiners first for my "Midder" Exam. I was given a Cadaver and a Leather Foetus, and a Box of varied forceps and other instruments, and was bidden to deliver a baby by forceps.

I had never either delivered one, nor assisted in a forceps delivery.

Bravely, however, I selected two halves that fitted each other, and proceeded with the left hand to pass the forceps per Vaginam, and with the right hand to adjust each blade to the head of Foetus which was in vertical presentation.

After some clumsy hand work I delivered the Foetus triumphantly.

The Examiner Dr. Lewers quietly, coldly, and with staccato pronunciation said "Let me see, you are Oldfield of Bart.'s. Perhaps you do not know that during parturition a woman's abdomen does not open. Good morning, Oldfield."

At that time I was already a Barrister and therefore appreciated to the full the delicate but cutting irony of the reproof and could only reply "Thank you Sir, I will do better next time."

Next time I knew my work from A to Z.

JOSIAH OLDFIELD.

8, Harley Street, London, W.1.
October 6, 1950.

POT POURRI

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

Dear Sir,

May we draw the attention of your readers to the Pot Pourri of the Ward Shows, which will be given at the Cripplegate Theatre on Saturday, December 30, 1950, at 8.30 p.m. There will be an additional performance on Friday, December 29, if the request for tickets is as overwhelming as last year. Tickets will be available from December 11, 1950.

Yours faithfully,

C. TODD, *Senior Resident.*
J. C. PITTMAN, *Hon. Sec., Dram. Soc.*

The Abernethian Room,
St. Bartholomew's Hospital.
November 14, 1950.

MUSICAL SOCIETY: FESTIVAL CHOIR

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

Dear Sir,

A circular has reached me, containing details of a concert to be given by the "United Hospitals Festival Choir" at the Albert Hall next May. The choir is to be composed of nurses and medical students. I enclose excerpts from the circular.

May I take this opportunity of reminding Bart.'s people that before the war there was an active Hospital Musical Society. Should anyone be moved to wake this dormant body, he may glad to know that there is a small sum—£5 10s. 10d.—in its Bank account.

Yours faithfully,

F. A. RICHARDS,
Hon. Treasurer, St. Batholomew's Hospital Musical Society.

Robinswood,
Cobham, Kent.
October 31, 1950.

UNITED HOSPITALS FESTIVAL CHOIR

(Chorus Master—Colin Ratcliffe)

ELIJAH — MENDELSSOHN

Ena Mitchell — Alfred Hepworth
Gladys Ripley — Norman Walker

Douglas Hawkridge—Organ

The
LONDON SYMPHONY ORCHESTRA
conducted by
JOSEF KRIPS

The Royal Albert Hall, Wednesday, May 30, 1951, at 7.30.

[If anyone would like to sing in the United Hospitals Festival Choir he should see MR. P. G. CRONK.—*Editor.*]

APPOINTMENTS

The undermentioned appointments to the Medical Staff have been made with effect from the dates given:—

Resident Assistant Gynaecologist & Obstetrician
Mr. J. J. O'Sullivan (re-appointed) January 1, 1951

Orthopaedic Department—Registrar
Mr. E. Shephard (re-appointed as Registrar) January 1, 1951

Junior Registrar to Dr. Cullinan
D. F. G. Campbell January 1, 1951

Junior Registrar to Mr. Hume
Mr. K. Lawrence January 1, 1951

Junior Registrar, Pathological Department
Mr. J. S. Jenkins December 1, 1950

HOUSE APPOINTMENTS

The undermentioned locum House Officers have been appointed for the period November 1 to December 31, 1950:—

Junior H.P. to Dr. Spence
Montgomery, B. K.

Junior H.S. to Mr. Naunton Morgan
Blakeway, I.

PRIZE IN HISTOLOGICAL DRAWING 1950

Awarded to:—Y. P. N. FORGET.

Prox. Accesserunt: A. E. Bashford, J. S. Malpas.

Highly Commended: R. C. Taylor.

BIRTH

GILSENAN.—On November 6, at 46, Waverley Road, St. Albans, to Tessa, wife of Dr. B. M. C. Gilsenan, a daughter—Clare Margarita Maria.

SPORT

RUGBY CLUB

Rugger Notes

F. I. Macadam has been appointed Captain of the 'A' XV.

P. B. Biddell has been appointed Captain of the Ext. 'A' XV.

On October 21 for the first time for many years, we fielded five XVs. We hope we shall be able to continue to do this throughout the season. So far this season 114 players have represented the hospital Rugger teams.

October 28 was quite a red-letter day, too. The 1st XV beat the R.E.M.E. Corps side 14—0; the 'A' XV just lost to De Havilland 3—5; the Extra 'A' XV beat Middlesex Hospital Extra 'A' 9—5; the 'B' XV beat London Irish 13—10 and the Extra 'B' lost to Old Elizabethans 13—3.

A special word of congratulations is due to the Extra 'A' XV. So far this season they have beaten St. Mary's Extra 'A' 12—9, Middlesex Extra 'A' 9—5, lost to St. Thomas' Extra 'A' 6—8, and beaten Harrow 26—5.

v. U.S. Chatham, October 7.

Result: Won 6—3.

Bart.'s played their second match of the season against U.S. Chatham in ideal conditions for fast open Rugby. The ensuing game, however, proved a little disappointing after the excellent showing of the team against Woodford the previous Saturday.

The opening exchanges were more or less even, Moyes asserting an early supremacy in the set scrums. After about 15 minutes' play Bart.'s scored a good try through John, who touched down after a determined run and well-judged kick ahead by Davies. Half-time arrived with the score 3—0 in Bart.'s favour.

Chatham soon equalised after the interval, their left-wing scoring after a blind side move from a set scrum near the Bart.'s line. Play became very uninspiring in the second half due to some unconstructive play by both sides. However, 5 minutes before the end Murphy scored the deciding try, showing admirable determination and fixity of purpose in crossing the line.

In the pack Moyes was his usual efficient self, whilst Havard led his men in great style. More cohesion is required before it becomes a force of considerable potential. In the backs Davies and Clare showed up well, but safer handling and straighter running in the centre are essential for the wing men to have opportunities to show their paces.

v. NOTTS, October 14.

Result: Lost 14—3.

This game started off at a cracking pace and our backs were not really a match for those of our opponents who threw the ball about with great accuracy and whose defence was most solid. Our own three-quarters were not tackling their opposite numbers first time; they also tended to run across and thus not avail themselves fully of their somewhat limited share of the ball. Notts scored twice in the first half and gave us a good demonstration of place-kicking by converting one and narrowly missing the other. Bart.'s were unfortunate in losing Cohen in the first half; his place was ably taken by Fitzgerald, to whom credit is due as he had not previously played at scrum half. He was responsible for a good breakaway, and thanks to efficient backing-up by Davies, the latter scored for the Hospital. The kick failed.

In the second half, Bart.'s scrum continued to play a grand game and did more than hold their own. However, Notts again showed us the advantages of consistently good goal kicking and scored on two penalties, one being a most difficult kick.

We were awarded more penalties than our opponents but lacked the kickers to make use of them, otherwise the match could have been drawn. Despite this, it was a keenly fought and most interesting game—and the team tried very hard.

v. ALDERSHOT SERVICES, October 21.

Result: Lost 11—6.

The Hospital was disappointing this afternoon. The forwards did not get together at all during the first half, and the backs ran across and hung on to the ball too long. By half-time the score was 8—0 to the Services.

In the second half the game improved. Bart.'s were pressing continuously, and two penalties were converted by Taylor and Dick. The forwards were at last pulling themselves together. Then a breakaway from one of the Services centres sent their left wing over for a try, and the game ended with the score 11—6.

v. HARLEQUIN WANDERERS, October 25.

Result: Won 11—0.

The Hospital put up a most encouraging performance this afternoon by defeating the Harlequin Wanderers on their own ground by 11 points to nil.

Both Kneebone and Taylor in the centre showed their best form of the season, and they were well served by their half-backs. The forwards, too, were in great form, overrunning a lively Harlequin pack.

The scoring opened in the first half when Taylor cut through and passed to Murphy who ran over 25 yards to touch down 10 yards in from the touchline. Dick converted the try into a goal.

Ten minutes later Taylor broke through and scored.

The second half was fairly even. Bart.'s forwards were most active, and their rushes always dangerous, but it was close. The fly-half, who dribbled over after Kneebone had been grounded ten yards from the line to make the score 11—0.

Long may the backs continue to show such thrust and the forwards such vigour.

v. R.E.M.E., October 28

Result : Won 14—0.

This afternoon Bart.'s beat the Corps side of the Royal Engineers by 14—0.

The forwards secured most of the ball, both from set-scrums, line-outs and in the loose; the backs took full advantage of this, although up against some determined tackling. The forward rushes always looked dangerous, and it was good to see the short pulling movements amongst the pack. Quick heels from the loose were rewarded by two of our tries.

In the last quarter of an hour apathy seemed to set in, during which poor tackling nearly allowed the opposition to break through on several occasions.

Tries were scored by Havard (2), Roche and Mackay, one being converted by Dick.

GOLF CLUB

Beveridge Cup

In the final of the Beveridge Cup foursomes, Bart.'s (the holders) represented by L. R. Gracey and R. V. Fiddian, defeated the Guy's couple, Grant and I. Caldwell, the English international.

Bart.'s were under no illusion about the magnitude of their task. Caldwell is a Walker Cup trialist and Grant reputed to be a very steady 1 handicap player. However, any doubts as to the outcome were quickly dispelled when Fiddian put in a telling thrust by driving the 1st green with his brassie. Caldwell, however, to the satisfaction of Bart.'s onlookers, found the bunkers guarding the green with a No. 3 iron shot. This initial lead of one up was quickly followed up on the 2nd hole, Bart.'s getting down in bogey 5 to a 6 by Guy's. From then on Guy's never really recovered from this lightning thrust. Although winning the 3rd in a bogey 4 they were quickly reduced to 2 down again at the short 5th, where Caldwell bunkered his tee shot. The 7th was lost to a bogey 4 and the short 8th would have gone the same way had not Fiddian recovered with a brilliantly played bunker shot.

The turn was reached with Bart.'s 1 up and the long tenth was played impeccably, Fiddian finding the green with a brassie shot of the very first water. The 11th and 12th were halved unspectacularly in bogey though Fiddian's putting was beginning to show early signs of choreiform movement. With a par at the 13th Bart.'s got their nose well in front and became 3 up. The 14th was nearly lost on the green where Fiddian had an acute exacerbation of his chorea and jerked the ball well past the pin; Gracey, after coolly holing the return putt, was heard to remark that he thought his adrenal secretion must have gone up a good two units; however, it was not considered necessary to carry out any special investigations.

Guy's now vigorously counter-attacked and we caught a glimpse of the real Caldwell when he lashed his drive several miles down the 15th fairway—Grant carried on the bad work by finding the green with a diabolically good iron shot, winning the hole in a bogey 4 to a 5. Bart.'s were now heavily pressed and lost the 16th after Gracey, determined to give his partner as much bunker practice as possible, found a hazard to the right of the green. Fiddian was a little too strong with his niblick and the hole was lost to a bogey 3. Tight-lipped, the Bart.'s couple and their supporters made their way to the 17th tee with the score at only 1 up. Caldwell's drive was pushed out and found the rough, but Fiddian hit a splendid drive which disappeared somewhere in the eastern sky—he was unlucky enough to have found the edge of the rough which juts out, rather inconveniently, onto the fairway. However, Gracey, drawing out his 2 iron as if it were Excalibur and he King Arthur, lashed the ball onto the green, the ball finishing 15 yards from the pin—a truly great shot. To their everlasting credit, Guy's were quite unperturbed by this and Grant answered with a similar shot which landed short of the green and ran on, to end just inside

the other ball. It was Fiddian to putt first, and without a trace of his former trouble, laid the putt almost dead. Caldwell was woefully short by a matter of 2 yards and Grant missed his putt. Then Gracey, with calm deliberation, stepped up, and amid thunderous applause from all 5 Bart.'s supporters, tapped the ball into the hole and Bart.'s were home by 2 and 1.

This brings to a conclusion a year in which 5 matches have been won, 2 drawn and 1 lost.

The following have been awarded their colours for this year:—

L. R. Gracey, R. V. Fiddian, M. Braimbridge, R. E. Dreaper, C. V. R. Elliott, J. S. Dodge, D. H. Rushton.

RIFLE CLUB

Officers elected, season 1950-51:—

President—Mr. H. Jackson Burrows.

Vice-Presidents—Dr. G. Canti, Dr. G. E. Francis, Mr. C. Boswell.

Captain—B. D. Lascelles.

Hon. Secs.—J. H. Fairley and T. B. Catnach.

Hon. Treasurer—M. B. McKerrow.

Committee Members—M. C. Hall, F. B. Thoresby, J. S. Bunting.

We apologise to J. S. Bunting, who won the Benetfink Cup, for an error in the report in the October issue.

CRICKET CLUB

Officers for the 1951 season:—

President—Mr. J. E. A. O'Connell.

Vice-Presidents—Dr. Geoffrey Bourne, Dr. N. C. Oswald, Prof. Sir James Paterson Ross, Prof. A. Wormall.

Captain—M. Braimbridge.

Vice-Captain—H. B. Ross.

Secretary—P. B. Biddell.

Treasurer—B. N. Foy.

WOMEN'S HOCKEY CLUB

1st XI

v. Guys. Home. October 14. Won 6—2.

v. Atlanta. Home. October 21. Lost 3—5.

v. Chislehurst Beavers. Home. October 28. Won 4—2.

v. L.S.E. Home. November 1. Won 3—2.

The season has started well in spite of disappointingly little support from the newcomers. The match against Atlanta was particularly enjoyable although we did not manage to win.

1st XI Oxford Tour

v. St. Anne's. November 3. Won 4—0.

v. Lady Margaret Hall. November 4. Won 5—0.

v. Queen's. November 5. Lost 4—6.

v. Somerville. November 6. Lost 1—2.

The team spent a most enjoyable week-end at Oxford. The results of the matches were satisfactory and we were entertained royally by all our opponents. We hope to return this hospitality and to make this new venture an annual event.