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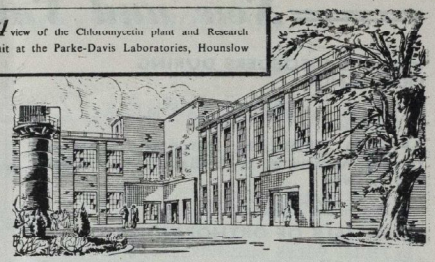

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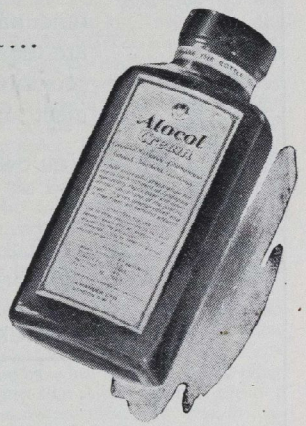

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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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BARTHOLOMEWTIDE

ENGLAND must have been out of her senses when she abolished the Bartholomew Fair. For seven centuries it had enriched and entertained London. Apart from its popularity as an annual amusement, it had a very real background of religion and trade. When Rahere founded the Priory of St. Bartholomew in 1123 the agricultural fair, then known as the King's Market, gained the attraction of pilgrims who were bound for the shrine of the Saint. The men of the Market met with the friars, monks and pilgrims and they became so tied together, that Bartholomew Fair, as it was called, was annexed to the Priory by Henry the First. It was the custom that the Fair be held in the Priory Churchyard and Mulberry Gardens. It was opened by the Lord Mayor on St. Bartholomew's Eve and lasted for a fortnight, during which livestock, leather and pewter were sold, though the Fair, and indeed England, relied chiefly on the sale of wool and cloth for their prosperity. The other diversions of the Fair were quieter than those which were to follow. The public were easily amused by joustings, executions, such as that of the Scottish Wallace, music, Morris dancing and "healings" at the Shrine, which were well rehearsed, though none the less miraculous. The Fair changed little until the time of the Reformation.

With the Dissolution of the Monasteries came the end of the Shrine and its pilgrims, and with the passing of the monks, the loss of religious restraint. Bartholomew Fair gave up its mediaeval complexion for one more ruddy and robust. Monks and gospellers gave place to mummers and the Players; Colporters turned to selling gingerbread and sweatmeats; and purveyors of relics became mountebanks peddling nostrums, elixirs and love potions. Fortune tellers, prodigies, monsters, acrobats, astrologers and cutpurses flocked to the Fair for profit, as did more honest folk, who came to enjoy the plays, puppet shows, scholars' disputations, good eating, pommage and ale. So the Barthaolomew Fair continued, making money for some, and giving gaiety and pleasure to all.

The Cloth Fair was sponsored by the Guild of Merchant Taylors, who were deputed to inspect the market, and to try the measures of the drapers and clothiers against a silver yardstick. Any merchant, who was found with an unlawful yard, might be sent to the stocks or the whipping post by the Court of Piepowders held within the Priory Gates or at the "Hand and Shears," an alehouse within the Fair. During the opening ceremonies the Lord Mayor, preceded by trumpeters, visited Newgate Gaol, where he was given a stoup of mead with nutmeg and sugar, before taking his place at the gates of the Priory and declaring the Fair open.

The Fair was in its hey-day during the seventeenth century, the very time that Ben Jonson portrays in his play. Every Londoner, no matter who he was, would visit the Fair. Some, like Adam Overdo, did not wish to be discovered there and went in disguise. Not so Lady Castlemaine, the mistress of Charles the Second, who was recognised by Pepys at a puppet show. Evelyn notes the "celebrated follies of Bartholomew's Fair" in his Diary, and John Locke enjoyed elbowing his way about the crowd and hobnobbing with the rest of the world. There was no Fair in the year of the Plague or the following year. The enthusiastic Pepys writes "went twice round Bartholo-

mew Fair, which I am glad to see again after two years missing it by the Plague."

The Puritans, as represented by Ben Jonson's Zeal-of-the-land Busy, had sworn to suppress the Playhouse and the Fair; acting was forbidden, and the delicious roast pork and hot gingerbread in the shapes of animals, often called Bartholomew Babies, were declared lusts of the flesh. The Fair certainly lost much of its glitter during the Commonwealth though it was never closed. Immediately after the Restoration, however, "Stageplayers and all other who do show Motions, and Strange Sights," were hurrying to the Master of the Revels for their licences to perform once more. At the end of the seventeenth century the Fair was reduced to three days. With the growth of Leeds, the Cloth Fair declined. The Fair gradually became smaller and smaller, and it was finally suppressed by the City Corporation, who bought the land and charged such exorbitant rates that it was no longer possible to maintain a tradition to which age had given an apparent immortality. Save for a brief resurrection during the celebrations of the eight hundredth anniversary of our Hospital, the Fair was proclaimed for the last time in 1855.

(Bartholomew Fair

Sharing the Stocks

Adam Overdo—MR. ROGER LIVESEY; *Humphrey Waspe*—MR. ALEC CLUNES
Zeal of the land Busy—MR. MARK DIGNAM

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And now the Fair is all but forgotten. This year, as every year, passes by without celebration, or even a reminder of this great tradition. If a dinner of roast pork and hot gingerbread washed down with mead is too much to ask, let us have "Bartholomew Babies" for tea (the recipe is still preserved). Meanwhile those who want more of Bartholomew Fair may read Ben Johson or recall Mr. George Devine's production of his play at the Old Vic this summer, in which the cast recreated the rumbustious hurly-burly scenes with their gallimaufry of English characters. Except for a small superfluity of "enarmities" and false noses, perhaps, this is the Bartholomew Fair we should like to remember.

THE VICIOUS CIRCLE

A Disease Mechanism with General Implications

By W. A. BOURNE

"WHAT I always say *is*," said Cozens Bailey, "the fate of the general surgeon has been sealed by the cystoscope." Since his day specialties have become so numerous and necessary that the fates of general surgeons and physicians have not only been sealed but have almost overtaken them. The specialties are, however, merely the special organs of medical science, which need using as we use our own special organs, sensory or effector, interpreting and integrating their activities by a higher central faculty. Young men must not be allowed to think that concentration on one organ or metabolic process is the highest form of mental activity. It is often easy, because specialists who know more and more about less and less can do their jobs with less thought than the non-specialists; and we only really know things we do, such as golf or gastrectomy, when constant practice lets us do them without thinking. But no one *should* commit gastrectom without thinking: the mental exertion we save by specialisation we must spend on general principles.

An example of a general principle is the "vicious circle," a chain of circumstances constituting a situation in which the process of solving one difficulty creates a new problem involving increased difficulty in the original situation (Webster's). This general definition applies to so many clinical situations that the establishment of vicious circles seems essential to many diseases, if not all. We must appreciate that the formation of a chain of circumstances is not the essential trouble. A chain was there before: our bodies are inevitably chains or circles of processes and organs, and when the old links form a new and vicious chain, or a link in the old chain becomes vicious, we have a disease.

As the first of a few examples from very many instances, consider persistent vomiting, including the so-called cyclic form. Vomiting is the only means of ridding the body of toxic substances the vomiting centre knows. So far as that centre is concerned, all poisons that reach it come through the stomach, and it acts accordingly. It is, therefore, deceived by poisons made inwardly, as by ketosis, when the liver is overworked by a high metabolic rate in hyperthyroidism or fever (one degree rise in temperature raises the B.M.R. by 7 per cent.; a temperature of 103 degrees means a B.M.R. of plus 33 per cent), or has naturally low carbohydrate reserves, or gets little or relatively little carbohydrates in the diet. In such cases, when the poison is not taken by mouth, but the antidote might be, vomiting is definitely a bad thing. Yet in this chain few links are really abnormal. Vomiting is a normal reflex: the diet must contain some fat: keto-bodies are intermediate bodies in fat metabolism: thyroid activity and the metabolic rate are closely connected: fever protects against infection. Excess or defect of a link is what makes the circle a vicious one, and it is the detection and treatment of this link which is needed.

Other biochemical vicious circles may be analysed. Alkalosis from high intestinal obstruction is liable to happen in duodenal ulcer where the vomit is likely to be of particularly high acidity and where the patient often adds to his troubles by self-administration of excessive alkalies. Uraemia leads through vomiting to dehydration and a still higher blood urea: the patient must be compelled to excrete large daily quantities of low specific gravity urine—e.g. 3½ pints at 1008—if he is to avoid accumulation of metabolites. In salt depletion leading to anorexia and diminished intake, urine testing for salt excretion is an important control. (Marriott, 1947.)

Haemorrhage produces a vicious circle not by anaemia or anoxaemia but by anoxia. What kills bleeding or bled people is not what happens in the blood but what happens, first in the vessel walls, and then in the tissues they supply. Peripheral vasoconstriction, designed to direct a maximum blood supply to the vital centres in the medulla, deprives the very extensive capillary system itself of oxygen: In addition to side effects—I have seen two cases of cardiac infarction in gastro-intestinal bleeding—anoxia results in the formation by the liver of a vaso-depressive material, which adds to the effects of capillary anoxia so that irreversible shock is produced and the vital centres are starved through the mechanism designed to protect them. Against this,

earlier transfusion, ampler oxygen and more courageous use of new drugs to raise the pressure seem our best defences. (Chambers, 1948.)

Renal anoxia might oppose the vaso-depressive mechanism in haemorrhagic shock, since it produces a vaso-excitor material, but in such cases a vicious circle of local vaso-constriction seems to prevent its entry into the general circulation. However, while taking blood pressure recordings on patients operated on for severe haematemesis, I have seen one surprising rise suggesting that some source of vaso-excitor material had been tapped. Rise of blood pressure due to renal anoxia develops undoubtedly in the course of generalised vascular spasm from emotional strain, from vascular defect or from local renal disease: and the vicious circle of hypertension results. (Zweifach, 1948.) The principles of its treatment are not easy to practise.

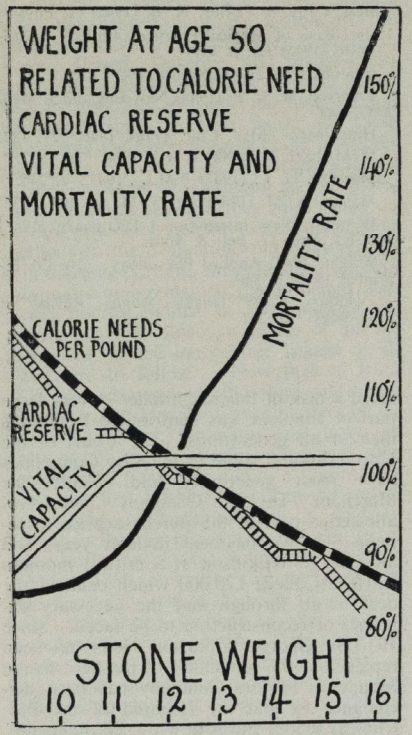
Cardiac failure is sometimes determined by a vicious circle involving cardiac response to increasing venous pressure. Normal and normally loaded hearts respond by enlargement with increase in output, but, if overloaded, over-enlarge till a rise in venous pressure gives a fall in output. Hearts failing from valvular disease, hypertension, or coronary damage follow this same vicious circle. Reduction of venous pressure by venesection, digitalis, diuresis or acupuncture may reverse the process and restore normal cardiac size and efficiency. (McMichael, 1948.)

In mechanics of the skeleton, vicious circles easily develop. By the directest possible transmission of bodily weight through the centre of gravity, minimum muscular effort is needed to maintain posture. Excess effort is needed in proportion to deformity, and postural defect will automatically tend to perpetuate and increase itself.

The nutrition of bones and joints is largely dependent on balanced blood supply. Diminution of blood flow tends to produce decalcification (disuse atrophy), but the vascular congestion of acute rheumatoid arthritis may also be manifested by calcium absorption around the affected joints. In this latter condition rest is required to protect the tissues and diminish hyperaemia: movement, particularly knitting, will perpetuate the vicious circle of increased blood flow and calcium loss. When the active rheumatoid process has ceased, or if trauma or osteo-arthritis are present, movement is desirable to avoid the alternative vicious circle of disuse, decalcification and deformity.

Respiratory vicious circles are of several kinds. Defective movements of the thoracic cage and diaphragm are found in some individuals: this so-called "hypoventilation syndrome" seems at first to be largely psychogenic, but progresses to real physical limitation. Defective lung expansion involves the almost complete use of some alveoli and almost complete collapse of others. In conditions of respiratory or circulatory depression the areas of lung tissue in use may suffice for excretion of carbon-dioxide, thus removing a natural stimulus to deepened respiration, but do not provide for absorption of sufficient oxygen to meet bodily needs: a vicious circle is again set up. (Wright, 1942.) Pulmonary engorgement in cardiac failure results in a stiffening of the lung which makes more forceful muscular efforts necessary for satisfactory expiration and inspiration, and also renders the Hering-Breuer reflex more sensitive, so that the act of inspiration is checked before the lungs are fully expanded. (Best and Taylor, 1945) (1). These circles, which all tend to produce shallow breathing, are reversed by breathing exercises, oxygen and carbon-dioxide inhalation, and depression of the pulmonary reflex by morphia.

Obesity is an example of a vicious circle, vicious in more ways than one, for above the age of 35 the mortality increases by 1 or 2 per cent. for each pound above the optimum weight of 12½ stone. (Emerson, 1948). The total calorie requirement increases, but not in proportion to the increase in weight, so that the caloric requirements per pound fall at a rate which is the same as the diminution in cardiac reserve estimated by the two-step tolerance curve tables. (Master, 1944). Thus, as a man gets heavier his caloric requirements by no means keep pace with his increasing size, yet his capacity for expending unnecessary calorie intake diminishes. Spontaneous weight reduction is therefore unlikely. Mortality only begins to increase more rapidly than weight above about 12 stone, and it is at this level that the vital capacity, which has run strictly parallel with increasing weight, now becomes constant. "I believe it will be found that when the weight exceeds this limit the vital capacity will considerably decrease, and that probably . . . from the mere circumstance of fat preventing the mobility of the thoracic boundaries" (Hutchinson, 1846), due to sub-diaphragmatic accumulation of fat or what may be termed a lipo-peritoneum. This relative diminution of vital capacity in those who are over-weight is likely to have an adverse effect on the course of many diseases from which the obese suffer.



Mortality rates, vital capacity, cardiac reserve, and calorie need, expressed as percentages of calculated average for man aged 50, height 5 feet 11 inches, weight 12 stone 7 pounds. (Emerson, Hutchinson, Master and Oppenheimer, Best and Taylor.)

In seeking, in the animal kingdom, similar conditions to human obesity, only one suggests itself, namely hibernation. In a state of nature animals have otherwise no apparent tendency to become obese. It may be said that human obesity is a preparation for a hibernation that never happens. Hibernating animals do nothing and eat nothing. The obese human does little and eats too much.

Weight reduction in the hibernating animal occurs through simple starvation, and relative starvation is our only means of weight reduction in the human. There is a rough level of calorie requirement for each individual according to his surface area and activity, and there is no physiological excuse for a higher calorie intake, and no physiological means of dealing with the excess. What the level is can be roughly calculated if a subject on a diet of known calorie value loses weight for a sufficient length of time for the likelihood of fluid loss to be excluded. This weight is lost by burning fat. One pound of human fat gives 3,500 calories (Best & Taylor, 1945) (2) and the loss of one pound per week means the provision of 500 calories per day from the subject's own tissues. The amount of food which should be added to a reducing diet to keep the weight stable can thus be estimated.

Such a rule is not, however, likely to be obeyed, since civilised man chooses his menu by emotional impulse rather than metabolic rationale. Here we find a new type of vicious circle, the mutual effect of body and mind, but must go further than a simple "holism" which regards mind plus body as the whole man and the whole explanation of disease. The body seems only the means a personality has of expressing itself upon or adapting itself to its environment. The body takes the strain between the personality and the environment as a bicycle chain takes the strain between the foot on the pedal and the wheel on the road. When the chain breaks it breaks at one link, and when the body breaks it does so in one system, determined by an organ inferiority conditioned often by some vicious circle.

Returning again to the chain of circumstances in the dictionary definition, but taking this wider view, we see mind, body and environment interacting. In considering the so-often-vicious circle of mind, body and estate, holistic medicine expands into social medicine. Even this is not a complete circle. We have forgotten a factor which is so inevitable in every disease that we take it for granted and often fail to grasp its influence on the whole disease process. We have forgotten ourselves, for the full circle becomes mind, body estate—and doctor. Now this also has become incomplete. The

efficiency of the new circle will be good or bad according to its links—mind, body, estate, doctor—and State.

Through a range of conditions—mechanical deformities, respiratory, circulatory, metabolic and other bodily activities, up to the activities of individual and mass psychology—we have seen each as a circle of related factors. These factors may be set revolving in a direction adverse to the individual's welfare, but are hardly ever intrinsically new, though their relation may be. The disturbance is usually an excess or a deficiency, breaking down the dynamic equilibrium which gives health and life. Even what we think of as static physical postural equilibrium depends on muscles that derive their balanced tension from reversible chemical changes intimately associated with a widespread electrical activity which appears, in some parts of the body, to be a necessary condition of consciousness itself. All forms of physical matter and activity appear interconnected, if not interchangeable, with each other, and with the stuff that dreams are made of.

If we take this view of the vicious circle, it is impossible not to feel that, though their duties will grow continuously harder, the fate of general physicians and surgeons and practitioners must never be allowed to be sealed by any specialty whatsoever.

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We should like to correct an error in the Editorial published in the July issue. It was stated that part of the Charterhouse site was purchased in 1921, the year the Medical College obtained its Charter of Incorporation. In fact the whole site was purchased by the Medical College in 1933. We are grateful to Dr. C. F. Harris for pointing out this mistake.

Dr. Harris has also explained how the very substantial sum of money required to buy the site was raised.

"Four distinct groups of people played their part in this happy result. Without the energy and foresight of Sir Girling Ball it is improbable that the College, who had little in the way of accumulated funds, could have faced a task of this magnitude. A very large part of the sum was contributed by Bart.'s men of all generations. The Court of the University and some of the City Companies gave most generously and, finally, the Merchant Taylors Company themselves allowed a part of the purchase price to remain over for payment in later years and Sir George Wilkinson at a critical moment lent the College £20,000 which enabled the deal to go through and the necessary expenses of reconstruction to be faced. Since 1933 Sir George Wilkinson's loan has been repaid and the remainder of the debt to the Merchant Taylors Company has been discharged, so that the freehold of the Pre-Clinical school site is now owned, unencumbered, by the College."

ABERNETHIAN SOCIETY

At the Annual General Meeting of the Abernethian Society, held on June 21, the following officers were elected for 1951/52:

Presidents: Gains Davies, M. B. McKerrow.
Vice-Presidents: C. W. Coole, J. N. Todd.
Secretaries: J. F. Preece, D. F. P. Wooding.
Pre-clinical representatives: H. V. Blake, Miss M. V. Burridge.

THE STORY OF DERMATOLOGY

By R. M. B. MacKenna

(Continued)

After the French Revolution, France became pre-eminent in Medicine. In November, 1801, the old St. Louis Hospital in Paris was made a dermatological centre: a group of masters gathered there whose prestige was unchallenged until the middle of the nineteenth century. Alibert, Biett, Cazenave, Rayer, Gibert, Devergie and Bazin were among the greatest, and it is only the shortness of time that prevents me from paying adequate tribute to their work. Of these Bazin was the forerunner of Unna in appreciating the application of the natural sciences to the problems of Dermatology, both because of the light which they might shed on morbid processes, and the usefulness of their methods in the evaluation and treatment of skin diseases. Despite this, classification and systematisation remained the principal academic interest, whilst in all countries the minute study of objective details of disease proceeded, to the inestimable benefit of all who were to follow. Nevertheless, from 1820 onwards, applied physiology and histopathology and histology were matters of interest in France, Germany and Italy; in 1839 Schönlein, a Berlin physician, discovered that favus was due to a fungus, this being the first introduction of mycology to dermatology. (Incidentally, it is said of Schönlein that he introduced the routine of urine testing in clinical practice).

From 1850 onwards, Greater Germany held the field. Although we in this country had incorporated sections of our medical schools in our universities so that, for example, Lord Chesterfield could write of having seen anatomical dissections at Cambridge, Germany first showed the world the advantage of associating medicine with the natural sciences as an integral part of its universities. The great German Hospitals became in effect university laboratories for medical research, with the largest opportunities for study by scientific methods. Pusey suggests that the application of the laboratory method to the study of disease is perhaps the chief contribution of the German system to medicine. The Allgemeines Krakenhaus in Vienna was the first German institution to rise to international eminence; and no wonder. At various times, Rokitansky, Skoda, Politzer—I believe, Hebra, and later Wertheim were all on its staff . . . a galaxy of talent which has never been excelled. Many know the story how Ferdinand Hebra, a Moravian, became an assistant physician to Skoda's clinic in 1842. Presumably because he was a junior—quite literally "the dog's body"—he was given the skin cases to treat. They infested Skoda's clinic, 2,723 of them, of whom 2,197 had scabies. Hebra learned clinical medicine from Skoda; he was much influenced by Rokitansky, who suggested the application of the newer pathology of those days to dermatology. Nevertheless, clinical dermatology became his consuming interest, and he became the greatest clinical teacher of all time. Strangely, in his later days, he became aloof to biological conceptions of disease and even spurned histo-pathology.

Everyone interested in Dermatology went to Vienna (and such was the influence of the school created by Hebra, that this habit lasted until at least 1900), so it was not surprising that in 1875 Paul Gerson Unna, a post-graduate student from Strassburg, should reach the great city at the age of twenty-five. Unna had already invented new staining methods with picrocarmine and with osmic acid for microscopy. In Vienna he came chiefly under the influence of Auspitz and developed great ingenuity in microscopical technique. He remained in Vienna only for a short time, and thereafter took his M.D. in 1876 and by 1881 had established a private clinic at Eimsbüttel, near Hamburg. A few years later he began to develop a private hospital and laboratory which in time grew to be a large institution. As the strength of Vienna waned, Unna's clinic became one of the greatest centres in Europe for dermatological students. Now why Unna went to Hamburg I cannot tell you, although others must know. There was no university there. He elected, apparently, to be a lone wolf, and by sheer genius built his own hospital, competing meanwhile with the talent of the European capitals and the slowly dawning lure of the U.S.A. Many of his earlier papers aroused much hostility, but despite this, a steady torrent of papers bearing his signature

poured from Hamburg. A complete list of Unna's publications up to the age of forty-three includes 26 papers on anatomical and physiological subjects, 53 on pathology, 55 on therapeutics, 27 on histological and bacteriological techniques and 12 on such miscellaneous subjects as "The use of Chloroform Water as a solvent of drugs" and "Albuminuria during the inunction of Styrax." How was it done? How could a man attend to his practice, complete his hospital duties, and yet undertake and publish the results of so much research? Either devilishly good system. You can take your devilishly good system. You can take your choice.

Unna's major contribution to nosology was in 1887 when he published two papers, the first "What do we know of Seborrhoea?" the second "Seborrhoeic Eczema," for it was he who recognised seborrhoeic dermatitis as a separate entity. There are few, if any, present today who have not had to learn some of Unna's work concerning keratohyalin, eleiden and cornification of the epidermis; few who have not used the methods of staining he introduced, or who have not employed some variety of the zinc gelatin paste which he described in 1883. When he died in 1929 it was the end of an epoch.

Now the influence of Unna's work, which was copied, improved and developed in Germany by Jadassohn and others, has been world wide. Particularly it has influenced the American schools, for it was Unna's great contribution to Dermatology that he led dermatologists out of the clinic and into the laboratory and taught them to appropriate all the aids of the biological sciences for the investigation and comprehension of cutaneous disease.

Hebra, as we have seen, made Dermatology a speciality. He died in 1880. Of his contemporaries and of those who followed him, I can select only a few for mention. Carl Wilhelm Boeck (1808-1875) of Christiana was a professor of surgery, skin diseases and syphilis. He and D. C. Danielssen performed important work on leprosy and described the extraordinary ravages of unchecked scabies ("Norwegian scabies"). G. A. Hansen discovered the bacillus of leprosy in 1871 and demonstrated it to the Medical Society of Christiana in 1874. These men built and fostered the independent, vigorous Scandinavian school and were followed by Caesar Boeck (1845-1917) and N. R. Finsen (1860-1904). It was Caesar Boeck who introduced the conception of Sarcoidosis. The Scandinavians have been eminent in many fields but particularly in the study of tuberculosis and sarcoidosis. In our own time their work has been continued by Schaumann, Haxthausen, Lomholt and others.

The work of the French School has been —and still is—so vital, especially in clinical dermatology, therapy and histopathology that I cannot attempt to do more than remind you of the names of some of its alumni:— Alibert, Biett, Cazenave who in 1851 gave a well-known malady the name of lupus erythematodes, Gibert who was the first to recognise pityriasis rosea as an entity, Bazin who described erythema induratum, and also many other maladies, Vidal whose name is associated with lichen simplex chronicus, Besnier, Hallopeau, Brocq, Darier and may others, down to Charpy of Lyons who in our day was a pioneer of the treatment of lupus vulgaris by the administration of Vitamin D. To show you what scant justice I have done to French Dermatology let me point to this omission: The Curies isolated radium in Paris in 1898; three years later, M. Becquerel burned himself by carrying some radium in his waistcoat pocket, and Pierre Curie deliberately exposed his arm, for ten hours, to the action of a radioactive tube. A burn appeared which took fifty-two days to heal and Pierre sent a report to the Academy of Sciences about this very personal experiment in dermatology. P. Curie with Bouchard and Balthazard proceeded to study the action of radium on animals, and thus it was found that by destroying morbid cells, radium could cure skin diseases, lupus, and certain types of cancer (Eve Curie, 1950).

Since the days of Fracastoro and Malpighi the Italians have been constant contributors to dermatology. From 1800-1850 dermatology in the U.S.A. was moulded on the English and French schools. After 1860 it was moulded by German influence. Since approximately 1920 it has forged ahead on paths which the rest of the world has often been grateful to follow. In 1845, W. Worcester, Professor of Physical Diagnosis and General Pathology in the Medical School of Cleveland published "A Synopsis of... Diseases of the Skin." This was the forerunner of a number of text-books which have set a standard for others to emulate. In 1871 a chair of dermatology

was established at Harvard and in 1873 Duhring was appointed the first lecturer in dermatology at the University of Pennsylvania. He became "professor" in 1875 and founded a tradition which makes Pennsylvania a dermatological mecca to this day. Among his pupils were Van Harlingen, Hartzell and Stelwagon and these men with G. H. Fox, J. A. Fordyce and others, so stimulated the fertile soil of American endeavour that now many clinics in the U.S.A. are of world-wide renown and importance.

And what of ourselves? Erasmus Wilson (1809-1884) was one of Hebra's pupils who, despite the prejudice of his day against specialism, devoted himself to dermatology. His contributions were many, and his work on lichen planus outstanding. Nevertheless, he became President of the Royal College of Surgeons! He was a versatile man, of outstanding generosity. Among other matters, he brought Cleopatra's needle to London and set it up on the Embankment at his own expense; the venture is said to have cost £10,000. Tilbury Fox (1836-79) made many contributions to dermatology, but his greatest contribution was to establish impetigo contagiosa as a clinical entity and to prove by experimental innoculation that it was contagious. The word impetigo is probably derived from *impetus* . . . a violent attack, and since the days of Celsus had been used to describe many recurring eruptions characterised by the violence of their efflorescence. Jonathan Hutchinson (1827-1913) is famous chiefly for his work on syphilis; both he and Tilbury Fox described dysidrosis. Colcott Fox, Radcliffe Crocker, Malcolm Morris, J. J. Pringle of London, and H. G. Brooke of Manchester were among the last of the Victorians and passed a tradition to the safe keeping of Norman Walker in Edinburgh, Adamson, Macleod, Sequeira, Whitfield and others in London and the provinces. During the twentieth century, anaphylaxis and allergy have become accepted concepts. An enormous amount of work has been done in bacteriology, general and histo-pathology, bio-chemistry and psychiatry; in therapy, carbon dioxide "snow" (introduced by W. A. Pusey in 1905) ultra violet and X-rays, radium, radon and thorium X have been added to our armamentarium. Our knowledge of pharmacology and materia medica has greatly increased (I need scarcely mention the impact on dermatology as on other branches of medicine of sulphonamides and antibiotics); to a degree which few realise, the standards of writing of text-books and papers have improved.

You will have noted one grave omission from this essay; I have made no specific reference to my predecessors at St. Bartholomew's. This has been done deliberately as Dr. A. C. Roxburgh has published an interesting paper on this subject (see *St. Bart. Hospital Journal*, June, 1951).

The future of Dermatology lies in the hands of the bio-chemists who alone can tell us of the changes which occur in the tissues before the signs of disease become manifest. The physiologists also must lend their aid and the pharmaceutical chemists can help us greatly. We require the help of the psychiatrists before we can unravel fully the mysteries of aetiology; also we must continue to evoke the assistance of the histo-pathologists. There are bacterial concepts which for decades have been accepted with but little question that require re-valuation. But by now most of the cutaneous maladies to which man is prone have been described, even in their aberrant forms. Certain "sports" will arise from time to time, such as the "Tropical Lichen Planus" of World War II; but the clinician who hopes to make his mark in our generation cannot be content to confine his activities solely to the clinic. He must follow the example of Unna, and also bring to the work the powers of observation, the patience and the attitude of mind which were first commended by the Ancient Greeks; by doing this he may in time become one of the small number of men whose work "continueth far beyond their knowing."

Envoy and Reference

The dates of the births and deaths of the Early Fathers of Medicine are often uncertain and therefore in works of reference there is often variance in this matter. The reader is asked to regard those given in this lecture as approximately correct but not necessarily exact. I have drawn freely on "The History of Dermatology" by the late William Allen Pusey, sometime Professor of Dermatology in the University of Illinois, published in London in 1933 by Baillière, Tindall and Cox. Information has also been obtained from A. Castiglioni's, History of Medicine (1946) published in New York by

A. A. Knopf, the xith edition of The Encyclopaedia Britannica, and from D. L. Sayer's preface to her translation of "The Comedy of Dante Alighieri" (Penguin Classics, 1949). I have to thank Dr. A. J. Marshall, Mr. J. L. Thornton and Mr. R. C. Trevelyan, who have kindly advised me on matters pertaining to their respective spheres of Zoology, Literature and Classics.

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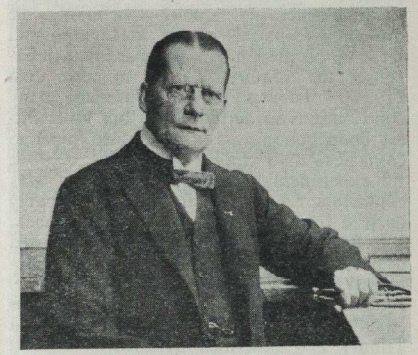
OBITUARY

DR. J. H. DRYSDALE

Dr. John Hannah Drysdale died in Buenos Aires on July 13, 1951, at the age of 88. So passes a great man. Great musicians achieve personal immortality because their works of genius have an appeal unfettered by language. Poets of genius have a lesser life after death. The original gifts to humanity of pioneer scientists are immortal, but cannot transmit the personality of their authors. Few people have any real idea of Newton, Pasteur, or Lister as men. The great teacher comes between these two types. The lectures of Abernethy are still referred to as patterns of the dramatic.

Drysdale, or Dropsy, to use the unflattering but affectionate nickname which always stuck to him, was one of those rare men who exert this type of profound personal influence on their contemporaries and juniors. He avoided the public eye, and eluded private practice. He was a bachelor, and his whole life was centred in Bart.'s. He would arrive rather before lunch, and would visit his wards if any special problem required it. His lunch was abstemious, often consisting of a Bath bun and a cup of coffee. It would be followed by a State Express cigarette, taken from the inevitable flat yellow tin. After his work was done, however, he had a fine appreciation of a good wine, and a choice cigar. After lunch he would visit the post mortem room, where his acute perception would often prompt questions which might be embarrassing to his less observant colleagues.

At 1.30 he would begin his ward round. This consisted of a slow peregrination from



bed to bed and might last until 4.0 p.m. He and his pupils stood all the time. In spite of this he was always followed by visitors from other firms, for his teaching was rightly assessed at a high value.

He was never didactic, and so was avoided by the student whose mental hunger was restricted to a desire for lists and examination mnemonics.

By deft questions, founded upon physiology, physics and anatomy, he would, for example, encourage a first-time clerk to build up for himself there and then, the changes produced in the heart and in the peripheral blood stream by an aortic valve leak.

He had been one of the first demonstrators of pathology, and I cherish a recollection of him, top hat on the back of his head, and a

Havannah in his mouth, making subcultures of B. typhosus. In the field of clinical pathology too his gift was to select and to portray the essentials. One of his many remarks which I remember was "If you know the anatomy and the physiology of an organ, and if you know the fundamentals of the process of inflammation, you can foretell the clinical picture of an inflammatory process in that organ." I once turned this to account in a written examination, in which I was faced with a question on pancreatitis, a subject of which I was ignorant. I built up from basic principles a sufficiently good answer to pass.

His power of "gutting" some recent advance so as to extract the essentials, free from confusing details, was equalled by the mental vividness of his teaching by the bedside; but more valuable than everything else was the course in the technique of accurate thinking which his ward rounds almost unconsciously inculcated. No looseness of thought or of statement was allowed to pass unchallenged. "Unless you express yourself accurately you will not think accurately," he used to say.

The cliche, the verbose generalisation, the pompous dictum, used in some answer, were all punctured by his secondary question "When you have said that, what exactly **have** you said?" He often introduced humour to point a moral. "If a patient vomited material looking like coffee, what would be your first thought?" he once asked. "That he might have a gastric carcinoma," was the reply. "I would first think," countered Dropsy, "that he might have swallowed some coffee."

These lines are not appropriate to the many broadly humorous incidents, largely intellectual, by which his memory lives, but even in his passing, this gift of humour, so strong an ingredient in his make-up, must be recorded as a weapon of destructive criticism, and as a support to constructive teaching.

He was never pompous or diadactic, but always sympathetic and kindly to his juniors, and ready to help with his opinion. In his equals or seniors, stupidities or poses were attacked or ridiculed without mercy.

To one seeking his advice about a course of action he would say "I never give advice, but I will tell you what I think."

A strong candidate for the post of chief assistant to his firm was asked by him to defer his application for six months on the grounds that a fellow applicant from a Dominion would benefit from a six months' tenure of the position. Eighteen months later the first applicant, now holding the post, was approached by Dropsy in the square. The "Old Man" presented him with an envelope. "This is a present," he said, "and as such is not the concern of the Inspector of Taxes." The envelope contained a cheque for £100 which in those days, represented the salary, for six months, of a medical chief assistant. Few very wealthy men would have been so acutely aware that the renouncement of his chief assistantship for six months with the loss of £100 might constitute a real financial sacrifice.

With typical self-effacing generosity he resigned from the Staff two or three years before his time, and thus renounced his whole life's interest: for the honour and prestige, and the vigorous health of Bart.'s were what he lived for. He took this step in order to create a vacancy for a man who might otherwise become too old to stand a chance of election to the Staff.

He was an authority on blood disorders, and on diseases of the heart. He from the first mastered and clarified in his teaching the then new outlook upon cardiac disease and cardiac arrhythmias introduced by Mackenzie, and confirmed and amplified by Lewis.

He gave to Bart.'s, if I remember rightly, its first prototype electrocardiograph, one of the first two in London, the other being at University College.

Although those who remember his personality grow fewer with the years, his influence as the greatest clinical teacher of his generation still infiltrates and permeates, perhaps unnoticed, the fountain of medical teaching and practice, which nourishes what is best in our great hospital's tradition.

Geoffrey Bourne.

MATTER FOR THE JOURNAL

Matter should be handed to the Editor, typed and ready for the printer, at least one month before it is due to be published.

DOCTOR AND MUSICIAN

By BOYD NEEL

CHANGING professions has probably seemed less drastic to me than to an outside observer, because as far back as I can remember I have always had a passion for music. As a very small boy I used to listen by the hour to my mother playing Chopin, while I pored over books containing pictures of ancient Egypt and Rome. Such are the powers of suggestion on a child's mind, that to this day I cannot hear certain pieces of music without a mental picture of those old books arising.

Schooldays did not allow of much development of one's musical life, and although I had the usual piano lessons, and appeared at school concerts as the so-called "promising pupil," it was all very much a matter of routine. Four years of Naval training at the end of the 1914 war did nothing to stimulate the musician in me, as can readily be imagined. But then came three years at Cambridge, where I went to take a medical degree. You see, one had to have some sort of a profession, and at that time the thought of making music my profession had never entered my head, probably because anyone taking music as a means of livelihood was usually regarded as mad!

Cambridge, however, as it happened, provided the spark which lit the musical fire. There was every facility for hearing good music, for meeting musical people, and for generally enlarging one's knowledge of the art. But, you will ask, what about your study of medicine? Well, that went on more or less automatically with periodical bouts of genuine enthusiasm for the work. Anatomy and physiology fascinated me, but pathology I found unutterably boring. The pathology lecture theatre, however, was a large place, and in my seat in the back row many an orchestral score was studied during discourses on diseased livers and spleens. I managed to pass the necessary exams, and came to London to complete my studies at a famous hospital. I was now just twenty-one, and music was the ruling passion of my life. Every spare moment I had from my hospital work was spent at concerts and operatic performances, or having lessons in harmony, counterpoint and orchestration. Orchestral music of all kinds formed my greatest interest, and I began to study the methods of famous conductors. It was about this time that I discovered that I had an exceptionally good musical memory. If only I could have memorised varieties of bacteria as easily as I could the score of a symphony!

However, I must count the three years of my student work at the hospital as among the happiest I ever spent.

It was just about this time that I began to go abroad whenever I had a holiday, and in the summer I usually managed to spend a couple of months on the Continent, mostly in Germany, where I heard much music of all kinds, and put in some really hard study. I had many friends in Munich at that time, and owe a great deal of my musical knowledge, such as it is, to that famous institution. Music, however, was still only my hobby, and qualified as a doctor, I was, for a time, carried away with enthusiasm for my medical work. I held many hospital appointments such as House Surgeon, House Physician, and Casualty Officer. Now, any House Surgeon of a large general hospital will tell you that he has very little spare time during his daily round to devote himself to any outside interests, and this was precisely my own experience. Music was certainly not pushed aside, however. It was always there as a background to everything I did; but in my enthusiasm for hospital work, especially surgery, which I really loved, there was no time for serious study.

At the end of my time at hospital, I again went to Germany for a long holiday, and found all the old enthusiasm sweeping over me again. On my return, the question was whether music was going to remain just a hobby, or whether it was going to become the main thing in my life. This question more or less answered itself, and in the way one would expect. It is no good getting up one morning and announcing that one is going to be a musician, because by the end of the day one realises that tomorrow's meals have got to come from somewhere, and living, especially in London, costs money. So the problem had to be considered from all sides and the best solution found. This was where the fun began. The only method of earning a living which I had acquired was through the profession of a doctor, so doctor it would have to be, any way for a time. Now, was it possible to be the sort of doctor who would have enough spare time to start some musical activity which might eventually develop, and, in time, supplant the medical side? Possibly. But here another problem presented itself. Such a doctor would have to have very little medical work, which would automatically mean very little pay, and as money and livelihood were essential, the circle seemed vicious and unbreakable. At this moment, luck was very much on my side, as it has been so many times both before and since. Several times I have met the right person just at the right time, and this time it was a doctor whose practice was in one of the slum quarters of London, but who lived in a more fashionable district. Not being resident, he naturally required someone who would sleep on the premises, to save him coming down during the night should there be any urgent calls, and who would also help a certain amount with the practice. I think I can truthfully say that without the help and sympathy of this man, it would have been impossible for me to realise my ambitions, and I shall always remember this with gratitude. He was a lover of music himself, and quite a fair pianist, so that his sympathy sprang from a real understanding.

I now began my transition period in earnest. I first began to pick up odd jobs as a singer, having studied the art for some years with very moderate success, but I soon saw that this would not get me very far, and the urge to become a conductor became stronger than ever. So for the next few years amateur orchestras writhed under my first onslaughts with the baton, but I was learning all the time, and by the end of this period I had got an amateur orchestra to give quite a fair performance of several easy symphonies.

In the part of London in which I lived at that time, I met every variety of human being. I am sure it widened my outlook far more than anything else could have done. And it was not without its humours. In fact, it is the amusing incidents and characters which remain most vividly in the memory. I cannot think why more novels are not written by doctors who have worked in such practices. The material for character study is immense, varied, and at first-hand. This experience also began to make me realise why the greatest musicians have almost invariably sprung from the very lowest surroundings. The passion for an escape of any sort must have fired the greatest imaginations with some of their finest fancies. I could understand why Beethoven lived in filth and why Mozart died a pauper. The material world mattered so little to them.

Well, after some years of conducting amateur orchestras, I began to feel that the time had come to extend my activities. What was I to do? Professional orchestras are not to be found waiting about looking for unknown conductors. The only solution as I could see it, was to form my own orchestra. One or two professional musicians whom I knew had urged me to do this for some time, but I had been naturally chary of taking the plunge. Several problems at once presented themselves. There were already plenty of permanent symphony orchestras in London and elsewhere, and to form yet another would have been unnecessary and extremely costly. No, the orchestra would have to be something slightly out of the ordinary. I decided, therefore, that for novelty the orchestra should consist entirely of string instruments, as at that time, as far as I knew, there was no other permanently constituted body of strings in the country. I consulted many experts on orchestration and balance, and finally came to the conclusion that the minimum number of strings possible was eighteen, divided up as ten violins, three violas, three 'cellos, and two double-basses. I also decided that the orchestra should consist entirely of young people. This was a bold, and up to that time quite original idea, but the chance taken then has justified itself over and over again. When I say young people, I mean *very* young people, that is to say, the average age of the orchestra when it was formed was twenty-one. I should think that this was probably unique. I know that its appearance on the concert platform in the early days often raised a smile among the audience, when they saw this group of apparently large children, walk on. But how, you will of course want to know, could such young players possess the necessary technique for such a venture, and how, if such players even existed, could one collect them? This was another moment when Dame Fortune smiled very kindly. In some astonishing way, which I have never to this day discovered, the news went round that I

was searching for this type of player, and I was inundated with applications from all over the place. I held auditions, and the extraordinary thing was that in a few days a large number of possibles had appeared, and quite a number of probables.

After three months of rehearsals on days when I was free from my medical work, I felt that the time had come to make a public appearance. This was done with a certain amount of trepidation and no little success, and six months later the orchestra gave its first broadcast, since when it has regularly been on the air at least once a month. After its first appearance, its success was so apparent to me that I saw the time had come to give up my medical work for good, and to concentrate all my energies on to what I could see had a big future, if only it could be successfully nursed through the difficult first stages. I am glad to be able to say now that the initial storms were successfully weathered, and that the orchestra looks like having a long and happy life. It has now a large and varied sphere of activity, and has made many trips abroad.

It is impossible to say, if such and such a thing had not happened, whether one would have swapped horses or not. In my own case I felt that it was inevitable only during the last year or two before it actually happened. But, as I have explained, my case had to be one of gradual transition owing to the nature of the circumstances. For anyone reversing the process, and becoming a doctor after being a musician, the whole thing would have to be premeditated for a long time, since it takes at least six years now to become qualified in medicine. Once qualified, of course, the change over could be made immediately. But I do not know of any case of this actually happening. Medical men, as a whole, take far more interest in the arts, than artists do in science. There are many medical men of my acquaintance who are most excellent executant musicians, painters and writers. This is quite understandable. It is all bound up with the principle of mental escape which I mentioned before. The medical man must of necessity be something of a materialist possessed of the best type of cynicism. But latent in everybody is the feeling for the need of expression and a craving for the beautiful. Where so much hard reality is met with as in the average doctor's life, art forms a way of escape eagerly seized upon by many men. Musicians living in an atmosphere of artistic expression do not feel a similar need, but I have noticed the interesting fact that the musician's spare time is spent in pursuits which are the very antithesis of his art. This is exactly what one would expect. In either profession, however, the range is so vast and the possible knowledge so amazingly varied, that enormous variety can be enjoyed within its own limits. And nothing truer was ever said than that variety is the spice of life.

Since taking up music as my profession I have certainly enjoyed life more than I did as a doctor—not because the work is any lighter, but because it is work which I like more. If anything, the work is harder, and I find music is a sterner mistress than medicine. Nowadays it seems almost impossible to get a holiday. When I was a doctor I had a definite period every year; but now I have to take week-ends and odd days when I can because I never know what is going to turn up next. In the medical profession you are always clearing up the mess, so to speak, but in this job you are always preparing for something coming along. It is the thinking ahead that ties one down—planning and preparing programmes.

I suppose sometimes I feel I should like to have my surgeon's instruments back in my hands, but I have no great craving for it. It has been a real swap and I do not feel that I ever want to go back—although, of course, I may have to. You never know.

ADVANCED WARDMANSHIP

(With furtlher appologies to Stephen Potter)

Since our last paper was read as the Picklestone-Smythe lecture to the Association of Wardsmen, research has progressed at the Lesser Snelling Cottage Hospital, and we have been able to produce a paper enumerating a few points in Advanced Wardsmanship, comprising:—Chiefmanship, or When to laugh on Ward-rounds, Outpatientsmanship, and Sister Counter-play.

Chiefmanship

This is the subtle art of stimulating a Chief to laugh, either at the Wardsman, other students, or the patient. To make a joke at the Chief's expense will undoubtedly bring its reward from one's fellows, but the Wardsman who is foolhardy enough to try it is advised to skip our chapter on Housejobmanship.

Smithson-Grierson,—that clever exponent of the Counter-ploy,—gained the essential one-upness, when his Chief observed that, on being asked to listen to a chest, Smithson-Grierson withdrew from his pocket two end pieces, gazed intently at each, and finally selecting a diaphragm, proceeded to auscultate. The conversation then went somewhat like this :—

Chief "Tell me, Smithson-Grierson, what criteria do you observe in your selection of an end piece ?"

Smithson-Grierson (after reflection): "I usually take the one with least tobacco in it, Sir."

It is a wise policy for all clerks and dressers to reply spontaneously to the question : "Have I told you the story of .....? "—with a questioning "Oh, do tell us!" After the seventh or eighth repetition of the anecdote, it requires a well trained firm to answer : "No" in a decisive manner. Nevertheless, this is *Basic Chiefmanship*, and must be closely followed.

The response can be varied with the story. There is the "Smile Understanding," as between medical men, the "Laugh Polite," —for the benefit of the patient,—and the "Laugh Natural,"—never heard after the first week on any firm. The "Laugh Hilarious," a rare thing, is heard very occasionally in Gynocological Outpatients, and in the sluice at Christmas when Sister is off duty.[1]

Outpatientsmanship

This is very advanced Wardsmanship, and so often comes too soon in the young Wardsman's career. He must not assume that he can blithely sweep into the cubicle, look straight through three labourers with cleft palates, a tailor's assistant with leprosy, and a carpenter with a ganglion, and say in a blasé, cultured voice :— "Anything to see, old man ?"—and then idly file his nails, and recount his experiences of the previous night with a Belt on Twilight to his discomfitted acquaintance, who is trying to elicit a history of Onychogryphosis from a very deaf pastrycook. This is *NOT* Wardmanship.[2] The true Wardsman is ploying against his fellow students, and a Chief or Registrar. Too often it is forgotten that under an exterior of classifications and differential diagnoses, there lies a Wardsman of well tried cunning; one who has learnt the hard way, before manuals and handbooks and the ploysman's Vade Mecum were written. Many a student, who has smarted under a rhetorical lash, has been the victim of an experienced Wardsman.

The author had the misfortune to lose the essential one-upness in an ante-natal clinic. When examining his first pregnant abdomen, he had a foetal stethoscope thrust into his powerless hands by a sister. In a moment of blind panic he applied it firmly to the abdomen, three fingers below the umbilicus, and, listening, heard nothing. Unhappily, it was not being used in its accustomed manner, and the reverse ends were applied to their respective parts;—abdomen and ear. "Mr.....," said a crisply drawled voice, "The foetus has little desire to hear you."[3]

Do not ploy when reading a history in OPs. This always annoys the Chiefs, and their favourite counter-ploy is dead silence, which is, of course, disturbing, and one catches the effects of the ploy on the rebound.

It is permissible, if the Chief approves of your diagnosis, and, beaming upon you, holds out his right hand for the notes, to grasp it in a firm handshake. This should

1. Not, of course, to be confused with the nurse's "Laugh Hysterical" when she drops the month's quota of thermometers.

2. The outpatient is not fair game. "He is likened unto a sitting bird" (Smythe, 1859-96), and is only to be ployed by the Wardswomen beginners.

3. A suitable reply was not immediately available. A consultant Wardsman would have perhaps counter-ployed with :— "But it would be making history if it did." This is the sort of thing that all Wardsmen must face. Defeat is only to be taken in one's stride, as experience gained. One day the self-same ploy may well be used by the author against some other Wardsman of less experience. Only false pride would stop him from using it. A good ploy should never be wasted.

It is, of course, not advisable to copy all the basic ploys used by Chiefs. Do not call the female patients "Popsie," as only great experience and smooth Wardsmanship will carry that one off. Choose your own terms of endearment, such as "dear." "luv," or "mother."

be done with confidence, and is not a gambit to be repeated with the same Chief.[4]

It was P. Q. Masterling, a Wardsman of acknowledged standing and experience, who was informed by a Chief, that if he pursued his studies diligently, he would one day, like him, drive a Bentley. This gave Masterling the essential one-upness, as he counter-ployed with no reply at all, using Nicechap-manship. The whole class knew very well that he drove a Rolls Royce. Only afterwards was the Chief informed. This is correct use of the *Ploy Delayed*, or lasting one-upness.

OPs. calls for quick ploy and counter, and the complex gambit is usually out of place.

The correct answer to the stick of chalk flung at the dozing Wardsman in the back row by the radiator, with instructions to inscribe on the board a classification of a disease entirely unknown to him, has not yet been devised. The author has toyed with the idea of throwing the chalk across the room to some weaker fellow, but he would rather see some other Wardsman attempt it first, as he is doubtful of the course counter-ploying might take.

Counter Sister Play

Our research unit at the Lesser Snelling Cottage Hospital has progressed little in this very advanced aspect of Wardsmanship.

The unit was very nearly annihilated by the glance of a passing Matron, after attempting a particularly unsuccessful simple ploy. In view of continued failure, the editor of this journal has consented to accept and publish ploys and gambits used and experienced by Wardsmen in the course of Sister Counter-play. He will offer as a prize for the most practical or interesting anecdote, one of Mr. Stephen Potter's great works :— "Lifemanship," or "Gamesmanship." To be limited to 300 words, and the author's and editor's decision to be very final indeed.[5]

It is said that the practice of medicine is an art as well as a science. How much more so must this be true of Wardsmanship, once the basic principles are mastered. A bad student or doctor can never be a good Wardsman.

4. P. Q. Masterling, whose gambit it is, always wears the tie of the Chief's old college before he uses it, as he holds that the spirit of cameraderie flows better between them under such circumstances

5. This is a very good opportunity for the use of "New Statesmanship" by the practised Life-man-cum-Wardsman.

Entries for this competition of ploys and gambits of the practical gamesman, in which anyone is welcome to compete, should be confined to Counter-Sisterplay. Entries should be put in the Editorial post or upon the Editorial desk by midnight Monday, September 24th. The Editor reserves the right to publish part or the whole of any entry.

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* * *

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

CORRESPONDENCE

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

Dear Sir,

I have been at Bart.'s for under a year. I hesitate from such short experience to find fault with its teaching method, but the infant criticism which was born soon after my arrival has so grown that ten months later I am unable to restrain it from giving voice. It has often been said that the clinical training period should be spent "in acquiring skills," but this seems not to be encouraged here.

This criticism could be summarised as a sense of lack of responsibility. I have been given no duties which are *my* duties: I know that if I shirk anything someone else will do it for me. The only matter in which this does not apply is the attendance of compulsory lectures, ward-rounds, and practical classes. I wonder whether this should not be the other way round—that my responsibilities should be, not to the lecturers and the porters with their attendance sheets, but to the patients in the wards. My approach to them seems to be limited to interference. I can take a history and an examination from them, certainly, but what can I give them in exchange? Of what service can I be to them? Of very little, for I seem not to be trusted. Perhaps this is right, perhaps the patients who have suffered already from my examining would suffer more from my attention; but in less than two years I could be qualified: I should find it a great help and my patients would benefit then, if in the meanwhile I were to be entrusted with responsible duties. At present I do not regularly do the dressings on my patients, and I am definitely discouraged from any attempt to do them in the female wards. When I am duty dresser in the evening, or on Sunday, the only dressings I do are a few left over by the nurses. As in the wards, so in the out patients' departments. It is seldom indeed that I am privileged to stitch up a wound or lance a boil, and yet in two years time I shall be expected, with no further experience, to be perfect in these things. In some of the medical wards the clerks are not required to write up the patient's notes, and where they do write them it is seldom that they are read or appraised by the staff. In the operating theatre the dresser has to be scrubbed up ready, when there are already two assistants, and he will not even hold a retractor. In these ways have the dressers and clerks lost their duties in the hospital to become mere students. But enough of criticism, I must try to suggest remedies.

It is true that a lack of responsibility is typical of our age, but that does not mean that an educated community should not try to restore it. The student must have set duties. I should have liked to feel that I *had* to do the dressings, and that they were my contribution to the treatment. I should have liked my notes to be appraised, for then at least there would have been some point in my writing them. In the theatre I would rather have assisted the sister and nurses, than have stood awkwardly by the surgeon, learning little, and helping less. As one of two duty dressers I should probably not have enjoyed staying on in the evening to do *all* the dressings, but I should have learned how to do them properly. I believe that I am not alone in the feelings that I have expressed.

"Responsible" is defined by the dictionary as "liable to be called to account; of good credit or position; trustworthy"—very apt descriptions of the sort of medical student we should all like to be.

Yours truly,

G. F. B. BIRDWOOD

Abernethian Room,
July 25, 1951.

THE THREE COUNTIES BART'S DINNER

Gloucestershire, Hertfordshire and Worcestershire

The Three Counties Bart.'s Dinner will be held this year on October 5 at the Abbey Hotel, Malvern. Would all Bart.'s men living or practising in any of the three counties, who would like to come, please write to me:—Dr. D. E. Oakley, 11, Park Road West, Wolverhampton.

THE PRACTICE OF SURGERY FIFTY YEARS AGO

By E. V. DE VOSS

At the beginning of this century aseptic surgery was in its infancy, but it had a good start at St. Bartholomew's Hospital in the persons and practice of Sir Henry Butlin and Mr. Lockwood—especially the latter.

Most surgeons had vagaries of their own, but the sisters and theatre nurses knew how to cope with them. For instance Sir Thomas Smith, a magnificent surgeon, whose wounds healed as if by magic, was most accommodating in the matter of antiseptics. "All right, sister," he would say to Sister Laurence, "put a dash of carbolic in it, if you like."

Mr. Lockwood, on the other hand, made a ritual of "preparatory dressings" the night before the operation. The patient who was going to have his appendix removed on Saturday afternoon had to undergo a preliminary process of a really drastic nature on Friday evening. One patient said to me: "If *this* is a preparatory dressing, Sister, whatever will the operation be like!" I reassured him that it would not take nearly so long, and in any case he would then be blissfully asleep and would wake-up, quite comfortable, in bed—without his appendix.

Dressings were very colourful. Some of the surgeons liked blue gauze, some pale lilac: iodoform was a lively yellow and boracic lint a bright pink. Sometimes dressings were put in a fireproof dish with a cover and baked in my ward-kitchen oven—that being handy for the New Theatre.

Some of the surgeons were marvels of speed and dexterity, and their sense of touch, too, bordered on the miraculous. "Cut down here, Dickson," Mr. John Langton would say, tapping a finger over a boy's hip. "You will find the pus deep down there"—and there it was. In those days there were no X-rays, but there were many "hip-children" with deep-seated abscesses which did not "point."

For malignant diseases there was often an "exploratory operation," after which the patient was told what had been revealed and what chances there were of complete eradication.

Some of the surgeons used to have "field days," and then worked with amazing speed. Mr. Butlin would be down for a very long list on Friday afternoons and operated from 1.30 to nearly six o'clock, broken by a tea-interval in the instrument room. There Wright was in charge of the instruments, which were boiled in a large copper kettle with a tray. Wright was an imperturbable man and knew everything. Snippings were taken of the dressings that had been "sterilised," and of the patient's skin, and these were taken to the Pathological Laboratory in sterilized tubes to see if they would "grow." Wright took charge of these matters and was called the "recording angel."

Leeches were still used. *Bleeding* was also carried out. There were special metal bowls for this purpose with marks on them to indicate the amount taken.* *Cupping* was also occasionally done—on the back of the patient, who did not seem to mind the process. In fact patients were seldom refractory and seemed to appreciate these drastic attentions. They also like a good strong medicines—three times a day—and a good dose of *Haustus Sennae Co.* S.O.S.

TWO HUNDRED YEARS AGO . . .

From the Hospital Journal of 1751:

Grace Porter, Sister of Treasurers Ward, is dismissed from her employment, for taking greater fees from her patients than are allowed by the orders of the Hospital & for rude behaviour to a gentleman visiting the poor patients in her ward & distributing his private charity to them & for unkindness to her patients.

And one week later . . .

Upon the reading of the petition of Grace Porter, the late sister of Treasurers Ward, thereby acknowledging her faults and promising never to be guilty of the like offences for the future; and it appearing to the Committee that she was very capable of her business and had always been careful of her patients, but sometimes subject to violence of temper, Resolved submission and ordered that she should be restored to her employment on her submission and promise of better behaviour for the future. And Mr. Treasurer reprimanded her, & enjoyned her to behave better for the future.

CLINICAL CASE-BOOK

A CASE OF HIATUS HERNIA IN THE NEW BORN

Maureen M., born 21.3.51.

History of the present condition

A normal pregnancy and delivery. Birth weight 6 lbs. 13 oz. Onset of vomiting on the first day of life, the vomitus contained mucus and at times it was blood stained.

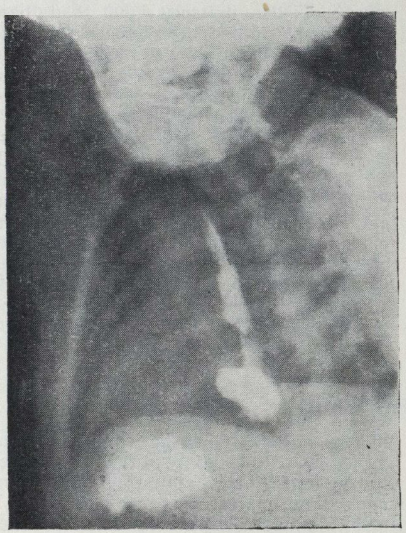
On examination

Nothing abnormal was discovered. There was no evidence of birth injury. No pyloric tumour was palpable.

Progress

Gastric lavage was performed with no improvement and the vomiting persisted, while the infant continued to lose weight.

A barium swallow showed a "typical short oesophagus and diaphragmatic hiatal hernia."



Management

Thickened feeds of Bengers Food and an evaporated milk mixture were given and the infant nursed in an upright position. The baby gained weight slowly. On her last examination (aged 12 weeks) the weight was 9 lb. 8 oz. (expected weight 11 lb. 7 oz.) and she was taking her feeds well, with only occasional vomiting.

Differential Diagnosis

Vomiting in the newborn may be due to :—

1. Gastric irritation after swallowing liquor amnii.
2. Birth trauma, e.g., intracranial haemorrhage.
3. Feeding mismanagement.
4. Infections.
5. Congenital defects in the alimentary tract :
   (a) Pyloric stenosis; (b) Pylorospasm; (c) Tracheo-oesophageal fistula; (d) Diaphragmatic hiatus hernia; (e) Meconeum ileus; (f) Oesophageal or intestinal atresia; (g) Imperforate anus.
6. Uraemia or alkalosis.
7. Atrophy or internal haemorrhage of the adrenal cortex.

Discussion

Two types of hiatus hernia have been described : the congenital thoracic stomach with a short oesophagus, and the true herniation of the stomach through a wide oesophageal hiatus. Recent work suggests that the congenital short oesophagus is rare. Olsen and Harrington in a series of 220 cases of hiatus hernia found only 4 per cent. of such cases. The condition has only been recognised for about thirty years and a hundred cases have been described. Husfeldt and his colleagues believe that this figure gives a false impression. After only three years' work (1947-50) in a limited field they have collected 14 cases. Progress in thoracic surgery, which has focused attention on this condition, has made the distinction between a congenital short oesophagus and true hiatus hernia important, because the stomach can easily be drawn into the abdomen where there is a hiatus hernia, but not if the oesophagus is congenitally short. In many babies the stomach, together with a looped vagus, is easily drawn into the abdomen. Both these facts point to a herniation of the stomach into the thorax. A larger case series will eventually give the relative frequency of these two varieties of hiatus hernia.

Both the true hiatus hernia and the congenitally short oesophagus are frequently associated with peptic ulceration. In Olsen and Harrington's 220 cases, 199 were examined with an oesophagoscope and 110 were found to have ulcers. Peptic ulceration of the oesophagus causes fibrosis leading to constriction of the lumen and a shortening in length. In the past peptic ulceration of the oesophagus was thought to be rare, and all cases of shortening following fibrosis were attributed to congenital shortening. It is now recognised that such fibrosis may occur in cases of hiatus hernia, where the oesophagus is originally of normal length. Once fibrosis has occurred, however, it is difficult to tell to which category the patient originally belonged. Peptic ulceration is thought to be due to gastric regurgitation, which is normally controlled by three mechanisms : firstly by constriction of the cardiac sphincter; secondly, by the contraction of the diaphragmatic muscle fibres around the oesophagus as it passes through them; thirdly by the action of the valve like fold formed by the entrance of the oesophagus into the side of the fundus. This fold becomes more pronounced when the stomach is filled, on deep inspiration, and when the abdominal pressure is raised. In hiatus hernia, the oesophagus enters at the top of the stomach and the cardiac sphincter alone is frequently inadequate to prevent regurgitation.

If it is correct that true hiatal hernias are relatively common, the interesting question arises as to why the herniation should occur at all. An abnormally wide hiatus has been accounted for by Bund as being due to a persistent right sided embryological pouch (pneumoenteric recess). This theory has been discarded as the hernia is usually found on the left. Akerbund (1926) and later Harrington (1947) suggest that the stomach is delayed in its descent from the pharynx to the abdomen, and is caught by the developing diaphragm which closes about its larger circumference, and when the stomach eventually does descend it leaves an abnormally large hiatus. Venhause and his co-workers (1947) explains the large hiatus by an imbalance of the sympathetic and parasympathetic control of the cardia, the opposite to that said to be found in cadriospasm; others have proposed a fatty or fibroceptic degeneration of the diaphragm. Herniation is most likely to occur in the supine position during inspiration, which accounts for pain and discomfort, which is felt worst when lying down and is relieved by sitting up. Some affected children indeed may sleep upright.

Dey and his colleagues (1946) suggest a contributary cause. They have found that stimulation of the vagus in rabbits and dogs, leads to spasm and shortening of the oesophagus and they have quoted a series of cases of recurrent hiatal hernias in man which they consider are due to this cause. Reflex vagal stimulation occurs on distension of the stomach or gall bladder and arises from the peritoneum, and the resultant spasm may also account for an apparent shortening of the oesophagus in cases of true hiatus hernia.

Treatment

This disease in later life is seldom serious but always unpleasant. Conservative treatment rarely cures, and recurrent dyspepsia and dysphagia continue throughout life. Children remain thin and fail to thrive, and there is a serious risk of peptic ulceration. Conservative treatment is indicated where there is anatomical shortening, where symptoms are mild, in infants, unfit for operation and where there are no suitable surgical facilities. In the last two eventualities operation later is advisable as scarring is more severe in children than in adults. Some believe it occurs during the first few months of life (Browne-Kelly), though Husfeldt and his co-workers state that permanent shortening does not occur under two to three years. Conservative treatment consists of small frequent thickened feeds. The children are propped up whilst they are eating and for some time afterwards. Plenty of fluids are said to prevent oesophagitis (Wamberg

Äkerlund Äke (1926). Acta Radiol. Stockh. *6*. 3.
Neuhauser, E. B. D., and Berenberg, W. (1947). Radiology. *48*. 780.
Olsen, A. M. and Harrington, S. W. (1948). J. Thorac. Surg. *17*. 189.
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Allison, P. R. (1948). Thorax *3*. 20.

We would like to thank Dr. C. F. Harris for permission to publish this case and Dr. T. G. Millichap for his help and patience.

1946), and alkalies may relieve pain. The hernia is aggravated by overeating.

At operation the oesophagus is mobilised and the stomach drawn down, sometimes phrenic interruption is necessary before the cardia can be secured in its normal position. Up to the present few cases have been treated surgically, but with early operation a 75-80 per cent. cure rate has been obtained.

L. FELDBERG, C. M. RANT

EXAMINATION RESULTS

UNIVERSITY OF CAMBRIDGE

Final M.B. Examination — **June, 1951**

Part I (Old Regulations)	Fiddian, R. V.		
Part II (Old Regulations)	Shore, E. C.		
Part I (New Regulations)			
Andrewes, J. F.	Gracey, L. R. H.	Law, R. R.	Sarma, V.
Cronk, P. G.	Greenhalgh, G. P.		
Part II (New Regulations)			
Atkinson, R. S.	Downey, M. F.	Hardman, B. M. H.	Law, R. R.
Braimbridge, M.	Gracey, L. R. H.	Huntsman, R. G.	Williams, J. A.
Cronk, P. G.			

The following students have completed the examination for the Degree M.B., B. Chir. (Cantab.)

Atkinson, R. S.	Downey, M. F.	Huntsman, R. G.	Shore, E. C.
Braimbridge, M.	Gracey, L. R. H.	Law, R. R.	Williams, J. A.
Cronk, P. G.	Hardman, B. M. H.		

ROYAL COLLEGE OF SURGEONS

Subject to the approval of the Council of the R.C.S. at a meeting held on 14th June, 1951, the following are entitled to the Diploma of Fellow:—

Barker, E. A.	Georgeson, W. S.	Monks, P. J. W.	Roy, A. K.
Bastable, J. R. G.	Hartley, C. E.	Murley, A. H. G.	Rhydderch, A. I.
Bleasell, K. F.	Jones, J. T.	Panchalingam, S.	Seyal, N. A. K.
Burke, T.	Lawrence, K.	Potter, J. McE.	Shephard, E.
Chen, J. H. M.	MacGregor, W. G.	Rawlinson, J. K. McC.	Silva, J. F.

UNIVERSITY OF LONDON

Examination for the Academic Postgraduate Diploma in Public Health — **June, 1951**

Fawkes, M. A.

Examination for the Academic Postgraduate Diploma in Bacteriology — **July, 1951**

Manning, J. D.

Examination for the Postgraduate Diploma in Medical Radiology (Diagnosis) — **July, 1951**

Green, B. Kimmel, S. A. Liston, W. P.

Examination for the Postgraduate Diploma in Medical Radiology (Therapy) — **July, 1951**

Pablot, P. J.

CONJOINT BOARD

Final Examination — **July, 1951**

Batey, I. S.	Cohen, H.	Parker, R. B.	Tabor, A. M.
Chia, A. K.	Hall, M. C.	Stoke, J. C. J.	Watts, M. B.
Chitty, W. A.	Moore, J. D.		
Medicine			
Cohen, H.	Gracey, L. R. H.	Matthews, P. D.	Picthall, G.
Dean, D. W. J.	Hazelton, S. F.	O'Reilly, P. B.	Shore, E. C.
Surgery			
Barnes, J.	Evans, E. W.	Lumley, P. W.	Thomas, G. E. M.
Beattie, A. O. C.	Haigh, P. G.	Matthews, P. D.	Watson, L. P. E.
Blake, A. S.	Hazelton, S. F.	Power, G. H. D'A.	Whittard, B. R.
Dean, D. W. J.	Leigh, J. G. G.	Scott, A. E. R.	
Midwifery			
Almond, F. A.	Butcher, R. H. G.	Gobert-Jones, J. A.	Husainee, M. M.
Batey, I. S.	Chitty, W. A.	Goff, E. G.	Waddy, G. W.
Beale, I. R.	Cohen, H.	Goodspeed, A. H.	Whittard, B. R.
Beattie, A. O. C.	Dickman, H. R.	Haigh, P. G.	

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

Barnes, J.	Dean, D. W. J.	Hazelton, S. F.	Shore, E. C.
Beattie, A. O. C.	Goff, E. G.	Leigh, J. G. G.	Thomas, G. E. M.
Cohen, H.	Haig, P. G.	Matthews, P. D.	

SO TO SPEAK . . .

Original Sin

Psoriasis is due to a guilt-complex developed in utero.

Cut down in his prime

At that moment the victim cries out in agony and he is riveted temporarily to the spot where the perforation felled him.

A textbook of Surgery.

Please return, if not satisfied

"If you don't become pregnant by September come back and see me again."

All in the day's work

First Session

SATURDAY, JUNE 9, 1951

8.00 a.m. General Registration.

9.00—12.00 Ovulation and Conception.

—From the Program of the Society for the Study of Sterility.

SPORT

CRICKET CLUB

v. **OLD ALLEYNIANS** at Dulwich Common.

June 3. Match Drawn.

Old Alleynians 203 for 8 declared. (Braimbridge 4 for 62). Bart'.s 93 for 8. (Winton 29.)

A weak Bart.'s side were outplayed by the Old Alleynians, but were saved from defeat by good defensive batting on the part of Winton and Lawson.

2nd Round Cup Match

v. **ST. MARY'S HOSPITAL,** June 6, at Teddington.

St. Mary's won the toss and batted first. Despite a good innings of 36 by Somper, 5 wickets were down for 108—the result of accurate bowling and keen fielding. Winton, particularly, bowled well to his field and was swinging the ball deceptively.

Willis then came in and proceeded to attack the bowling. He gave a fine display of scientific hitting, although aided by a modicum of the fortune which favours the brave and two missed chances. He was eventually caught and bowled by Ross, who confidently held on to a skier as he collided with extra cover. The remaining wickets fell for another 7 runs and St. Mary's were all out for 190 on a good batting wicket. The fielding was safe throughout except for the chances alluded to above, one of which was far from easy. May held a good catch at leg slip to dispose of Liscombe.

The Hospital failed to make the runs in the face of some excellent spin bowling by Speight. Tomlinson played a very fine innings of 65, containing some beautiful shots; but he was not in his most dominant mood and had some anxious moments when facing Speight. Ross and Biddell provided useful support and at one time the score was 113 for 2. Unfortunately the middle batting collapsed and Bart's were all out for 176, despite a few terminal blows by Roche and Haigh.

SCORES

St. Mary's Hospital

Reddy b. Taylor	15
Robertson l.b.w, b. Taylor	15
Somper stpd. Roche b. Braimbridge	36
Thompson b. Clappen	7
Lawrence l.b.w., b. Winton	42
Liscombe c. May b. Winton	6
Willis c. and b. Ross	53
Speight l.b.w., b. Ross	0
Moller not out	0
Ellis b. Winton	4
Baxandall b. Winton	0
Extras	12
	190

	O.	M.	R.	W.
Taylor	14	4	44	2
Winton	16	4	32	4
Haigh	13	2	30	0
Clappen	10	1	35	1
Braimbridge	5	0	21	1
Ross	5	1	10	2

St. Bartholomew's Hospital

H. B. Ross stpd. Reddy, b. Speight	25
D. L. Hodgson b. Boxandall	5
J. D. W. Tomlinson stpd. Reddy, b. Speight	65
P. B. Biddell l.b.w., b. Boxandall	31
M. Braimbridge c. Robertson, b. Speight	8
A. G. May c. Reddy, b. Ellis	9
J. A. Clappen c. Willis, b. Speight	4
D. W. Roche c. Robertson b. Speight	13
F. W. Winton, stpd. Reddy b. Speight	1
P. G. Haigh not out	11
J. H. K. Taylor c. Robertson b. Speight	0
Extras	4
	176

	O.	M.	R.	W.
Boxandall	15	4	39	2
Thompson	13	0	39	0
Speight	24.1	7	74	7
Ellis	8	0	20	1

TENNIS CLUB

v. **STANMORE** at Stanmore, June 10. Won by 6 wickets.

Stanmore 209 for 9 dec. (Winton 4 for 34; Ross 2 for 14). Bart.'s 214 for 4 (May 86 n.o.; Clappen 30 n.o. Braimbridge 41; Waterhouse 30).

This was a good victory, Stanmore declaring at 209 after over 3 hours batting and leaving the Hospital 2¼ hours in which to get the runs.

May and Clappen got the last 70 runs in half an hour.

v. **HORLICK'S C.C.** at Slough, June 6. Won by 86 runs.

Bart.'s 217 for 8 dec. (May 48; Lawson 48).

Horlick's 131 (Arthur 4 for 21; Winton 3 for 34; Clappen 3 for 50).

v. **BROMLEY,** at Chislehurst, July 1. Drawn.

Bromley 193 for 5 (Arthur 2 for 19; Foy 2 for 39).

Bart:'s 108 for 5 (May 44; Ross 35).

v. **HORNSEY,** at Hornsey, July 7. Lost by 6 wickets.

Bart.'s 184 (Ross 58; May 56; Waterhouse 42).

Hornsey 187 for 4.

PAST v. **PRESENT,** at Chislehurst, July 8. Won by 165 runs.

Present 297 for 2 dec. (Waterhouse 82; Ross 75; Clappen 71 n.o.; May 59 n.o.).

Past 132 (Harold 51; Arthur 5 for 45; Clappen 3 for 7).

v. **HAMPSTEAD,** at Chislehurst, July 14. Lost by 5 wkts.

Bart.'s 199 for 5 dec. (May 79; Waterhouse 50; Aubin 47 n.o.)

Hampstead 200 for 5 (Ross 5 for 41).

Bart.'s won the toss and declared at 199 for 5. Waterhouse played many good shots, and May yet again showed form almost worthy of his namesake. P. B. H. Aubin delighted us with an interesting 47 not out—he now considers himself as a batsman rather than a bowler, presumably considering that the ballet-like neatness of his footwork is wasted in the latter sphere.

Hampstead batted attractively and knocked off the runs with 4 minutes to spare in 2½ hours, despite some good bowling by Ross.

v. **FINCHLEY,** at Chislehurst, July 15. Won by 149 runs.

Bart.'s 183 for 7 dec. (May 52; Cairns 42).

Finchley 34 (Arthur 6 for 16; Foy 3 for 5).

Bart.'s batted first and made 183 for 7, Cairns contributing a neat 42 and May his inevitable half century. Finchley collapsed against the good spin bowling of Arthur and Foy. But it was not good enough to explain the way that batsman after batsman was seen to prod suspiciously at half volleys and full tosses. They seemed to be suffering from some form of mass hypnosis induced by illusionist Arthur.

1st VI v. **THE STAFF,** July 15. Won 5-4.

SCORE (Bart.'s scores first).

Stuart Steven and Mark Mehta v. S. Lacey and J. Briggs: 6-1, 4-6, 1-6; v. W. Havard and D. Pearsons: 6-8, 6-3, 9-7; v. L. Dowie and J. Mellows: 5-7, 3-6.

John Stevens and Geoffrey Manning v. S. Lacey and J. Briggs: 6-4, 1-6, 5-7; v. Havard and D. Pearsons: 6-2, 4-6, 6-4; v. L. Dowie and J. Mellows: 5-7, 2-6.

Donald Fraser and Frank Musgrove v. S. Lacey and J. Briggs: 6-3, 6-2; v. W. Havard and D. Pearsons: 6-2, 4-6, 6-1; v. L. Dowie and J. Mellows: 6-4, 8.6.

Mr. Fraser had gathered a strong team, and the result depended on the last set of the last event, which had the players (and spectators) rather dyspnoeic.

Stuart Steven and Mark Mehta ran hard and fast in winning their first two events, but lost the decider to Havard and Pearsons.

John Stevens' services bid fair to rupture the net but those that came over (the majority!) were exceedingly difficult to take. He was partnered by Geoffrey Manning who occasionally found orthopaedics more than an academic problem, though he, too, worried his opponents.

Mr. Donald Fraser and Frank Musgrove found some initial difficulty in combining but later on Mr. Fraser caused us much trouble in retrieving his smooth deliveries.

It was interesting to note that the post-graduate vocabulary was no whit inferior to the undergraduates—indeed, some of their shots evoked quite a brotherly feeling. Tennis can be *so* provoking.

Altogether this was an extremely enjoyable match in every way and one that should be a regular yearly fixture.

BOAT CLUB

A most encouraging and successful summer has ended by Bart.'s winning a cup at Kingston Regatta, and sending a crew to take part in the Danish International Regatta at Copenhagen.

At Walton Regatta on June 9th we entered a Junior Four which, after only very little practice together, succeeded in reaching the final. They were very unlucky to be beaten by only two feet by a good school four. This same four entered for the Junior Fours at Kingston Regatta on June 30, and this time made no mistake about winning the cup. After beating Neptune R.C. (Oxford) easily and Westminster Bank R.C. by 1½ lengths they met St. George's Hospital in the final and defeated them by about four lengths. The Dean Challenge Cup which they won is, I believe, the first cup ever won by a Bart.'s crew in an open regatta.

Marlow Regatta is, after Henley, the second biggest regatta in the country, and Bart.'s were represented by two eights. The "A" crew distinguished itself by reaching the semi-final after previously eliminating Weybridge Rowing Club and National Provincial Bank R.C. We were then beaten by Christ Church, Oxford, a fitter crew who went on to win the cup. The "B" crew were beaten by the other finalists—Keble College, Oxford.

The fact that the Hospital has been represented at almost every up-river regatta this summer, and has distinguished itself in Junior events, is most encouraging for the future of Bart.'s rowing, and we hope it will not be long before the Hospital can enter for, and win, Senior events.

Crews at Marlow Regatta were:—

"A" Crew: Bow, J. F. D. Damment; 2, J. M. Gray; 3, R. G. D. Newill; 4, G. D. Langham; 5, J. M. Jones; 6, D. H. Black; 7, J. D. Salmon; Str., P. E. Mann; Cox, P. A. Clark.

"B" Crew: Bow, C. J. W. Hunter; 2, C. C. Turner; 3, W. G. Harris; 4, A. D. M. Thomas; 5, M. F. D. Burton; 6, A. H. Luscombe; 7, P. J. G. Smart; Str., P. G. Burton; Cox, F. J. C. Millard.

Winners of the Dean Challenge Cup, Kingston Regatta, were: Bow, J. D. Salmon; 2, D. H. Black; 3, J. M. Jones; Str., P. E. Mann; Cox, P. A. Clark.

Awards

Honours for 1950-51 have been awarded to R. G. D. Newill, R. Goldsmith and P. E. Mann.

Colours have been awarded to J. D. Salmon, R. J. Blow, G. F. B. Birdwood, W. P. Fitt, R. J. Knight, J. W. B. Palmer, P. J. G. Smart.

Officers

At the annual general meeting on June 19, the following were elected officers for next year:—

President—Dr. B. W. Town.

Vice-Presidents—Prof. K. J. Franklin, Prof. A. Wormall, Dr. A. W. Spence, Dr. J. H. Coulson, Mr. O. S. Tubbs, Mr. H. H. M. Ward (Thames R.C.).

Captain—G. F. B. Birdwood.

Hon. Secretary—P. E. Mann.

Committee members—R. G. D. Newill, R. J. Blow, P. J. G. Smart, F. J. C. Millard.

BOOK REVIEWS

THE NOSE, EAR AND THROAT for Nurses and Dressers, by Michael Vlasto. 4th Edition, 1951. Faber & Faber, pp. viii + 214, illus. 132. Price 8s. 6d.

This is a book for the nurse written by a surgeon. It describes in simple language the elements of anatomy and pathology in so far as they concern the work of an E.N.T. department; and it describes briefly and clearly most of the standard procedures used there, laying emphasis on the part that must be played by the nurse. The book contains many illustrations; of especial value are the anatomical drawings which are of a high standard, and the illustrations of instruments.

In this edition the book has been revised thoroughly and brought up to date. It is perhaps a pity that revision stopped just short of replacing certain illustrations of nursing techniques which have outlived the sartorial fashions of the parties concerned.

Though the book is intended primarily for nurses, medical students may well find it a useful introduction to their E.N.T. course.

OPERATING ROOM PROCEDURES FOR NURSES, by Jean D. Jolly. Published by Messrs. Faber & Faber. 3rd Edition. Price 7s. 6d.

This book stays open in the hand in a co-operative way. Its price is moderate and the illustrations good. It contains a great deal of information, including some descriptions such as that of Keynes' flask which are not obviously useful. The style is inelegant even for a surgical handbook, e.g., "very major operations." "sterile nurse," "manipuate taps by foot or turn on by elbow." It is very difficult for a writer to please other Training Schools about procedures, and since the author is evidently a practical expert it is unnecessary to criticise details. We were however impressed to learn that the Scottish surgeon is able and willing after scrubbing for ten minutes to immerse his hands in carbolic 1 in 20 for five minutes.

DIATHERMY—Short wave Therapy Inductothermy. Long wave Therapy, by W. Beaumont. 2nd Ed. 1951. H. K. Lewis, pages viii+230. Illus. 114. Price 21s.

The main title of this book—"Diathermy"—needs elaboration. The subjects described are medical and short wave diathermy; those forms in which tissue is heated but not destroyed. The book is a specialist one and not to be recommended to medical students in general. On the other hand to those physiotherapists and specialists in physical medicine to whom it is addressed it will be invaluable. A knowledge of electricity is presumed, and this serves to simplify the text which is singularly free of clogging or repetitive detail. The various treatments are logically and concisely described in clear and readable type. The profuse illustration does in the main illustrate the text. The book is well produced. In reviewing this, the second edition, I have avoided comparison with that of 1939 as the many changes have given us almost a new work.

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Old Bart's man, wishing to sell house and pracice in St. Vincent, British West Indies (turnover £3,000) invites enquiries

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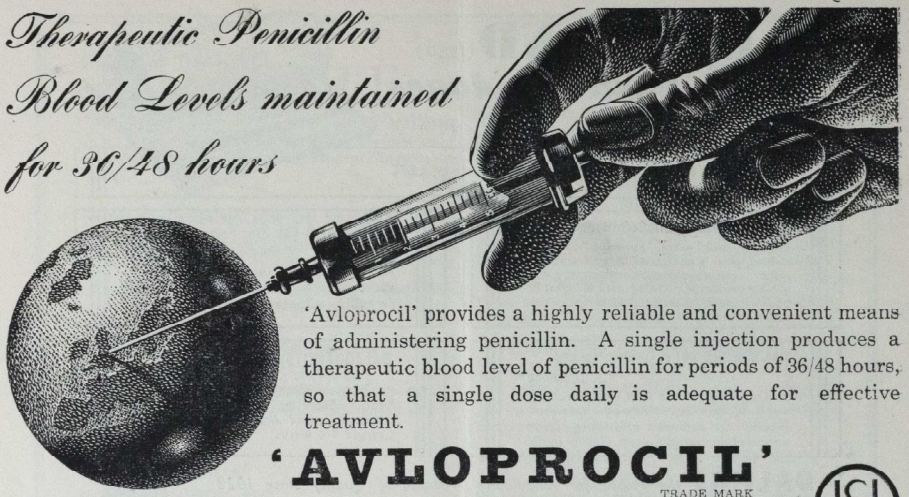

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SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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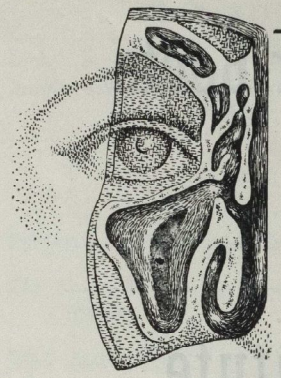

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ST. BARTHOLOMEW'S

HOSPITAL JOURNAL

Vol LV OCTOBER, 1951 No. 10

SYLLABUBS AND CREAM

A good cook is half a physician, for the physic doth come from the kitchen; wherefore the physician and the cook, for sick men, must consult together.
From "A BREVIARY OF DIET" *by* DR. ANDREW BORDE, 1490-1549

THERE is no place in England, perhaps in the world, where food and drink might once be had in such quality, or in such abundance, as in that area of London around our Hospital. There is certainly no place, today, where it is worse prepared and served, and eaten with less delicacy or taste, leisure or enjoyment.

The standard of English cookery has tumbled alarmingly, and our pride of good food ebbed sadly away. Old men are tiresome when they tell us "what things used to be." The young are given such foolish and soul-destroying advice as "Don't be greedy" and "Don't fuss." The rest of us, who have been overtaken so insidiously by the New Age, are happy to be rounded up from our individual paths and made to run in the universal rut. We seem content to be elbowed about in canteens and milk-bars, uncomplaining at the "*Kozi Kafe*," or the ubiquitous Lyons, which now replace the foison of old city chop-houses. Gadgets, "without which no modern kitchen is complete," and other time-savers and wife-pacifyers are a temptation to slothful cooks. Men account for their tempers by their ulcers, instead of blaming both upon ill-enjoyed food prepared by Science not Art. Food, dried, food canned, food "vitaminised," food frozen, food fortified, but is there nowhere to be found a meal well cooked and attractively served?

The English table was at its most succulent during Tudor times. In the days of Henry the Eighth and Elizabeth, wholesome food was plentiful and appetites were keen. Meats were heavily seasoned with saffron and cinnamon. Vegetables and fruit were becoming popular, although the American tuber had not yet arrived. Courses were relieved by "Subtleties," made from sweetmeats. Here is a description of such a subtlety to be tasted at a dinner held by the Archbishop of Canterbury: "A Soltelte. Seint Andrew sitting on an hie Auter of astate, with bemes of gold; afore him knelyng ye Bisshope in pontificalibus: his Croser kneling behind him coped." Altogether it seems to have been a very promising affair. When visitors were invited to dinner, they would rightly expect a fine meal and a pleasant evening to follow. Before setting off from home, each guest would select himself a large and ornamental spoon to put in his pocket, then he might take a lute or viol from off the wall and set off through the city to enjoy the fare and to amuse the company. But these happy days of good living were not to last. The Puritans, who confused pleasures of the table with pleasures of the Flesh, interrupted our national tradition, and our culinary art has never recovered. Ever since, it has been a little shameful to take pleasure in the good things of life.

The true Epicure is one who appreciates the craft of cooking and the art of arrangement. He must be unconventional (for convention is but a stale thing), and he may shirk from nothing by way of experiment. When he travels abroad he should accept whatever is given him with interest and appreciation. When the Epicure is at home he shows his guests how distinction may be

granted to the commonplace, and flavour given to the flavourless. Now once, the people of this part of London were Epicures, artists and craftsmen of good living. They were delightfully unconventional too, and would celebrate the freezing over of the Thames by roasting a whole ox on the ice. They were enthusiastic and discerning, such as Dr. Johnson. In spite of an accusation that he ate with "ravenous greediness" the Doctor showed great discrimination both in his diet and that of his cat. Poor Boswell, who had an antipathy to cats, relates "I shall never forget the indulgence with which he treated Hodge, his cat, for whom he himself used to go out and buy oysters, lest the servants, having the trouble, should take a dislike to the poor creature." But then oysters used to be plentiful, and perhaps because they were easy to buy, they were considered less of a delicacy than they are nowadays. Mr. Sam Weller makes this point more clear. Mr. Pickwick was driving to Ipswich from the Magpie and Stump, when Sam observes:

> "It is a wery remarkable circumstance, Sir, that poverty and oysters seem always to go together."
>
> "I don't understand you, Sam," said Mr. Pickwick.
>
> "What I mean, Sir," said Sam, "is that the poorer a place is, the greater call there seems to be for oysters. Look here, Sir, here's an oyster stall for ev'ry half dozen houses. The street's lined vith 'em. Blessed if I don't think that ven a man's wery poor, he rushes out of his lodgings and eats oysters in reg'lar desparation."

Good food might be had at all the famous alehouses and taverns that used to stand around our Hospital. Few remain. The Olde Cocke, the Cheshire Cheese, where you may be shown a chair in which Dr. Johnson might conceivably have sat, Lloyds Coffee House and the George and Vulture, once the headquarters of Mr. Pickwick himself. Hard by, stands Number Three the Poultry, where one hundred and twenty years ago, the original Mr. Pimm, once a Kentish farm lad, stood long nights over his alembic, compounding his celebrated cocktail. The gastronomical associations with this part of London are endless. With unfailing regularity the turtles make their pilgrimage from the Ascencion Isles to the table of the Mansion House. Nearer to our Hospital, at 24 Milk Street, was born Isabella Mayson; she later became Mrs. Beeton and edited the most famous of all cookery books. And not so far, in Bell Yard, at the corner of Fetter Lane and Fleet Street, the finest meat-pies in all England were sold next door to Mr. S. Todd's hairdressing saloon.

Editorial jibes against the refectory bestow some kind of immunity to their readers by reason of their repetition. In a similar way, we pass with unseeing eyes the dull messes; hot-pot and potatoes slothfully served from icecream scoops, cabinet pudding covered by all-concealing custard. We wend our way round awkward chairs, and sit at tables covered with pools of coffee and ice cream wrappings. We eat from chipped and heavy china with bent and broken irons. This is what we have come to, and in the torpid parlance of the day "We couldn't care less."

As a nation it is time that we looked to our food. If we wait there will be no one to care, and national individuality will be swallowed up with health giving salads, washed down with iced water. We must develop care, forethought, selection, scholarship, fastidiousness, delicacy, discrimination and refinement. A cook without these qualities is a misfortune; but if we lack them, it is a disaster.

By way of experiment we are beginning a column of notes and news which we hope will be of interest to all readers. We are frequently urged to start a "gossip" column in the style of that of the earlier journals. Small items of news about the Hospital and its members both past and present will be included together with anything to which subscribers wish to give publicity. If this is an innovation of which you approve, please do not hesitate to send any information or item which you think may be of interest.

Such a column depends entirely on the amount of material which is submitted. We are particularly short of So To Speak contributions and we would welcome any that you can collect, write out and send to the Editor. We are also pleased to insert notices of Birth, Death, Marriage and Engagement, which will be free of charge. We very much hope that this column will be of interest to old Bart.'s men who represent by far the largest proportion of our subscribers.

We should like to congratulate Miss P. J. Lindrops and Mr. J. F. Pearce on their success in the recent B.Sc. Special (Physiology) Examination. Both were amongst the first classes, only six being awarded for the whole London area. Miss Lindrops is the first woman from this Medical School to obtain the degree. This was the first time since the Blitz that the course has been run internally, and perhaps we may extend our congratulations to the Physiology, Biochemistry and Zoology departments.

On September 3 a Memorial Service was held at St. Bartholomew's-the-Less for Professor Grey Turner. At one time Acting Director of the Surgical Unit, he was made an Honorary Perpetual Student of St. Bartholomew's Hospital in June, 1929. Professor Grey Turner addressed the Abernethian Society on several occasions.

Lieut-Colonel Stanley Mills, M.C., D.C.M., formerly adjutant and Battery Commander of the 3rd London Brigade, R.F.A., was, after the first world war, one of the moving spirits in arranging for all ranks to contribute one day's pay to provide a Regimental Memorial which took the form of endowing a bed at St. Bartholomew's Hospital. Colonel Mills was recently concussed in a bus accident in the city. He was brought to this Hospital and admitted to Bowlby Ward. When he recovered consciousness, he found himself in the very bed his regiment had endowed.

On September 3, during the recent twenty-sixth annual congress of anaesthetists, 200 delegates from 30 counties attended a meeting organised by Dr. Langton Hewer, in honour of the late Dr. H. E. G. Boyle. After the delegates had gathered in the Great Hall of the Hospital, Mr. A. C. King demonstrated some early anaesthetic apparatus including Boyles original design. After tea, Dr. G. Witteridge lectured to the visitors on some of the archives and plate of the Hospital.

With reference to the last month's Editorial on Bartholomewtide celebrations, this interesting letter has been received, part of which is printed below:—

"The Lord Mayor's drinking of a 'stoup of mead, flavoured with nutmeg' before his opening of the Bartholomew Fair was not an arbitrary choice from the contemporary wine list on the part of the Keeper of Newgate Goal, in fact, mead was the wine of Bartholomewtide. If mead has a patron saint, St. Bartholomew is a strong candidate. For it is on his day, August 24, that the old ceremony of the 'Blessing of the mead' has traditionally taken place for many centuries.

"At one time mead, which is a wine prepared from fermented honey, was prepared all over Europe. To the Norsemen, Celts and Saxons mead was a magic drink bestowing immortality and a gift for song upon the drinkers. Upon the Goths, however, it had a different effect, that of an aphrodisiac; according to custom, husband and wife supped mead for a month after marriage, which gives a clue to the origin of the words 'honeymoon' and 'lune de mid.' To the English monks it was considered an *elixir vitae*, an improvement to the digestion, which possessed special properties against Rheumatism and the Gout.

"Mead was of many kinds and of such melliflous names as *Metheglin, Sackmead, Bochet, Cyser, Pyment, Hippocras* and *Melomel*. It was chiefly prepared in Priories and religious houses, and as likely as not in the Pre-Reformation Priory of St. Bartholomew itself, as indeed were many other good things. But with the dissolution of the monasteries, the decline in apiculture and the import of cheap foreign wines, the last of mead making was seen, until a recent revival at St. Michaels Mount, Trevayler, Cornwall. With this revival in mead making, its close connection with St. Bartholomew, and perhaps the Priory, there is every reason for you to lift up your mazers (for such is the vessel from which mead should be taken) and drink to the Future, as well as the Past."

The Abernethian Society have announced their programme for the early part of this session.

The Inaugural Address will be given on October 11 by Dr. E. R. Cullinan. His subject is "Mind and Body."

On October 25 a programme of films will be shown.

On November 1, His Honour Sir Tom Eastham will speak on "Bart.'s 50 years ago." Sir Tom Eastham was a student at this Hospital at the turn of the century, and is now Senior Official Referee of the Supreme Court of Judicature.

The meetings on October 11 and November 1 will be held in the Clinical Lecture Theatre and that on October 25 at Charterhouse Square.

THE ROTGUT LETTERS

By EDWARD R. CULLINAN

THE College of Insana is situated in one of the murkiest districts of the "Land of Evil Phantasy." There, teachers and pupils are all spirits of the devil, imbued with evil, who study and practice the worst possible methods of treatment of disease. When a pupil graduates from the College he is sent out to treat one particular patient in his own home and stays with him until his health has been completely ruined. Each graduate, while doing such domiciliary treatment, keeps in regular correspondence with his Tutor at the College, who sends him detailed guidance in the finest methods of health destruction. Penalties for failure are ghastly.

The following is the first of a series of letters from Rotgut, Senior Tutor of Medicine at Insana, to one of his recently qualified pupils, Twistgas. Every sentiment expressed in these perfidious letters is designed to outwit the Enemy—the word used at the College to describe those practitioners of medicine on "Earth" who try to do their best to tend and heal the sick. The Tutor's knowledge of medicine is adequate: his knowledge of evil and its' application is profound. It will be clear to those reading the letters that Rotgut has plagiarised, though so poorly, the Screwtape Papers by Mr. C. S. Lewis. Naturally, the Tutor's evil nature allows of no apology, but the transcriber offers them on his behalf, most humbly.

My loathsome Twistgas,

You very lucky young devil! Fancy, so soon after your wretched graduation, being given such a perfect disease to mishandle as duodenal ulcer. And what a beautiful patient to treat. You tell me he is a man of early middle-age, lean in stature, keen and ambitious, with a practical mind, who drives himself and others relentlessly and has a continual underlying tension and sense of frustration. Splendid! And how interesting that his symptoms began about six months after his demobilisation from the Army at the end of the War, when he was straining every muscle to reinstate himself in business and, at the same time, to readjust his domestic life after years of separation. Superb! It's a pity the Enemy has had a go at treatment already, but don't worry. From what you write, not too much good seems to have been done, and you will have ample apportunity to infuse our own most poisonous ideas.

Our master is ever preaching the dictum that treatment should at all times be directed to the disease and never to the patient himself. Nowhere is the truth of this fundamental lie more clearly demonstrated than in the treatment of duodenal ulcer. Don't ever forget that, Twistgas, it's the essence.

In this disease of remission and relapse, you must always keep two objects clearly in view; firstly, you must try your damndest to bring about a recrudescence of the ulcer: secondly, when you have done so, you must adopt every device to delay its healing.

You say that your patient is now in a quiescent phase, but is worried because his pain returns at ever-shortening intervals. Magnificent. Start treatment at once. He has told you that the Enemy once advised him to take things quietly, to have adequate rest, to lead a regular life, and to eat frequent meals and develop a tranquil mind. Kill this sedition immediately. It's the Enemy's most deadly weapon and fatal to our inglorious cause. By habit, your patient gets up late, hurries his breakfast, races to the railway station, plans so much work and responsibility for the day that he cannot possibly complete it, wastes half-an-hour wondering how he can get through it, chain smokes all the day, takes his work to lunch, gulps his food against the clock, returns to work, goes home tired in the evening, maybe does a bit of hard gardening for the sake of his health, has a quick glass or two of gin on an empty stomach before dinner, works afterwards late into the night, and goes to bed tense and frustrated with the feeling of a task unfinished. And so it goes on. Superb! Tell him, "It's just the thing. That's how a real tough man should live. Why shouldn't he, one of the greyhounds of the Earth, live hard, work hard, and rise above his fellows?" That's the sophistry for him. Carry on in that strain, Twistgas. You won't have long to wait for symptoms.

As your master told you in his systematic lectures, this mode of living may not be the cause of duodenal ulceration, but it will most certainly lead to most delectable trouble, if a tendency to ulcer exists.

But be very careful of details, Twistgas. One of your late contemporaries, since expelled and now suffering untold tortures, once did the dreadful thing of giving a patient just like yours, half-a-grain of phenobarbitone twice a day to "deaden his sensibilities." The crass fool! He nearly cured the man!

And be careful, too, of that tot of gin, Twistgas. See that your patient has at least two tots; one may soothe his mind and do more good than harm.

Now some words about food. Impress upon your victim that it is not *how* he lives, but *what* he eats which matters. Give him a detailed diet sheet stressing the vital need of sticking to every item. He'll love it and swallow it all in more senses than one. Say nothing about allowing leisure for meals, of eating at regular times and at frequent intervals, about chewing food well, or any of those other wicked truths of the Enemy. To illustrate what I mean, imagine that your patient worked in a factory twenty minutes bus-ride from home. Then I should have advised you to encourage him to return to his home during the dinner-hour, rather than risk not getting decent food at the canteen. Have you ever stood at a bus-stop outside a large factory when the hooter blows, Twistgas? If you have, you'll see the point.

But, again, be careful. My advice about a detailed diet sheet would be very dangerous to our cause if your man had a gastric ulcer; but with a duodenal ulcer, it's unsound enough.

Also, had the miserable fellow been a factory worker, it would have been important to ensure that he was changed from day to night shifts at monthly intervals—a most successful method of deranging the regularity of his habits.

During the quiescent phase, don't worry too much about smoking; effects vary in different people. But when winter comes, encourage him not to put on more clothes. Tell him to be hardy and how good for him it is to keep cold. Ha! Ha! That's a subtle one, Twistgas!

While you're waiting for a return of pain, you can fill in time with chats on chronic sepsis. Tonsillectomy and sinus operations, especially in the winter, and dental extractions without replacement by adequate dentures are most amusing diversions during the remission.

But there's no need for impatience. If you've followed my advice you'll soon be dealing with a relapse. Then is your testing time, Twistgas. The devil help you if you fail, and never forget the shocking penalties of failure.

Now for my advice on treatment during the active phase. The first essential is to tell the man to keep on his feet and work at all costs. There must be no namby-pamby nonsense about rest. Perhaps he's heard of wicked treatments such as bed-rest and continuous milk-feeding by an intragastric drip. Kill such ideas, at once. "What does he think he is? A silly weakling who can't stand a little pain?" And so on and so on.

Advice concerning diet is difficult. The ideal would be well-spiced, coarse, indigestible food, but he won't fall for that one. He'll demand a bland diet. Very well, let him have it, but see that it is not an adequate diet, otherwise you may lose the inestimable advantage of getting vague food deficiencies and the consequent slow deterioration of his health. Then, again, what a fool you'd feel if the man had an operation with an adequate store of Vitamin C in his body. His wounds might heal.

But the really important thing about diet, is to get him thoroughly muddled about the time relationship between food and pain. It's as easy as sin. He won't have spotted the sequence; food—relief—pain—food, and so on. He will think food is the cause of pain and will be afraid to eat. Splendid! Stress it! Tell him to go without food, except for one large meal a day. You'll enjoy the result, Twistgas.

Another most amusing joke can be played with alkalies. Your patient will delight in them. Fine! Encourage their use in large quantities. In particular, frequent big doses of sodium bicarbonate are the greatest fun. Pain will be temporarily relieved by these better than by anything else. How is the poor sap to know that the liberation of carbon dioxide leads to large outpouring of acid in the stomach, followed by worse pain, later?

More important still, he'll never recognise the cause and effect of massive alkalies and the delightful depression, irritability, lassitude, mental confusion and headache of the alkalosis which may ensue if you've given enough.

When contemplating drugs remember the Master's three points. "No poorly absorbed antacids, such as magnesium trisilicate! No belladona! No phenobarbitone!"

Now is your time to praise smoking—tell him it'll soothe his nerves. Persuade him to take hard exercise, particularly lifting down and pulling up heavy objects—a splendid device for aggravating pain recently discovered by Scabroot. Above all, never let him have an enjoyable holiday—the pain might disappear completely, though the ulcer crater persists. In spite of all your efforts, the pain will probably ultimately clear. Never mind. Impress upon him the convincing lie that lack of pain means the ulcer has healed, and get him back to his old bad habits as soon as possible.

During the relapse, your patient may ask you about the value of surgical treatment. You've got something there! An ecstatic moment! Even the Enemy is undecided about the indications for operation in uncomplicated duodenal ulcer. Certain of the wretched fellows maintain that if an ulcer has had strict medical treatment and afterwards breaks down while the patient is leading as reasonably careful a life as can be expected, a partial gastrectomy should be performed. That wicked operation, done in such cases, especially when the patient is of sound mental calibre, is often only too successful. Fortunately, your man has never had really strict medical treatment, so the issue is exquisitely clouded. The more chronic the symptoms, and the more stable the man, the more you must advise against operation. With luck, you may have an even bigger opportunity. He may have a posterior wall ulcer with deep boring pain going through to the back or radiating round the right lower ribs, perhaps with frequent vomiting, which the Enemy may have labelled a neurosis. Delightful! Hee! Hee! No operations here! But the stupid wretch may persist in his desire for surgery. Very well: elaborate the immediate dangers of gastrectomy. Tell him of the failure to gain weight, the wind, the fainting attacks, and all the rarer sequelae. If he forces your hand, devil forbid, advise him to have a safe, simple procedure, such as a partial vagotomy, which will be a magnificent failure, or a gastroenterostomy which, with evil fortune, will lead to a nice anastomotic ulcer.

Finally, give him general unwise advice on living. Encourage him to live his life to the full according to his own lights: (they're dim enough). You will have the filthy satisfaction of knowing you are slowly breaking up his health. Never relax your efforts, Twistgas. The devil punish you if you fail, as you know he will. I shall be watching you for the slightest slip, and then, my lad, the tortures! No amount of yammering will help you.

I still sweat with horror when I recall the ghastly instance of a patient with a duodenal ulcer, who was allowed to slide back to one of the Enemy. The swine taught him to understand an aphorism of Socrates which, loosely translated, was "that a man should undertake that which he is able—to attempt more smacks of covetousness." It made the patient twice as efficient in his work and cured his ulcer! Twistgas, beware!

With my foulest regards,

Eternally yours,

ROTGUT.

P.S.—I have not discussed the mishandling of the complications of duodenal ulcer, but may write you later about it.—R.

THE "FAT BOY" AND THE FIRE

On the first anniversary of the Fire a Nonconformist Minister said in a sermon that the Fire could not have been occasioned by the sin of blasphemy, for in that case it would have begun in Billingsgate; nor by the sin of lewdness, since then Drury Lane would have caught fire first; nor by the sin of lying, for then the flames must have started in the Houses of Parliament. "Nay, my beloved Brethren," he said, "it was occasioned by the sin of gluttony for it began at Pudding Lane and ended at Pye Corner."

Pudding Lane is the site of the Monument. Pye Corner, where the Fire was finally put out, is in Smithfield. The site may be seen from the Abernethian Room windows—it is marked by the strangely suitable emblem of the Fat Boy.

"ffortune."

WHAT ABOUT WINE?

By MONSIEUR ANDRE L. SIMON

WHAT is wine? Wine is the suitably fermented juice of fresh grapes. It is mostly water, from 80 to 90 per cent., with 10 to 15 per cent. ethyl alcohol, the natural result of fermentation of grape sugar, plus a number of all kinds of vegetal and mineral salts and substances, vitamins and the like, all of them in very small quantities but of the utmost importance, since they are responsible for the flavour, "bouquet" or fragrance, colour, savour and individuality of every wine. Wine is truly a natural product with a personality of its own, but in a constant state of flux, like everything that is endowed with life. Wine begins by being hard, green, sharp, and not at all attractive; then it shakes off its bad manners in the lees of the cask or the sediment of the bottle, and it becomes gracious, a pleasant partner for the kind of food that suits it best, and so desirable a partner that in all times and among all the more highly civilised peoples of the earth, wine has always been considered worth more than any money that it cost to buy. But the time comes when a wine becomes feeble and sour: when it is too old. It also happens that a wine may catch a chill or suffer from bad storage or any other form of ill treatment, so that it is sick or crippled and unfit to drink. This is why one must not be content to drink labels nor imagine that the older the wine the better it must necessarily be. Not only each kind of wine but each bottle of the same vintage wine differs from all others; the difference may be very small or it may be very great, but the fact remains that no wine can be taken for granted and that each bottle that is opened has to be approached not merely with an open mouth but with on open mind. Will it be as good or better than the last bottle of the same wine, or of any other bottle, that we had before? There are so many different species of grapes, grown in so many different vineyards all over the world, under such varying climatic conditions from year to year, that one could easily drink wine every day of the year and never twice the same wine. This variety of wine is an enormous asset: it means that wine never needs be boring: it is ever a new experience whether one tries the cheaper or the better kinds. The best wine is the wine that you like best at the time. The food, the weather, the company and the mood of the moment all have their say in the matter. If you only take the trouble to look for it, you can find the right wine that will be best at the time. Books on wine give you simple advice about white wine with fish and red wine with red meat; dry wines to be served before sweet ones; old wines being better served after than before younger ones. All this is good advice up to a point, but there is nothing that can take the place of practice. To be guided does not mean that you must surrender your own will, and we all have a taste of our own. Nobody has the monopoly of good taste; although there is, unfortunately, such a thing as bad taste. There are people who do not mind, even if they do not actually like it, the stink of corky wine, that is wine which has been tainted by a mouldy, defective cork. Happily corky, flat, vinegary, and otherwise defective bottles of wine are the exception. A sick wine is fit for the sink and for nothing else. A sound wine may be young or old, red or white, light or strong, fair or fine, but it is a good wine, which is what matters most. There are a very great number of good wines, healthy wines, just as there are a great number of good people, whatever the cynics may say; but there are only a very few great wines, just as there are only a very few really great people in the world. And great wines just like great people must be given time to show their worth. There is nothing to show which of two bonny little baby boys in their cradles will be a bishop and which will be a convict fifty years hence. In the case of wine, there is no need to wait quite so long to know which will become really great, and which has to lose more than it gains with age. Many wines, particularly white wines, are only fit to drink at their best, when very young. They do not possess any outstanding merit which is slow to come forth, and their greatest asset is their freshness and liveliness. Of course, they cannot be expected to have the exquisite "bouquet" or fragrance of the great Chateaux of Bordeaux, of the rare Cote d'Or Burgundies or of the priceless *Trockenbeeren auslese* Hocks, wines which are outside the reach of all but the more wealthy amateurs of wine. What Shake-

speare meant, when he spoke of wine as "that good familiar creature," and what we can still enjoy today, if we do not waste too much money on cosmetics, dogs and pools, is plain, young white or red wine, sound and honest wine, which will make our meals more interesting, more enjoyable, hence also more profitable, since it is a fact that the food that we enjoy is that which does us the most good.

OBITUARY

JAMES LAIDLAW MAXWELL

James Laidlaw Maxwell, C.B.E., M.D., B.S. (Lond.), L.R.C.P., M.R.C.S., died at Hanchow, Chekiang, in China, on August 10, 1951, after a very short illness of cerebral malaria. He was born in Birmingham, on June 9, 1873. He was educated at University College School, then in Gower Street, before he went on to St. Bartholomew's Hospital. He did well as a student, winning the Matthews Duncan Medal. He later became one of Mr. Langton's House Surgeons. He was a prominent member of the Student Christian Association, and, when he was free, gave much valuable help to the Islington Medical Mission.

Leaving England in 1900, he went to China as a Medical Missionary of the English Presbyterian Church. He was appointed the Medical Superintendent of the Tainan Hospital, at Formosa, a hospital which his father, Dr. James L. Maxwell, had founded in 1865. During the Great War he served in the R.A.M.C. He returned to Formosa and stayed until 1923, when he left to become Secretary of the China Medical Missionary Association, in Shanghai. Four years later he was appointed Head of the Department of Field Research, Librarian of the Henry Lester Institute, and the Far East Medical Adviser to the International Mission to Lepers. He travelled widely throughout China, and with his experience and help he was able to advise and assist in research carried on in distant parts. He was particularly interested in Lepers and published his book, *A Handbook on Leprosy*, specially for use in China, and also jointly *Diseases of China*. In 1936 he travelled up the Yangtze with the hospital ship to Hankow, on Flood Relief work. Later, he was made Director of the Institute of Hospital Technology at Hanchow and was awarded the C.B.E. for his work as General Secretary of the International Red Cross for Central China.

In 1940, at the age of 65, he escaped from China and returned to England, where he settled into general practice in Flintwick, Bedfordshire, so that he might set others free for the services. He became Vice-President of the Mission to Lepers. He underwent a serious operation in April, 1947, and with his health restored, he once more volunteered to return to China to work for the Mission to Lepers. After two and a half years labour, he established an agricultural colony for Lepers at Zang-peh, twenty miles from Hanchow. But lately, with the restrictions imposed by the new government, he felt that his work was done, and when he died he was preparing to leave for England. He was 76.

In 1901 he married Miss Millicent Saunders, a former Sister at St. Bartholomew's Hospital. They were to have celebrated their golden wedding anniversary this October in the company of their three daughters and their families in Manila and Sydney. We offer our deep sympathy to Mrs. Maxwell and to her family.

This is but a bare summary of a life dedicated to medical service. No words of mine can picture the close bonds which united him to all his relatives. To all those who worked with him, he was a trusted and loved companion.

J. P. M.

DEATH

St. Bartholomew's Hospital Nurse's League.

Burgleigh—On August 29, 1951, Kathleen Lucretia, only daughter of the late Captain Henry Charles Burgleigh, R.N., former Matron of the Royal Hospital for Sick Children, Edinburgh, aged 87 years.

EDUCATION OF THE PUBLIC CONCERNING CANCER

By MALCOLM DONALDSON

IF you happen to see two people talking near the Fountain and becoming more and more hot under the collar, it is a fairly safe bet that they are discussing this important subject. It is a curious thing that in any such argument the opinions of the antagonists and protagonists are as sharply divided as those between a teetotaller and a chronic tippler. In the following article it is hoped to express the views of both parties by trying to answer the following questions:—

Why should the suggestion of Cancer Education be put forward even when nobody suggests that the public should be instructed in all other diseases, such as appendicitis, etc. Surely the answer is that cancer differs from nearly all other fatal (if untreated) diseases, in that during the early stages it causes the victim no pain or discomfort or any other inconvenience. Nobody will deny the overwhelming necessity for diagnosis whilst the tumour is still small and localised. This is shown in every statistical table dealing with the results of treatment. Some people, however, have argued that a great many cases, in some cases the majority, are "cured" (using the word "cured" as five years survival after commencement of treatment without any signs or symptoms of the disease) even when there is evidence that the tumour had been present for many months. There is a very simple explanation for this. The undifferentiated quickly growing tumour, which is less amenable to treatment either by surgery or radiotherapy, shows itself in a shorter time than the slow growing well differentiated growth. Since there is no question of an increasing immunity to the disease with the passage of time, it is obvious that the prospect of cure is greatly helped in both cases by early diagnosis.

Can early diagnosis be obtained without the education and co-operation of the patient? Until there is a blood or some other test invented (and there is no great hope of such at present) the answer is definitely NO.

Is there any evidence that late diagnosis, which is deplored by every surgeon and medical person, is due to the patient? The evidence that this is true is overwhelming. There are many consultants who remembering a few cases where the General Practitioner has been responsible, contend that the whole problem can be solved and early diagnosis obtained by helping the General Practitioner to be more cancer conscious. It is true that since on the average each G.P. only sees 8 cases a year, he or she should be given every help possible, and the Ministry have just completed six cancer films with that object in view, but this will be of little use if the patient does not go to the doctor. In 1945, the late and lamented Radium Commission, which was demolished by the late but possibly not lamented Minister of Health, started a Cancer Registration Card which is now used by 275 hospitals. This card contains much valuable information, among which is noted the delay occurring between the date on which the symptom was first noted, and the date on which the patient was first treated. Some of this delay, alas, is due to the difficulty of getting a cancer patient into hospital, which is a blot on the hospital organisation, but the majority of the delay is due to the patient not consulting the doctor, due undoubtedly to Fear and Ignorance.

The medium number of months delay from 30 different hospitals is given in Dr. Stocks' report "Studies on Medical and Population Subjects No. 3," Table 5, page 36.

It is of considerable interest to consider an average of the delays recorded from all these centres, especially those figures concerned with types of cancer which usually show symptoms when the disease is still not very far advanced, and in which favourable results from treatment can be obtained at that stage. The mortality figures stated here are taken from the 80,663 cancer deaths recorded for 1949 in the Registrar-General's report.

Breasts: Mortality 7,875. Average delay = 6.0 months. (Harnett has shown in the B.E.C.C. series that 16 per cent. of patients suffering from cancer of the breast waited more than a year.)

Cervix: Mortality 2,138. Average delay = 5.7 months.

Uterus (Unspecified): Mortality 2,109. Average delay for Cancer corporis — 10.3 months. (Probably includes a number of Carcinomata of Cervix.)

Rectum: Mortality 6,371. Average delay = 5.6 months.

Larynx: Mortality 1,123. Average delay = 6.6 months.

Buccal Cavity: Mortality 1,325. Average delay = 5.0 months.

Tongue: Mortality 655. Average delay = 5.0 months.

Lips: Average delay = 5.7 months.

Skin: Average delay = 7.5 months.

Rodent Ulcers over 2 years, show astonishing delay figures, but are of no importance as the mortality is negligible. Surely even the most rabid anti-educationist must be shaken by such figures.

Will education of the public reduce this delay? The proof of the pudding is in the eating, but this particular pudding like many other foods in this country, is practically non-existent, and the Ministry of Health, like the Ministry of Food, does not encourage an appetite for such things. In an answer to a recent question in the House of Commons it was stated that the Central Health Service Council had recently advised that it is undesirable at the present time for any cancer publicity to be carried out by any central government organisation direct to the general public. No reason was given.

The pudding, however, has been eaten in America and proved to be good. In Massachusetts, Cancer Education was started in 1927 but only on a very small scale, but in 1935 a real effort was made to educate the public. In that year the delay between the first symptom and seeing a doctor was 6.2 months, and a further delay in getting treatment was another 3.1 months. By 1948 the delay before seeing a doctor had been reduced to 3.9 months, and the subsequent delay in getting treatment was 2.3 months. These figures were published by the Public Health Authorities.

Finally why should Cancer be different from other diseases such as V.D., T.B., etc., which have benefited so much from education.

Can Education be carried out? Undoubtedly, by setting up local voluntary cancer education committees in every town. Massachusetts with a population of about 5 million has 355 of these committees.

Will such education flood the surgeries of the General Practitioner with people who are not ill? This is most unlikely as proper education emphasises that it is worse than useless to go to a doctor without having definite symptoms.

Will it congest the hospital with patients for investigation? The number sent for investigation will undoubtedly increase in time, but the most optimistic educationist cannot hope that knowledge will spread so rapidly as to embarrass the staff of hospitals, and in any case the stay in hospital of a patient with a growth that is still localised is much shorter than that for a patient with an advanced growth.

Will it cause more apprehension and fear of cancer than at present exists? This is the trump card of every anti-educationist. It is a very difficult if not impossible question to prove statistically, but a large survey made some years ago in America showed that cancer was the most feared of all diseases, and many medical people in this country do not realise how prevalent it is. At the present time cancer is discussed freely among Americans and in some other countries, but this is not a sign of increasing fear but points to the exact opposite. The person who fears most talks least. The way to get rid of worry is "to get it off the chest." "Knowledge is the antidote to Fear" [Emerson].

THE CLINICAL CASEBOOK

A CASE OF RAYNAUD'S DISEASE IN ASSOCIATION WITH THYROTOXICOSIS

History

Mrs. B. C., a secretary, aged 29 years, was admitted in January, 1951. She gave a history that five years ago whenever the second finger of the right hand became cold, it took on a dark purple colour. When the finger was warmed again, it became bright red, tingled and throbbed. Such attacks became more and more frequent until they occurred many times each day. Gradually these phenomena spread until all the fingers of the right hand were affected.

Between three and four years ago similar changes began to occur in the fingers of the left hand and finally both hands to the level of the wrists were involved. The attacks were particularly prone to occur when the patient passed from a warm room to a cold one. At this time her hands perspired profusely and she felt "nervy" and irritable.

Since about three months ago (October, 1950) the patient has suffered from a series of "blisters" on the middle and index fingers of her right hand. These ulcers each take a fair time to heal. They leave the fingers tender so that she finds it hard to type with them. During this time the big toe on the right foot was noticed to become blue in cold weather. There is no history of chilblains on the hands or the feet. The hands, previously so damp with perpiration, were now very dry.

It is interesting that apart from the aggravation of the condition in her hands the patient preferred the cold weather to hot weather.

Past History

When a child the patient had the usual childhood ailments. She was quite healthy until this condition began. Three years ago her own doctor diagnosed thyrotoxicosis and this was treated with 0.2 to 0.3 grams of thiouracil each day. For the past seven months she had taken only 0.1 grams of thiouracil every day. Until two months ago her appetite had been poor, it was quite good on admission. She had lost one stone in weight in the last six months.

Family and Social History

There was nothing relevant in her family history.

Seven years ago the patient was married, but six months later her husband deserted her. They were divorced and she reverted to her maiden name. This was a severe emotional upheaval for the patient. Since then, however, she has taken a job which she enjoys but which involves very long hours. She lives in lodgings.

Examination

The patient looked healthy but was rather excitable. There was slight proptosis of both eyes and eyelid retraction. There was slight lid-lag of the eyelids. The forehead wrinkled normally on looking upwards.

The thyroid gland was visible. The trachea was central and there was no enlargement of the cervical lymph nodes. The thyroid gland moved on swallowing and the right lobe of the gland was slightly enlarged. No bruit was audible over the gland.

The heart was normal except for a faint blowing systolic murmur at the apex. The pulse was of good volume and the rate was 86 per minute. The blood pressure was 120/70 mm.

The tone of the muscles of the arms was normal and all the voluntary movements were normal. There was a fine tremor of the hands when the arms were outstretched. The hands felt cold and were dry. The fingers were a purple colour and at the tips of the first and second fingers of the right hand there were small hard tender areas. Upon warming the hands the fingers became red in colour. All the reflexes were present and very brisk. In the right arm the pulses were easily felt but in the left arm the pulse of the brachial artery was difficult to palpate.

In the legs the muscle tone was normal and there was no wasting. The first metatarsophalangeal joint in the left foot was red but not tender or inflamed. The right leg and foot were normal.

Rectal examination and investigation of the urine showed nothing abnormal.

Special Investigations

The patient's white blood cell count was 5,800 per cmm. (20.1.51) and her haemoglobin was 11.88 grms. per cent. or 86 per cent. of normal (22.1.51). Her basal metabolic rate was estimated twice; on the first occasion (23.1.51) it was +43 per cent. N. and upon the second occasion (26.1.51) it was +3 per cent. N. There was a slight fall in pulse rate during the estimation upon both occasions. Her cervical spine was X-rayed (24.1.51) but no cervical rib was revealed.

Operation

The operation was performed by Professor Sir James Paterson Ross. The incision for the partial thyroidectomy was made deliberately lower than usual in order to provide adequate exposure for the subsequent ganglionectomy. The thyroid was found to be a fleshy hyperaemic gland. The right and left lobes were excised, leaving only a wedge of thyroid tissue at the posterior of each lobe containing the parathyroid glands. A pyramidal lobe of the gland and the isthmus were removed.

As the patient was in good condition after this operation it was possible to proceed with first a right and then a left cervical sympathetic ganglionectomy, from which operation she made a good recovery.

Conclusion

This case has been recorded because of the rarity of the two diseases in association the one with the other. I am extremely grateful to Professor Sir James Paterson Ross for his permission to record this case, and for his great help and encouragement during the preparation of this description.

M. J. CLARKE-WILLIAMS.

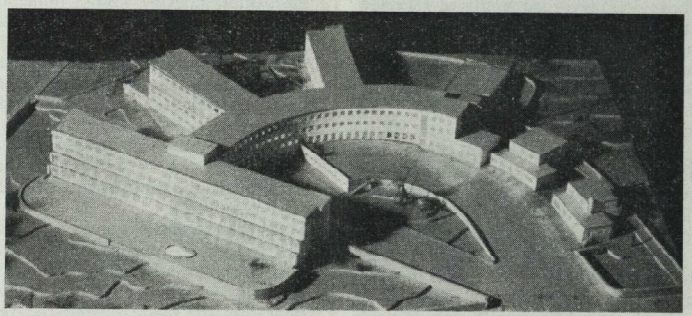
TWO CHILDRENS HOSPITALS IN HELSINKI

TERVE LAPSI KANSAN HUOMEN: A Healthy Child for tomorrows citizen.

A recent holiday gave me the chance to visit some of the newest hospitals in Helsinki. I was most struck by two, devoted entirely to the care of children. They have both been completed since the end of the war, and show every advance in the design of hospitals that experiment or experience from the past have made.

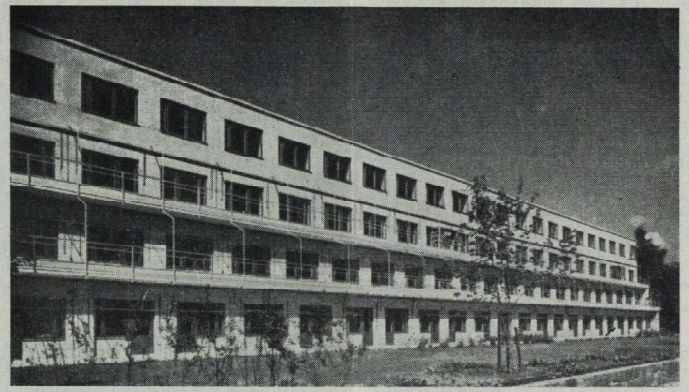
The first hospital ever to provide a clinic specially for children was the Hôpital des Enfants Malades, built in 1802, in Paris. In those days hospital wards were very large, when we think of these that we have today. Children died more often from infections which they caught whilst they were having treatment, than from the trouble from which they were to be cured. In 1875, Professor Rauchfuss of Leningrad built, for the first time, a "decentralised" hospital. St. Vladimir's in Moscow, was planned as a number of pavilions arranged around the main block of offices. One pavilion was kept for each infection. This was an improvement, though in practice, with the normal flux of infection some pavilions were too crowded, whilst others were empty. At the beginning of this century the general hospitals began to admit infants to special wards, and at once the problem of respiratory and intestinal infection developed. It was not enough to make wards smaller, and special isolation blocks and barrier nursing was tried. From this it was but a short step to the system which is used in this country today, where children and adults, who are infectious are sent to special Isolation Hospitals, which often enough have no attachment, or even an association with the general hospitals. Only non-infectious children, it is hoped, are admitted to the general wards. Should an infection spring up it is limited by scrupulous cleanliness and vigorous treatment. Like so many compromises this is by no means satisfactory. The Isolation Hospital is crowded at some seasons, and must cut down its staff at others. Meanwhile the children's wards are always open to potential infection, and an ill child may have to be moved to another hospital, and perhaps can no longer be treated in the same way. Again, nurses and students, who are undergoing their training in children's work, are often denied experience with the infectious diseases.

It is the first duty of the children's doctor to look after the health of fit children and keep them well. When a hospital has made this provision, it is time to think of the facilities for ill children. The avoidance of cross-infection, good food, adequate sun and the convenience of visitors and parents, are taken into consideration, with the opportunities for teaching, and the comfort of the staff. With this in mind, designs for the Children's Clinic were put forward. At last, after much thought, the building went ahead during the difficult years of the war, and the Clinic was finally completed in 1946. It is a design based on the experience of many countries, and the innovation of novel ideas. Architecturally the shape represents most nearly the £ sign, which combines the advantages of both the block and the pavilion designs. Each limb can function independently, and yet it is easy to move children and equipment about, and to reach the curved administrative block, and specialist departments, without passing into the cold and uncertain Finnish climate.



Model of the Children's Clinic *By kind permission of the LANCET.*

The Clinic is only four stories high, as taller buildings are said to increase risk of cross-infection, and no ward holds more than six beds. Many of the inside walls are made of glass, so that the Sister in charge can observe different wards at the same time, and keep a watchful eye on her probationers. Enormous expense and care has been lavished on the design of every part. Terraced balconies are staggered one above the other so that children on all floors may benefit from the sun. The isolation wards are barrier nursed with double doors, and a special bath and basin to every cubicle. Wherever the children are free to go, tables, chairs, lavatories and clothes pegs are arranged at a suitable height. Special rooms are set aside as pram parks. Children may wait in a playroom, provided with the time honoured rocking horse and stuffed animals, while their brothers and sisters are examined in another part of the building. Visitors, who are considered as part of the patient's treatment, have comfortable rooms set aside in which they may wait, or talk to the doctor in privacy about their children. There is no view in this hospital without the hallmark of Finnish art and design. Floors, walls and furniture are made from beautiful woods. Aquaria of ornamental tropical fish, if irrelevant, are certainly enlivening. Pictures and reproduction of the Finnish artists, Gallen Kallela and Edelfelt, add a nationalistic and rather sombre note; whilst from every window ledge and table climb and tumble great masses of cacti and flowering plants of more-than-oriental splendour.



The Sun Terrace *By kind permission of the LANCET.*

The Children's Castle was founded by the General Mannerheim League for Child Welfare, for the health and happiness of Finland's children. It now stands as a fitting memorial to Finland's greatest man of both peace and war. Principally, it provides advisory services, which are available to normal mothers and healthy children, in an effort to reduce infant mortality and ill health, which is very common in Northern Scandinavia. It offers special services, wards and clinics for handicapped children, and abandoned mothers, as well as opportunities for training nurses in midwifery, public health and child welfare work.

The idea of the Children's Castle had been conceived long before the war. Foundations were blasted from the rock in 1939, but the construction was held up during the war, and the Castle was not completed until 1948. It is built in a modern style to the design of the Finnish architects Borg, Flodin and Sorotta with the collaboration of Professor

Arvo Ylppo, who is the Professor of Paediatrics in Helsinki, and Chief Physician to both the Castle and the Clinic, and Miss Agnes Sinervo, the Matron. It stands close by the sea amongst the forest near the University medical centre, the hospital for internal medicine, the tuberculosis hospital and the hospital for occupational disease. A curved four-storied block of wards, special departments, and administration surround a playground and garden, which faces on to the sea. At one end, a twelve storied tower rises above the city. From the roof one may look out over Helsinki, and its colourful modern architecture, its green chrysoberyl sea set by a golden shore. In one direction, looking out over modern blocks of flats, one can see the Olympic stadium repaired and furbished for the coming Olympic Games, quite white against the Pre-Raphaelite green of the forests, and over to the west one can admire the three-masted sailing ships plying along the coastline. The Children's Castle is constructed from brick, concrete and glass. All the outside walls and some inside surfaces are decorated in sculptured forms and ornamental plasterwork said to be symbolic of the Child. Everywhere there is evidence of national style and eccentricities. Indoor creepers and flowers, Abutilon and Geranium, decorate the walls and floors. Spotless and efficient nurses patter about, like White Rabbits, disappearing down curving corridors heavy with the scent of flowers and floor polish. Sliding glass panels look out on to the children's playground; ornamental wooden doors open into a gymnasium or swimming bath. Much is made of a very modern tiled *Sauna*. (This is a Finnish Steam Bath, which is a traditional family affair, held every Saturday night. The family, ready for their bath, assemble in a small wooden panelled log cabin. Cold water is poured upon red hot rocks, this generates steam and promotes sweating, thereby the skin cleans itself. For those who wish to be able to say they have done the thing properly, it is necessary to chastise oneself mildly: laying about ones limbs with fresh birch switches, and finally leap out into the open, and roll in the snow.)

The tower is set aside for the resident medical nursing staff. Each person has a modern comfortable flat of their own, most attractively furnished, together with various communal rooms. In all there are 245 nurses, about 90 are experienced children's specialists, 90 more have an equivalent diploma to the S.R.N. and are undergoing further training, the balance is made up of probationers. In Finland, as in some parts of England, there is a great shortage of nurses, and they are encouraged to come from abroad. There are at present several nurses from England, and one from Bart.'s, undergoing specialist children's nursing.

Probably the least intended, and therefore perhaps the most important impression one receives on visiting these two Children's Hospitals, is the great pride which is taken in showing one round. There seems always to be a ready guide to conduct one and to answer every question, needless to say, in faultless English, and indeed any other European language. As I left the building I wondered what would be the reaction should a Finnish student knock at the Henry the Eighth gate and ask to see round our Hospital. I think we should rise to the occasion, I certainly hope so.

A. N. G.

TWO HUNDRED YEARS AGO . . .

From the Hospital Journal of February 24, 1651 :

It is necessary to erect Covered Sheds for the sheltering the Coaches and Horses of the Governors and other persons attending to the Business of the Hospital, from the Inclemancies of the Weather.

WESSEX RAHERE CLUB

The Fourth Autumn Dinner of the Club, membership of which is open to all Bart.'s men resident in the West Country, will be held at Fortt's Restaurant, Milsom Street, Bath, on November 3, 1951. Mr. Reginald Vick has been invited as Guest of Honour.

Details will be circulated to members and will gladly be sent to any eligible colleagues who are not already in touch by the Hon. Secretary, Mr. A. Daunt Bateman, 3, Circus, Bath.

CORRESPONDENCE

RESPONSIBILITY IN MEDICAL EDUCATION

To the Editor,
St. Bartholomew's Hospital Journal.
From
PROFESSOR SIR JAMES PATERSON ROSS

Dear Sir,

Mr. Birdwood's letter in the *September* Journal deserves an answer because it makes an honest attempt to state what he regards as a flaw in our method of educating clinical students and it suggests certain remedies. The letter should be read and discussed by the clinical teachers and by the Sisters as well as by Mr. Birdwood's contemporaries. Criticisms which are valid can then be faced, and those which are exaggerated or actually false can be discarded.

The letter suggests that things have changed and that dressers now have less responsibility for their patients than they had in days gone by. In fact there has not been any substantial change in the past forty years in regard to in-patients, and a dresser if he does his work properly should still, as in the past, be regarded by the patient as his "doctor." Often it is the dresser's name the patient remembers rather than the House Surgeon's or even the Chief's, if his dresser *has* been his dresser, and not his clerk. In the Casualty Department the difference now is that a dresser is not allowed to send a patient away until he has been seen by the House Surgeon; but a good House Surgeon will see to it that the dresser has made up his mind about the diagnosis and the treatment before the patient is presented to him; and then if he considers the dresser capable of undertaking the treatment he will entrust it to him.

It cannot be denied that the multiplication of Registrars has affected the training of House Surgeons, but the work of the dressers has been altered thereby to a far lesser extent, if at all. It should be understood, however, that the acquisition of skill is a long process which only starts before qualification, and is carried on during House Appointments and Registrarships. Mr. Birdwood is incorrect in stating that he will be expected to have attained perfection by the time he is qualified. On the contrary it is only then that he will begin to acquire certain forms of skill, in his early days only under supervision. It is chiefly for this reason that the pre-registration year of House Appointments is to be introduced.

On the other hand there are certain technical procedures which should be learnt (I do not say mastered) as a dresser; one is that of ward dressings, others those of venepuncture, aspiration of cysts, simple plaster bandaging and the like. I cannot accept the suggestion that our present teaching methods discourage dressers from performing these duties. It is certainly true that if the dresser does not undertake them they must be done by somebody else, but surely it is not suggested that the patients should be left without attention merely to goad the dresser into doing his duty.

Many dressers would agree with what Mr. Birdwood says about dressing in Women's Wards. It must be remembered, however, that many female patients are apprehensive about anything which may be painful, and it is reasonable that dressing technique and venepuncture should be practised first on men. But once they have acquired a certain degree of skill and confidence on the male side, dressers should arrange with the Sister on the other side that they do the dressings there also.

I believe that much of our difficulty arises from the practice in the Casualty Department and in the wards of approaching a patient with a piece of paper and a pen. If only dressers would examine their patients or do their dressings first, and write about it afterwards, they would train their fingers and their memories. As it is they are writing while the Nurses have to get on with the dressings in order that the patients maybe fed at the proper time.

Space does not permit me to answer in detail all the interesting points raised in Mr. Birdwood's letter, but I would like to assure him and his fellows that the opportunities are still available, as in the past, to everybody; it is the student he describes, who has a sense of responsibility, who will grab the opportunity ere it slips by. Nobody else can grab it for him, nor can any amount of driving make the poor student grab it if he does not want to.

Yours, etc.,

J. PATERSON ROSS.

1851 SUPPLEMENT

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

Dear Sir,

It gave me much pleasure to see that Messrs. Deane are again advertising their excellent Gas Bath (*August, page* 179, *Advertisements*). I had one such as this installed in my (then) town house in Park Crescent, and I confess myself admirably satisfied by its performance over the years. I have no hesitation in recommending it to any of my medical confrères, who may still feel the need for an elegant bath.

I am,

Sir,

Your obedient servant,

JAS. EMBLETHORPE.

Orpington.
September 2, 1951.

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

Dear Sir,

Arising from the reprint of John Snow's original article "On the Mode of Communication of Cholera" in your 1851 Supplement (*August, page* 173), it is interesting to note Snow's observation that poison could be rendered inert by decomposition. This gained credence in the following years and Nansen in his voyage to the North Pole said that he would prefer his men to eat the tins of putrid meat to those that were slightly tainted, on the grounds that the ferments in the former would destroy the ptomaice poisons.

Yours faithfully,

E. F. BROOKS.

Abernethian Room,
St. Bartholomew's Hospital.
August 31, 1951.

SO TO SPEAK . . .

More likely to be cord

"At operation we found a minute epididymis, which looked like a piece of fine string, and was histologically identified as such."

A letter from an editorial office of an Italian Journal inviting the editor of a British Journal to exchange their publications.

After having the typographie and editorial difficulties resulting from the state of war, our review now attained to the age of forty three years—has begun again its regular issues, having good hope that our work can considerably help in the diffusion of the victories which have been realised and will be aquired in the Hygienic, Microbiologic, and similar Scientific camps.

It is, therefore, our purpose to keep Italian readers continually informed about the works given out by your very interesting Review and contemporaneously to bid the contribution of the studies effected in Italy to your readers.

Then we have resolved to send regularly our Journal to your address requesting your kindness to send us, as exchange and essay, either your Review, or other eventual issues, anyhow, bearing relation to the programme of our Review. We shall deal very extensively of your works in every our faxicules. With all our consideration we express you many thanks.

DR. H. A. YOUNS.

STAFF APPOINTMENTS

The following appointments to the Medical Staff have been made, with effect from the dates shown:—

Casualty Physician—Dr. J. M. S. Knott from October 1, 1951.

Medical Professorial Unit.

Registrar—Dr. R. Marshall (vice Dr. J. M. S. Knott) from October 1, 1951.
Junior Registrar—Dr. P. J. Lawther (vice Dr. R. Marshall) from October 1, 1951.

Diagnostic X-ray Department.

Assistant Radiologist—Dr. W. D. Nichol from September 1, 1951.
Registrar—Dr. B. Green (replacing Dr. E. G. H. du Boulay for 1 year) from August 1, 1951.

Department of Aanaesthesia.

Resident Junior Registrar (S.R.A.)—Dr. N. E. Winsione (vice Dr. C. Todd) from October 1, 1951.
Resident Junior Registrar—Dr. P. H. Simmons (vice Dr. W. J. Wright) from November 1, 1951.

Orthopaedic Department.

Locum Registrar Mr. D. J. Tuffley (for 2 months in place of Mr. A. Murley) from August 1, 1951.

EXAMINATION RESULTS

UNIVERSITY OF LONDON

Branch I (Medicine) — **M.D. Examination** — **July, 1951**

Batten, J. C.	Jenkins, B. A. G.	Morgan, A. A.

Branch II (Pathology)

Collard, P. J.	Goodbody, R. A.	Manning, J. D.

Special Second Examination for Medical Degrees — **July, 1951**

Allen, A. B.	Cranston, C. J.	Hurst, R. B.	Thoresby, F. P.
Batey, I. S.	Cunningham, G. A. B.	Khurshid, M. N.	Topham, P. A.
Beasley, R. W. R.	Dunkley, A. H.	Macadam, F. I.	Wadge, D. A.
Bliss, P.	Gardiner, A. B.	Pagan, R. T.	Wetherall, J. M.
Castle, W. B.	Goss, G. C. L.	Robinson, M. R.	Wheeler, B. R.
Clare, K. A.	Graham, M. A. H.	Sanford, W.	Wilson, D. M.
Craggs, D. F.	Heywood, N.	Taylor, R. C.	

Special First Examination for Medical Degrees — **June, 1951**

Balhetchet, M. S.	Grant, C. B. T.	Lemon, J. H.	Plumptre, A. M. M.
Bekenn, P. J.	Haves, M. E. B.	Long, J. D. N.	Snart, A. G.
Bickham, E. E. M.	Hunter, C. J. W.	McGill, B. S.	Taggart, P. I.
Clissold, E.	Jewell, W. H. M.	Newton, S. E.	Tallack, J. S. T.
Cochrane, I. H.	Jutting, V. G.	Nicholson, J. R.	
Gillett, G. B.	Lawson, D. J.	Nixon, T. C. P.	

The following External Candidate has completed the First Medical

Pringle, L.

The following Higher School Candidates have qualified for exemption for the First Medical

Laurent, I. M. Millard, F. J. C.

B.Sc. Special Examination for Internal Students

Physiology—First Class Honours

Lindop, P. J. Pearce, J. F.

ROYAL COLLEGE OF SURGEONS

At the Primary Examination held in July, 1951, the following were successful:—

Birnstingl, M. A. Denny, W. R. Mehta, J. S. Watson, D. A.

SOCIETY OF APOTHECARIES

Final Examination — **1951**

Pathology	Medicine	Midwifery
Norman, M. H.	Norman, M. H.	Norman, M. H.

Surgery — **July, 1951**

Hewson, J. P. Norman, M. H.

The following candidates, having completed the Final Examination, are granted the Diploma of the Society:—

Hewson, J. P. Norman, M. H.

SCHOLARSHIPS AND FELLOWSHIPS

Cattlin Fellowship—H. W. Balme.

James & Henry Cooper and William Garlick Coventson Scholarship—H. M. Lloyd.

Lawrence Research Scholarship—J. R. B. Williams.

Combined Hospitals University Entrance Scholarship—Scholarship not awarded.

Exhibition—Thomas, D. P.

Shuter Scholarship—P. V. Burrows.

Junior Scholarships in Chemistry, Physics and Biology, 1951

1st Scholarship: C. B. T. Grant
2nd Scholarship: C. J. W. Hunter

B.Sc. Scholarships in Physiology—Malpas, J. M., Wickham, J. E. A., Witt, M. J.
Two Scholarships were divided equally between the above.

SPORT

HOCKEY CLUB

Results of the 1950-51 season :

1st XI—Played 21. Won 8. Drew 3. Lost 10.
2nd XI—Played 20. Won 10. Drew 3. Lost 7.
3rd XI—Played 6. Won 3. Drew 0. Lost 3.

Cup Competition :

1st XI—2nd round v. London Hospital, Won 3-1. Semi-final v. St. Thomas. Lost 2-3.

2nd XI—2nd round v. Middlesex Hospital, Won 8-0. Semi-final v. London Hospital, Won 6-0. Final v. Guys, Drew 1-1. Final replay, Won 4-1.

In his report on the season, the Captain said that the 1st XI had enjoyed a moderate season, which, however, showed marked improvement on the previous year. This was due, he thought, partly to greatly increased reserve strength (the Club was able to field three teams simultaneously for the first time), and partly to that nucleus of players who turned out so regularly week after week. Next year, however, he said, the Club must aim at turning out the same team each week, even if it meant those players unable to play regularly might have to stand down and be content with an occasional game.

Congratulations were offered to A. Baker and the 2nd XI on winning the Junior Cup in the first year of its reinstatement.

Officers, Season 1951-52 :

President—Professor Sir J. Paterson Ross.
Vice-Presidents—Professor Wormal, Professor Christie, Dr. G. Cunningham.
Captain—J. A. Clappen.
Secretary—J. B. Batterham.
Match Secretary—J. Tait.
Honorary Treasurer—D. Buttery.
Captain 2nd XI—J. J. McL. Hill.
Secretary—A. Ford.
Committee Member—J. P. N. Hicks.

The Hockey Club is at present composed almost entirely of clinical students, most of whom are approaching finals. This rather jeopardises the future of the Club insofar as very few new players are coming along and it is anticipated that this will inevitably spoil a good record.

Anyone who would care to play, whether they have used a hockey stick or not, will be welcome and more so if they come from Charterhouse Square.

J. P. N. H.

GOLF CLUB

At the Annual General Meeting the following were elected for the season 1951-52 :

Captain—C. J. R. Elliott.
Honorary Secretary—P. Sleight.

In contrast with the earlier matches this year, the weather has been ideal for the matches reported here, the sun shining consistently.

It has been difficult to raise a full strength team since three of our "star" players, Gracey, Fiddian and Rushton have been busy with their finals.

April 4 v. Chelsea Polytechnic. Lost 3-2.

In this match, played at Northwood G.C., Fiddian played well to beat one of the Carter twins. Deering, however, found the other twin too strong for him. Montagnon played very well in beating two opponents' better ball. St. J. Brown and Sleight both lost close matches.

April 12 v. London Hospital. Lost 4-2.

Fiddian again won his match. The only other Bart.'s player to do so was R. G. Dreaper. Elliott, however, had a very close match in which he was only beaten on the last green. Waterhouse, Deering and Sleight were also beaten. The match was played at Marylands G.C. near Romford.

May 14 v. The Staff.

Singles, Won 7-2 ; Foursomes, Won 2-0.

The Denham course was looking beautiful and playing very well indeed. The weather was again fine. Dr. George Graham, who has helped in this match for many years now, could not recall such bad conditions for over twenty years. We had lunch at the clubhouse before playing in the afternoon.

This year the staff, led by Dr. McIlroy, received three bisques in the 18 holes.

Gracey beat Dr. McIlroy and Fiddian won his match against Prof. Garrod. Bowman beat Dr. Morgan and Sleight lost to Dr. Graham. Dr. Brewer provided the other staff victory, over Dodge. Deering beat Dr. Knott and Elliott, Dr. Dawson. Greenhalgh and Waterhouse beat Dr. Hallwright and Dr. Knott respectively.

After tea we played foursomes. We were driven back to London by our hosts after a very enjoyable day.

June 20 v. Charing Cross Hospital. Won 4½-2½.

This match was arranged at short notice and

the hospital did well to win against a combined staff and students team from the Charing Cross Hospital.

In the top matches, Deering found his opponent too long for him, but hung on until eventually beaten 5 and 4. Elliott did well to halve with his 8 handicap opponent. Dreaper lost by 2 holes in another close match.

From here on the Bart.'s tail began to wag, Bowman won 6 and 4; Sleight 5 and 3; Lodge 7 and 6, and Waterhouse 3 and 1. Lodge, getting away well from the tees, drove the first green, an uphill 259 yards, for a birdie. The match was played in very pleasant surroundings at Porters Park G.C.

June 27 v. City of London Police. Drew 5-5.

A draw was a very fair result for this match played at Marylands G.C. Most of the matches were very close, being decided on the 17th or 18th greens.

Deering lost 4 and 3. Dr. McIlroy, Elliott, Blake, Bowman and Sleight won their matches. Dodge, Lodge, Waterhouse and Jones, H.D., lost narrowly.

RIFLE CLUB

Since the last report in the May issue, the Rifle Club has completed a very enjoyable, if not completely successful, full-bore season at Bisley.

Full-bore

Practice shoots were held at Bisley on several occasions for the chief event of the season, the Hospitals Cup match on July 13. In this event we were third ; after an excellent start at 200 yards with a 7-point lead, Guys Hospital overtook our score at 500 yards with a 5-point advantage, which they held at 600 yards.

Result : 1st Guys H., 454/525 ; 2nd St. Mary's H., 449/525 ; 3rd St. Bartholomew's H., 449/525 ; 4th St. Thomas' H., 448/525.

In individual events B. D. Lascelles entered for the King's Prize and is to be heartily congratulated on reaching the "King's Hundred."

Lascelles also won the Club's Benetfink Cup, awarded for the highest aggregate of three scores. 1st B. D. Lascelles, 113/120 ; 2nd J. E. Cradock-Watson, 111/120 ; 3rd J. Stevenson, 110/120.

The Handicap Cup was won by Clissold, 57/70, followed by H. G. Scott, 57/70, and J. H. Fairley, 54/70.

Small-bore

The final results of last season's small-bore events have been announced.

Inter-Collegiate League, Div. I (9 competing teams)—1st Imperial College "A," 2nd University College "A," 3rd St. Bartholomew's Hospital "A."

Inter-Collegiate League, Div. II (7 competing teams)—1st Imperial College "B," 2nd King's College "B," 3rd St. Bartholomew's Hospital "B."

Inter-Hospital's League (7 competing teams)—1st St. Mary's Hospital, 2nd St. Bartholomew's Hospital.

The Lady Ludlow Challenge Cup was won by C. D. Ellis 98, followed by B. D. Lascelles 97.

Honours

Honours have been awarded to J. E. Cradock-Watson and C. M. Vickery.

Team colours have been awarded to T. B. Catnach, J. H. Fairley, J. Stevenson and F. P. Thoresby.

Annual General Meeting

The Annual General Meeting will take place in A.R. Committee Room on Monday, October 8. Everyone interested in rifle or pistol shooting is invited to attend and freshmen will be especially welcome.

We look forward to a successful small-bore season and hope to bring the Inter-Collegiate Cup to Bart.'s.

BOOK REVIEWS

MEDICAL BOTANY, by Alexander Nelson. First Edition, 1951. E. & S. Livingstone Ltd., pp. xi. + 344 + 29 figures and plates. Price 30s.

"Medical Botany" seems to be a very unpretentious name to choose for such an intriguing book as this. Dr. Nelson sets sail from Plant Structure for the unexplored limbo of material which lies between medicine, botany, pharmacy, agriculture and gastronomy. Until this expedition only brief voyages have been described ; in this book many of those unexplored seas are charted. Dr. Nelson explains that the original encyclopaediac project proved too compendious and costly ; instead, he has retained what can only be described as the application of academic botany, the botanical background of medicine, and the significance of plant life on the health and well-being of animals.

In a short review, it is impossible to convey the delight in this book. Turn to any page : yams, sauercraut, capsicum and sassafrass, ergot and fungi, vegetable allergens, nettle stings and the Doctrine of Signatures. Dr. Nelson has been most fortunate to have the co-operation of E. & S. Livingstone to do justice to his work. This book was chosen by the National Book League for the Exhibition of British Book Design. Copies should be bought and placed in the library, the kitchens and the dispensary, and upon the bookshelf of every doctor and student, who realises that Life in general, and Medicine in particular, is the more interesting and important for one's straying from the strict confines of the curriculum.

DISEASES OF INFANCY AND CHILDHOOD, by Richard W. B. Ellis. E. & S. Livingstone, Ltd., 1951, pp. vii +695, figures 300. Price 42s.

In this new book on paediatrics the author gives us a fresh presentation of a subject, which is still new enough not to demand a stylised arrangement of matter or a didactic method. The whole book is intended to cover all the diseases of infancy and childhood. To compress this into a single volume is a considerable feat, with the result that it pinches at the toes. More needs to be said on Infant Feeding, the Care of the Premature Baby and some conditions, such as retrolental fibroplasia, are not mentioned at all. After all, these are the kind of thing one wants a book for ; one is prepared to skip the lengthy descriptions of congenital deformities, which compose nearly a sixth of the book. The approach is modern, the material up-to-date, the style is never dull and it is often amusing. The illustrations and the presentation are excellent. Both the author and the publishers are to be congratulated. When a second edition is called for, and this is the sort of book that needs a second edition before it is too late, the opportunity should be taken to redress

the balance of some sections, to correct some spelling errors, and to cut out some unnecessary material. But please retain the remarkable tale of the bezoar of papier mâché formed in the stomach of a child, who used regularly to devour the Scotsman.

A GUIDE TO PROFESSIONAL NURSING, by Bethina A. Bennett. Published by Messrs. Faber & Faber. Price 18s.

Those of us who are asked for advice by Nurses about post-graduate work have need of a book like this. It contains the information that one wants, and the addresses from which to obtain more. The style is sensible and clear and there are plenty of illustrations. It is not cheap but should be a useful reference book in any library.

THE STORY OF THE GROWTH OF NURSING, by A. E. Pavey. 3rd Edition. Faber, 1951, pp. xvi +498. Price 20s.

Miss Pavey's book must surely have been read by all nurses; for who, on finishing it, would not lend it to a friend, and what friend after reading the first page would be able to lay it down before the last? The story of the growth of nursing may sound a prosaic title, but the medical student, too, will find in this book, much to delight and interest him.

CHANCE AND DESIGN IN PHYSIOLOGICAL RESEARCH (Inaugural lecture at U.C. London), by Professor G. L. Brown. Lewis, 1951, pp. 14. Price 3s.

Under the title of Chance and Design in Physiological Research, Professor Brown outlines the way in which that research can be most usefully carried out. As an object lesson in clear thinking and an understanding of the human approach to a problem this booklet can be recommended.

ROYAL NORTHERN OPERATIVE SURGERY, by the Surgical Staff of the Royal Northern Hospital, edited by Sir Lancelot Barrington Ward. 2nd Edition, 1951. H. K. Lewis & Co., Ltd., pp. viii+638, illus. 498 (some coloured). Price 90s.

The impressive list of distinguished contributors beneath the skilled hand of their Editor, and the excellent quality of this publication, gives one great hope that this should prove a useful addition to the surgical bookshelf. But these impressions belie ones enthusiasm, for this book is of limited compass. It is purely a text-book of surgical techniques and nothing is included on diagnosis, pathology or natural history, and the paragraphs on the indications for surgery are the briefest in the book. The market for such a book will therefore be limited to practising surgeons, a market which will be further reduced, as those techniques used at the Royal Northern may not be universally aproved. The huge and multi-headed hydra of modern surgery (where one man cuts, there's room for a dozen to cut again), can no longer be slain by one man, and it is necessary for a team of contributors to cover the ground. With this difficulty circumvented another problem appears: the danger that different sections may follow differing patterns, though the editor, and the method of collective criticism, have reduced the sections to a well balanced symmetry. The excellent photographs and drawings in this book are well above the high standard, which we now take as our right in modern text-books. This second edition, after twelve years, is up to date with all well established surgical techniques. It will be valuable to those for whom it is intended, and to those it should be very valuable indeed.

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SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

NOVEMBER 1951

VOL. LV No. 11

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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November, 1951

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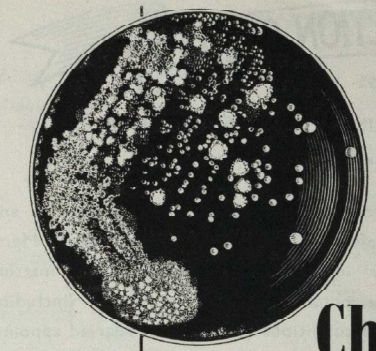

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1. Gray, J. D. Lancet, 1:150, 1950
2. Macrae, J. Lancet, 1:400, 1950

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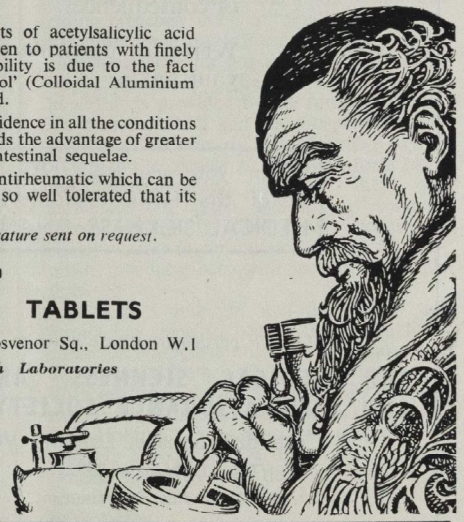

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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LV NOVEMBER, 1951 No. 11

GET OUT OF THAT ARMCHAIR!

This month I should like to describe to you a disease. It is not new. In fact it has been with us ever since the invention of the armchair. One or two cases have been reported in the literature from Ancient Greece. It is the Occupational Disease of the Armchair. The condition is ubiquitous, no strata of the community is spared, yet no one class is singled out for its attentions. (Though it is said by some authorities to affect those who have spent some of their life in the Indian Army.) Insidious in onset, the most chronic sufferer may be quite unaware of its steady and relentless progress. The complications: boredom, cynicism and a hypercritical attitude are dangerous, but unfortunately the condition is rarely fatal, in fact the disease seems to predispose to an increased expectancy of life. Treatment is difficult, and in prophylaxis lies our only hope. The disease is highly infectious, and whilst attending a case, one may find oneself likewise struck down. It is about its aetiology and prevention that I want to speak to you.

The date of invention of the armchair is not recorded, but it was a sad day for the world. Long years ago, when work was done, people fell to telling stories, reciting ballads and singing songs. The great Icelandic Sagas, and the songs of the Borderland are handed down to us still, though now in the printed word only. Leisure might be spent in other ways: furniture making, collecting butterflies and birds' eggs, putting little ships in bottles; women embroidered themselves beautiful dresses, whilst men took up other diverting occupations such as fishing and fowling. It was for the practical man that Izaak Walton wrote "The Compleat Angler." His book should be read under a bank of pollarded willows watching a bobbing float.

Nowadays the writer on Shooting draws his bead on the sitting shot, as the angling author baits his lure for armchair fishermen. Once we used to be a land of agricultural folk, and now the wheel is turning a complete circle, and the successful seek relaxation and retirement by getting back to the earth. First a country cottage is required, then a full-time gardener and an armchair from which to direct operations. By his elbow there is a pile of books on country life and lore, and another "How to make your garden pay." Despite this book's good advice, he is able to reduce his income tax by substantial losses incurred on the estate. A few do succeed, perhaps you, too, know such a man. He wears a hacking jacket and a pair of well-cut riding breeches; he is a "small farmer" for his blithesome appearance and his smooth cheeks preclude the possibility of his farming on a large scale. The key to his success, however, is provided by the fountain pen in his breast pocket, and his prosperity is due to writing on how to make farming pay.

Watch the crowds as they issue forth from the cinematograph theatre, they are exhausted but elated, and do you wonder? Conducted by Mr. Rank across oceans and snowy wastes in the magic seats of cinema-plush, they have been with Scott to the South Pole.

It is past midnight and the rest of the family has gone to bed; beneath the little circle of lampglow one can just make out the master of the household (in an armchair). With one hand he holds a glass of Ovaltine, and in the other the "Adventures of Sherlock Holmes." So much we see, but his spirit is abroad on Dartmoor, spectre-like, clothed in Ulster and deerstalker, it is in search of the terrible Hound of the Baskervilles.

A bespectacled bankclerk is queuing in the public library. "Have you the 'Life of Ricardo' or a 'Biography of Montague Norman'?" he asks. He cannot wait for his armchair but fondles the pages in the homeward bus. Here is at last the lodestone of success.

Now there is another form in which this affliction may conceal itself, more insidious, less conspicuous, but every bit as malign and inexorable in its progress. It is a peripatetic form of Armchairitis, if you will forgive the apparent contradiction. Let us see how a case might arise. Suppose our patient wants "music." In past days he might have taken his lute from off the wall, sat down at the harpsichord or asked one or two friends round for a musical evening. But not in these days. Sporting a pair of corduroys and a short but promising beard, he will set off for the Albert Hall, and sit in greatest discomfort at no inconsiderable expense to hear other people play. "Promming" is the keenest activity of this generation of musicians. Again, the wireless is an impersonal and apparently essential accompaniment to everything. Such music is no longer an occasion. This heard, but unlistened, sound is only noticed when it is switched off. The final comfort for the armchair musician was unwittingly made by Edison, when he invented his phonograph. Beethoven at breakfast is the last nail in the coffin of the amateur practical musician. Who will want to hear him play the "Revolutionary" when they can hear Paderewski? Would you dare to sing when Chaliapin and Melba can be brought back from the shadows? It is amusing and it is easy to mock the Victorian musical evening: a baritone, accompanied by the vicar's daughter on a tinkly piano, renders one of Sir Arthur Scott Gatty's splendid ballads, one hand rests upon his song-filled breast, and with the other he keeps his balance against a potted palm. There is brittle laughter and polite clapping in the gaslit room of stained glass and prosperous cigar smoke. But how different and how much better we are today, when empty people stare at a lifeless walnut veneered "Polygram" record player, the sort you don't wind up (the last instalment has not yet been paid). There is no laughter. Between the eight records, automatically changed, there is time to sip one's Nescafé and remark: "How well Schnabel's Emperor takes to wax"; or "Do you use an Argentinian thorn or a fibre stylus?" before you sit back in patent leather armchairs, and the confounded instrument begins again.

But perhaps our patient is not a musician. Art is more his metier. He will be an "artist" then. So he takes down his "Dawn Flight" by Peter Scott, and in its place he pins Van Gogh's "Green Man." The following day he sets off to the National Gallery and the next afire with keenness, he creeps the Tate. He is given for Christmas "The Impressionists," "Dutch Paintings of the Eighteenth Century" and the "Notebooks of Leonardo." Thus so quickly is the amateur artist extinguished, and Phoenix-like, in his ashes rises up the armchair artist. Would that he had been given a palette and brushes, and the simple advice: "Get in there and paint." But too late, he is now a confirmed "critic," armed with talk about pigment permanence, chiaroscuro and the restoration of Rembrandt's "Night Watch." He will never paint for his own pleasure again. He is too frightened by his ideals and unapproachably high standards. These are the ideals and standards of men of genius, and who wants to be a genius to enjoy himself? Most geniuses are profoundly unhappy and dissatisfied. One slices off his ear, another forsakes his family, yet another takes to drink.

So get out of those armchairs from which laws are laid down, and hypercritical nonsense, more calculated to condemn than to be constructive, is talked. Grow irises, keep pigs, bind books, ring church bells, or make a cake. Enjoy yourselves. But if you are discovered in an armchair, be sure you have your red carpet slippers on, then no one will take you seriously, least of all yourself.

The appeal for more matter of general interest about the Hospital from its past and present members has been most encouraging, and the idea of this column of miscellaneous notes and jottings seems to be a popular one. However keen a sleuth-hound for matter the Editor may be, he does depend on his readers to contribute such news. If you have any matter which you think may be of use, do not hesitate to send it in to the Editor. We are always very pleased to print notices of births, marriages and engagements; there will be no charge.

We should like to congratulate Arthur Wint on his achievements at running this year. He has represented Britain and St. Bartholomew's Hospital all over the world. At the beginning of the year he was in America, in April he visited Paris, in June Holland, and in August back to France and to Belgrade. In twenty 440 and 880 events he has been first without exception. On July 14 in the British Amateur Association Championships he broke a 25 year old record by winning the 880 yards in 1 min. 49.6 seconds. At the "News of the World" meeting he beat the half mile champion of America, Robert Chambers, in 1 min. 51.7 seconds. His fastest times this year have been 47.2 seconds for the 440 yards against France, and 1 min. 49.7 seconds for the 800 metres at Belgrade.

We wish him every success at the Olympic Games next year.

The Inter-Hospitals Regatta is being held at Putney on Wednesday, November 7. Last year the Boat Club won four events at this regatta, and they have high hopes of repeating their success. The Hard at Putney is the best place to watch from (just across the river from Putney Bridge station).

Their reorganisation of the Museum being now partly completed, Professor Blacklock and his staff have turned their attention to the Senior Pathology Course. The lectures have been extended to cover a two year period. They no longer occupy any part of the three month course, which is to be a purely practical one. The time so made available will be spent in a more complete course in Morbid Histology, and in Chemical and Clinical Pathology than was previously possible. Instruction in Pathology Clerking and in the practice of post-mortem examination is being included for the first time since the war. It is good to see these things back, and we shall hope to see even more of them in the future.

We welcome Bob Newill to the Journal as Sports Editor. He succeeds Mark Baimbridge, who has held this position for the last year. He was captain of the Boat Club. Would those of you who have matter for the Journal concerning Sport or the College Societies, please get in touch with him.

The Rifle Club have almost completed steps to restart .22 pistol shooting. This has been made possible by the presentation of a pistol by Sir Neil Hamilton Fairley.

Pistol shoots will be held at 4 p.m. on Wednesdays in the rifle range. Individual competitions will be arranged, and should we reach the necessary standard we will send a team to Bisley next year.

Anyone who is interested in pistol shooting will be most welcome.

The city has very few bookshops and none that specialises entirely in medical publications. If books or stationery are needed we must go to the "bookshop area" further west, a tiresome journey. We therefore welcome a new bookshop, even though we still have to take a bus or tube to Tottenham Court Road. You will find Lloyd-Luke, opposite the Middlesex Hospital, at 22, Cleveland Street, W.1, where you can pick out its attractive bow-windowed shopfront. It has been opened by Mr. W. Richard Lloyd and Mr. Douglas Luke, both of whom have been connected with medical publishing for many years. Anything from books to journals, stationery to subscriptions can be had, and even if it can't, we are sure that Mr. Lloyd or Mr. Luke would get it for you.

"Medical Students through the Ages" is the title of the address to be given to the Abernethian Society on November 15th. The speaker will be Mr. Zacchary Cope, who will be well known to many of our readers for his works in prose and verse on the Acute Abdomen.

On November 29 Dr. Russell Brain, the President of the Royal College of Physicians, will speak on "Some Literary Diagnoses."

Both these meetings will be at 5.30 p.m. in the Clinical Lecture Theatre.

MARRIAGES

The marriage took place on Friday, September 21st, at St. Peters Church, St. Albans, between Dr. Peter D. Matthews, Vice-President of the Students Union and Jean M. Evans, formerly a member of the nursing staff at this hospital.

The marriage took place on Saturday, September 22nd at St. Bartholomew's the Less, between Dr. J. Ian Burn, House surgeon to Mr. J. O'Connell, Hill End, and Miss Fiona Allen, formerly a member of the nursing staff at this Hospital.

IMMUNITY AND TUBERCULOSIS

By JOHN W. S. BLACKLOCK

IN any bacterial infection immunity may be natural or acquired and this holds good for tuberculosis in which, however, the additional factor of hypersensitivity or allergy plays an important part. Immunity and hypersensitivity are distinct from one another and concern the tissues of the human subject or the experimental animal, that is, the *soil*. The *seed*, the tubercle bacillus, must also be considered for the dose, due to either natural or experimental infection, may vary within wide limits and the virulence of different strains of bacilli and even individuals of the same strain, either of human or bovine type, may also vary. The degree of variation of virulence of cultures of freshly isolated strains is, however, probably not great in the case of bacilli causing tuberculosis of tissues other than the skin.

Natural Immunity

It has long been known that certain individuals are not liable to develop manifest disease though exposed to infection while others under the same conditions readily fall victims to it. In most bacterial diseases it is possible to demonstrate *in vitro* the presence and the degree of immunity, but this does not apply to tuberculosis, for so far as is known the tubercle bacillus forms no toxins. How then does it produce its effects? These appear to depend on some little understood host—parasite relationship, or they may be due to the metabolic activities of the bacillus while in contact with living susceptible tissue. Certain animals are highly resistant to experimental infection with tuberculosis as for example rats, sheep, goats and horses; others like guinea-pigs and monkeys are highly susceptible, while others, including man, occupy an intermediate position. That this natural immunity does not depend on humoral factors in resistant animals can readily be demonstrated by the fact that it is possible to grow the tubercle bacillus *in vitro* in the serum of these animals even when infinitesimal inocula are used. Thus it may be concluded that natural resistance is cellular in nature. A striking example of this, and one deserving further study, is the resistance of the bovine species to infection with the human type of tubercle bacillus, which when inoculated subcutaneously causes a localised retrogressive lesion which heals whereas the bovine bacillus causes rapidly progressive disease ending fatally. Yet the human type of bacillus grows far more luxuriantly on bovine serum than does the bovine.

The work of Fell and Brieger (1947) and others using tissue cultures of fibroblasts and macrophages from normal animals has shown that these cells can live and multiply *in vitro* side by side with tubercle bacilli. The macrophages under such conditions control the infection by actively phagocytosing the bacilli, the fibroblasts not having the same phagocytic capacity. From such experiments it would seem that natural immunity is of cellular nature and is dependent on the cells derived from the reticulo-endothelial system. It is the cells derived from this system that are particularly active in the reaction to tuberculosis infection as in the previously uninfected subject the mononuclear phagocytes are the first cells to appear around tubercle bacilli which have invaded the tissues. From these cells are derived the endothelioid cells which may help to limit the spread of infection. Sabin, Doan and Forkner (1930) and Sabin (1941) have shown experimentally that it is the lipid fraction of the tubercle bacillus, in particular the phosphatide and fatty acid derivatives and the wax of the organism which stimulate the proliferation of endothelioid cells, though the amounts they used experimentally were grossly in excess of what must occur in natural infection with small numbers of bacilli. The endothelioid follicle may disappear entirely and leave no trace in the highly immune animal, a fact which is well seen in the liver of experimental animals provided no necrosis and no proliferation of fibrous tissue has taken place. Thus infection may have occurred and no macroscopic or microscopic evidence of it ever having been present remain. If necrosis takes place in the follicle, and this is not due to the loss of blood supply to the centre of the follicle, then arrest of the disease by proliferation of fibrous tissue or calcification with fibrosis may follow. Such is the reaction which takes place in the naturally immune person and thus there is

no spread of the disease. What determines this natural immunity depends on many factors such as race, heredity, age and sex and the general health of the subject at the time of infection.

Race. The work of the South African Institute for Medical Research (1932) and that of Lyle Cummins (1935) has demonstrated that the adult African native, like the European, is almost universally infected with tubercle as shown by the results of the tuberculin test. Yet under the same environmental conditions as the European the African much more frequently develops the most fulminating types of tuberculosis. The same is true of the American negro as compared with the American white (McPhedran & Opie, 1936).

Heredity. In natural immunity heredity undoubtedly plays some part and it would seem easy to prove that this is the case, but the magnitude of the variable factors involved, particularly environmental, makes it one of the most difficult problems and even such experienced statisticians as Greenwood (1908-9) and Pearl (1920-21) reserve final judgment. As shown by Lurie (1941) in experimental studies in inbred rabbits, natural resistance to moderate doses of tubercle bacilli (for massive doses will overwhelm even the highest resistance) appears to depend on genetic constitution. He has been able by inbreeding rabbits over a period of several years to divide them into three groups—uniformly highly resistant, uniformly highly susceptible, and intermediate in resistance to respiratory infection by small doses of tubercle bacilli. Of fundamental importance, however, is his observation that the mononuclear leucocytes of the resistant strain of rabbits had the capacity to inhibit the growth of tubercle bacilli in their cytoplasm, whereas this was not the case in the susceptible strains. One cannot, of course, apply these results in rabbits to man as they have been obtained by a degree of inbreeding unknown in the human race.

Age. Primary infection may occur at any age and is most usual in childhood, though recent investigations tend to show that in the present decade such infections are occurring at a later age than in the past. This is all to the good as histological evidence shows that as age advances there is increasing fibrosis around primary lesions. Indeed there is a period between 5 years and puberty when the results of tuberculous infection are not so serious as at an earlier age. With the onset of puberty, however, there is an increased morbidity in tuberculosis which is partly related to changes of environment and of occupation of many adolescents, though probably the sex hormones may play a part, but of this we have no definite evidence. In contrast to the usual rapid spread of infection in the infant the defences of the older child and the adult more frequently localise the tubercle bacilli at the primary site of infection where they are eventually encapsulated and thus no spread to related lymphatic glands or generalisation occurs. Wallgren (1945), Ustvedt (1946) and myself (1932) have all drawn attention to the unfavourable course of primary infection in infancy and in the pre-school age. The slower evolution of the tuberculous reaction usually resulting in arrest characteristic of adult life must therefore depend on a lesser re-activity to the tubercle bacillus on the part of the tissues of the adult, as compared with those of the child. That this altered reactivity is not due to acquired resistance from previous infection is shown by the fact that the difference is apparent even in primary lung lesions. What causes this alteration in reaction of the tissues with increasing age is unknown. It must not, however, be concluded that all young children possess no natural resistance. Dramatic evidence that such exists in a proportion of children was provided by the Lubeck disaster where, owing to a probable contamination of a culture of B.C.G. with human tubercle bacilli, a vaccine containing virulent tubercle bacilli was administered by mouth to a large number of children. There is some doubt that all the children received exactly the same dose, but even taking this into account it is remarkable that of the 251 children receiving the vaccine only 28.7 per cent. died of tuberculosis due to the vaccination (Schürmann, 1932).

Acquired Immunity

It is debatable whether acquired immunity as a result of infection is of greater or less importance than natural immunity. Undoubtedly the acquired will reinforce the natural and like it may be depressed or abolished by such adverse factors as overwork, acute illness and malnutrition. Indeed these very factors may prevent the development of acquired immunity in which case a reinfection tuberculosis progresses rapidly resulting in an acute type of disease. In

man, acquired immunity results from natural infection, vaccination with living tubercle bacilli like B.C.G., or the vole bacillus, or vaccination with dead bacilli. In the experimental animal the guinea-pig has been mostly used—immunity can be readily produced by the inoculation of attenuated living tubercle bacilli, and the immunity so produced is usually much greater and more lasting than that resulting from the injection of dead bacilli. This suggests that in the living organisms there is some labile complex which is the immunising agent. This immunity cannot be transferred passively with the blood, and it does not pass from mother to foetus *in utero*. We have, as yet, no means of measuring this immunity by any *in vitro* test and the only way its presence can be demonstrated and its degree estimated is by injection of virulent organisms in the experimental animal or by study of the results of reinfection in the human subject. Acquired immunity localises a reinfection as has been shown by Krause and Willis (1925) in normal and in immune guinea-pigs. In the former it was found that the regional lymph nodes draining the site of cutaneous inoculation of tubercle bacilli when excised 24 hours after inoculation infected a fresh guinea-pig, whereas it was towards the end of the second week after cutaneous inoculation before the regional lymph nodes from a similarly treated immune animal became infective. The same is true in the case of air-borne infection in the human subject. In the infant the infecting bacilli proliferate rapidly in the primary lung lesion, and soon the tracheo-bronchial glands are infected and show typical tuberculous lymphadenitis. On the other hand in the adult who has acquired immunity as a result of childhood infection, the reinfection usually localises itself frequently just under the apex of the lung. There the bacilli proliferate slowly and remain localised to the site of infection, not spreading to the tracheobronchial glands which remain free from any lesion. Undoubtedly then in the immune subject there is something like an agglutination reaction in the tissues of reinfection. This results in a localisation and prevention of multiplication of bacilli, so giving time for the growth of granulation tissue. With the subsequent fibrosis, with or without calcification, there results the typical chronic arrested lesions which are frequently found in the apices of the lung. If, however, the acquired resistance is prevented from developing, or is depressed by adverse factors, then the tubercle bacilli multiply and spread and so acute and usually extensive lesions often complicated by generalisation of the infection occur.

As a result of natural or experimental infection with tubercle bacilli, tuberculo-immunity and tuberculo-hypersensitivity are produced concurrently. In the experimental animal these can be separated and each is a characteristic, apparently unrelated, biological phenomenon as tuberculo-hypersensitivity may be eliminated by desensitisation with tuberculin, the tuberculo-immunity remaining unimpaired. The localisation and destruction of virulent tubercle bacilli in reinfection is more effective and complete in the de-sensitised, non-hypersensitive immune than in the hypersensitive-immune animal (Birkhaug, 1942). In the natural infection of man and also in experimental infection in guinea-pigs (Willis, 1928) the hypersensitivity gradually wanes if the disease is arrested and resistance, the degree of which varies, remains.

What is the nature of the antigen which is responsible for the development of acquired immunity? Biological analyses of the bodies of killed tubercle bacilli so far have been unsatisfactory in answering this all-important question. The lipid (Boquet & Nègre, 1923; Pinner, 1928) and protein components (Seibert, 1933; Smithburn *et al.* 1934) have been found to be actively antigenic and will induce antibody formation when injected into normal animals, but none of these has the power of producing immunity (Sabin *et al.* 1930). None of the carbohydrate fractions so far obtained has been found to be complete antigens (Heidelberger & Menzel, 1932). More recently Choucroun (1947) has isolated a chloroform soluble carbohydrate-lipid complex from tubercle bacilli which has the power of inducing antibody formation when injected into normal animals, and she suggests that this complex may play a part in the mechanism of acquired immunity.

Hypersensitivity

This is the one factor in tuberculosis, about which most information is available. That a previous infection could so modify the tissues that a local hypersensitive reaction would develop when the infecting agent was again brought into contact with the tissues was first noticed by Jenner (1801) in relation to vaccinia. Later Koch (1891) applied this observation to tuberculosis in the now well-recognised Koch phenomenon. Experimentally the time taken for hypersensitivity to appear, as judged by the occurrence of a positive tuberculin reaction, varies depending on the individual and on the number of bacilli introduced into the tissues, and their virulence. With avirulent strains and dead bacilli the period is usually longer than with equal numbers of virulent organisms, because virulent bacilli have the capacity of multiplying quickly in the tissues producing great numbers of organisms from which large amounts of sensitising antigenic material are released. In man a positive tuberculin reaction takes from about 3 weeks to 3 months to develop after infection: in the case of the Lubeck disaster the period was 23 days (Schürmann, 1935): with heat-killed tubercle bacilli Goodwin and Schwentker (1934) noted the appearance of hypersensitivity 3 to 13 weeks following injection into infants. The reaction once it appears, as in all recent infections, is strongly positive, but with healing and fibrosis the reaction gradually wanes (Westwater, 1934). The strength of the reaction is, however, quite independent of the activity or extent of the disease. The reaction persists, though in a lesser degree than initially, so long as bacilli, living or dead are present to keep up the supply of antigenic material. Further, the intensity of the reaction may fluctuate from time to time depending on the amount of antigen liberated and the degree of encapsulation of the tubercle bacilli. It is doubtful if a positive reaction ever entirely disappears for in most cases where it is presumed negative after having been positive, a positive reaction may still be elicited by using high concentrations, e.g., 10 mg., of tuberculin for testing. Lloyd and Macpherson (1933) for example, found that in 96 per cent. of cases the reaction persisted throughout childhood and Ridehalgh (1942) noted in the Prophit survey that only one to two per cent. of reactors became negative each year. Zacks and Sartwell (1942) observed in an investigation of 1,000 subjects that the highest proportion of change from a positive to a negative reaction occurred between 5 and 14 years, viz., 12.7 per cent., the smallest, 1 per cent. in subjects over 20 years. Ferguson (1928) observed the fading or disappearance of the tuberculin reaction following B.C.G. vaccination within 2 to 5 years in a large percentage of cases. Owing to the benignity of the infection in B.C.G. vaccination and the fact that the bacilli die soon after inoculation, this period of 2 to 5 years should be regarded as a minimum for the disappearance of a positive reaction.

The effects of hypersensitivity largely depend on its degree and unlike an anaphylactic hypersensitivity that of the tuberculin type involves all tissues of the body. When it is high the disintegration products of the tubercle bacillus, produced as a result of the action of the living tissue on the organisms, act as irritants and poisons to all the tissues causing a rather acute type of inflammation with, in the early stages, a marked reaction on the part of the polymorphonuclear leucocytes followed by mononuclears. Later necrosis occurs at the sites of infection. This type of reaction is in marked contrast to the localised nature of the disease at the site of primary infection which occurs when the body is not hypersensitive. Indeed, the greatly enlarged caseating glands at the hilum of the lung in the primary complex are largely the result of high hypersensitivity. When these glands in relation to a primary focus do not become diseased the hypersensitivity has been low and the natural and acquired immunity high, so localising the bacilli to the site of infection, that is in the primary focus in the lung, and inhibiting their proliferation. This is what usually occurs when primary infection of the lung takes place in adolescence or adult life. Thus hypersensitivity renders the tuberculoproteins which are harmless to the normal animal capable of acting as acute irritants in the infected animal.

The degree of hypersensitivity varies much with race and with the individual: in general the higher the sensitivity the greater the liability to the onset of acute tuberculosis as Lyle Cummins (1935) has shown in the native recruits for the mines in South Africa. Though practically every adult is tuberculin positive (in London, about 90 per cent. are positive at the age of 24—Hart, 1932) only a small proportion develop active tuberculosis, due partly to the sensitivity being of a low order and partly to the co-existing natural and acquired immunity.

Hypersensitivity is cellular rather than humoral. It cannot be transferred by means of blood from hypersensitive guinea-pigs to normal recipient guinea-pigs (Corper & Cohn, 1945). No true antibody has been

demonstrated, though from all the experimental evidence it probably exists. It is undoubtedly associated with the cells for as shown by Rich and Lewis (1928 & 1932), cells from normal animals will continue to proliferate in tissue culture even in the presence of tuberculin. Those from hypersensitive animals, however, perish shortly after the same concentration of tuberculin is introduced into the culture. Purified protein derivative acts in the same way as tubercle bacilli in tissue culture, but not tuberculo-polysaccharide or nuclei acid (Heilman & Seibert, 1946).

The chemistry of tuberculo-hypersensitivity has been much investigated. Hypersensitivity occurs in natural infection and readily can be produced experimentally by the inoculation of living or dead bacilli. It is almost certainly associated with the protein components of the organisms though pure tuberculin (tuberculo-protein) even when administered in large amounts parenterally to normal animals will not induce hypersensitiveness to the usual amounts of tuberculin used in testing. Protein fractions can, however, provoke a typical tuberculin reaction in the hypersensitive animal (Seibert, 1928 & 1930; Dienes & Freund, 1926; Pinner, 1928). Besides possessing this high tuberculin activity, purified tuberculo-protein is non-toxic for normal guinea-pigs, sensitises anaphylactically but not allergically and fails to immunise against virulent tuberculous infection. Corper *et al* (1941) and Corper (1946), however, consider as questionable the liberation of tuberculin in appreciable amounts by tubercle bacilli *in vivo* though it is readily produced as a result of autolysis in liquid media once maximum growth has occurred, and for some time thereafter continues to increase with the ageing of the culture (Corper & Cohn, 1943 & 1944). As a result of his work Corper (1946) is of the opinion that there are two separate types of hypersensitiveness, viz., that elicited by tuberculin, which is of little importance, and that elicited by viable tubercle bacilli, which is of much importance in the actual disease.

Raffel (1946) failed to produce tuberculin hypersensitivity when large numbers of bacilli from which the phosphatides and waxes had been removed were injected into animals, though it occurred when the waxes were again added to the bacilli. When mixture of isolated protein and wax fractions were employed together for injection, a delayed type of tuberculin hypersensitivity was produced in guinea-pigs. None of these fractions, either alone or in combination, produced immunity, a fact which indicates that hypersensitivity and immunity are distinct entities. Choucroun (1947) claims that she has isolated a protein component of the tubercle bacillus which when injected intra-peritoneally in paraffin oil into normal animals will establish a hypersensitivity of tuberculin type.

The Bacilli

Types. The human, the bovine and the avian types of tubercle bacilli cause natural infection in man, infection with the last mentioned, however, is so rare that it can be almost disregarded. Both the human and bovine types may cause progressive disease in man, that due to the human type being the more common because the chances of infection with this type are greater than with the bovine. The human bacillus most frequently infects the lung, a site which is more suitable for the growth of tubercle bacilli than any part of the mucosa of the alimentary system. Indeed in the experimental animal it is relatively easy to produce lesions in the lung with either the human or bovine type by spraying tubercle bacilli into the trachea. On the other hand it is exceedingly difficult to cause infection in the alimentary system of animals by feeding. We cannot, however, assume that because of the less frequent or less extensive disease in man due to the bovine type that this type is less pathogenic for the human subject. Both types are equally pathogenic provided the bacillus involved is virulent, and sufficient numbers gain access to the tissues.

Virulence. Tubercle bacilli which have been recently isolated by culture from an active tuberculous lesion, except those from lupus, have all much the same virulence for the usual test animal, the guinea-pig. This virulence may be reduced or almost completely eliminated as in the case of B.C.G. by culture in suitable media for many generations. Does this reduction in virulence occur under natural conditions ? This would appear likely for using the same material from active tuberculous lesions, e.g. sputum or exudate from a tuberculous abscess, Jensen and Bindsler (1946) and myself (1932), have found that it is often possible to recover tubercle bacilli by cultural means when, by using many times a greater volume of the same inoculum, no lesions result in guinea-pigs killed 2 months or more after inoculation. This suggests that the tubercle bacilli in such material have been damaged as a result of the defensive measures of the human host, so that the tissues of the guinea-pig are capable of killing the scanty relatively avirulent bacilli introduced. In culture, however, away from the defensive action of living tissue, they survive and proliferate and in my cases small amounts of those cultures of the order of 0.001 mg. caused progressive tuberculosis when inoculated into the guinea-pig. The implications of these observations are wide for it is obvious that should we inhale such relatively avirulent forms then the tissues of the normal human respiratory system will, as in the guinea-pig, be capable of killing them. This may be an important factor in the production of acquired immunity and is worthy of further study. It may explain at least in part why we so often find only one primary lung focus in a child exposed to repeated and often long, continued, familial infection. Such a child must receive multiple infections and yet multiple primary lung lesions are uncommon.

Numbers. Another important factor in the production of tuberculosis is the number of bacilli which gain entrance to the body. This number must vary enormously, for as shown by Duguid (1946) a proportion of the droplets expelled during coughing by patients with open pulmonary tuberculosis may contain anything from 1 to 40,000 tubercle bacilli. It has been estimated that a droplet 0.3 mm. in diameter which could pass into the finer bronchioles could contain about 300 bacilli. The number of tubercle bacilli required to produce disease in the human subject is unknown. In the individual with a high immunity and a low hypersensitivity, small numbers are probably relatively harmless: moderate numbers may cause a lesion which progresses slowly for a time until arrested by increased immunity; large numbers, however, will swamp even the best immunity and cause progressive disease. On the other hand, in an individual with low immunity and high hypersensitivity, small numbers of bacilli will produce progressive disease as on account of the former the bacilli are not fixed at the site of infection and multiply rapidly. This rapid multiplication of the bacilli further increases the already high allergy due to the liberation of much antigenic material and thus the lesion produced is of an acute nature with widespread necrosis.

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STAFF APPOINTMENTS

The undermentioned appointments to the Medical Staff have been made with effect from the dates indicated:

Junior Medical Registrars
Dr. Bourne's firm — Dr. J. Matthias, for one year from 1.11.51, vice M. Wilkinson
Dr. Spence's firm — Dr. D. D. Felix-Davies, for one year from 1.11.51, vice J. L. G. Thomson
Dr. Scowen's firm — Dr. P. I. Banks, for one year from 1.11.51, vice H. Lloyd

Junior Surgical Registrars
Mr. Corbett's firm — Mr. D. A. Watson, for one year from 1.10.51, vice J. G. Jamieson
Mr. Hosford's firm — Mr. P. M. Weston, for one year from 1.11.51, vice R. Youngman

Junior Demonstrator of Pathology
Junior Registrar — Dr. T. W. Osborn, for one year from 1.10.51

Ophthalmic Department
Part-time Registrar — Mr. N. S. Moores, from 1.11.51, vice J. H. Dobree

Department for Venereal Diseases
Part-time Senior Registrar — Dr. G. Jelinek, from 1.10.51, vice P. C. Watson

Dental Department
Resident House Surgeon — Mr. P. H. S. Hooper, for 6 months from 1.10.51, vice J. Leitch

"ARSENIC AND OLD LACE"

At 7.30 p.m. on November 22 and 23 **"ARSENIC AND OLD LACE"** by Joseph Kesselring will be produced at the Cripplegate Theatre by the Dramatic Society. Tickets may be had from the Assistant Honorary Secretary, Miss Pamela Matheson.

ST. BARTHOLOMEW'S HOSPITAL MEDICAL COLLEGE WAR MEMORIAL FUND

Up to date a sum of £2,563 has been collected from 726 subscribers. We are extremely grateful to these old Bart.'s men, and I deeply regret my inability to send personal notes in reply to the many letters which have accompanied the subscriptions.

It has been our intention to collect £7,500, and we are publishing these figures in the hope that others who have not yet subscribed may be stimulated to do so.

J. PATERSON ROSS.

CAMBRIDGE GRADUATES CLUB OF ST. BARTHOLOMEW'S HOSPITAL

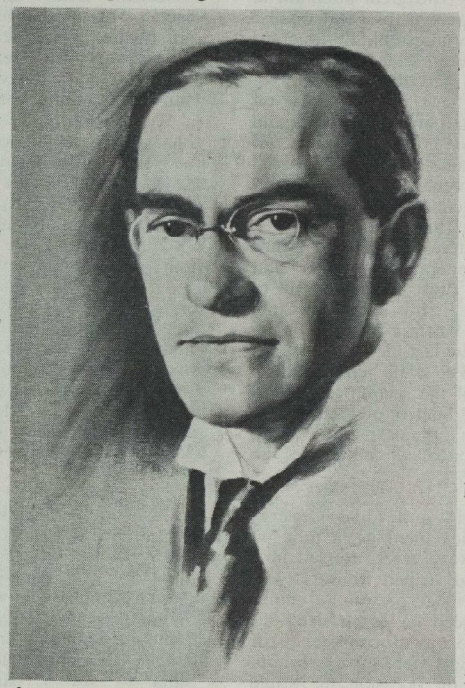
As readers of the *Journal* will know, this seventy-five year old club is now open to Women Graduates. They have agreed that the annual dinner should remain a men's affair, for the present at all events; but there will be also an annual sherry and cocktail party, open to all members, men and women.

The first Cocktail Party will be held on Friday, November 23rd in the Hospital Library at 6.0 p.m., and it is hoped that this will prove a happy precursor of many more. Members who have kept their names on the Club books will be notified in the usual way; the Secretaries would be grateful if any Bart's graduate, who wishes to come but does not receive a notice would write to Mr. H. Jackson Burrows, 25 Upper Wimpole Street, W.1.

OBITUARY

GEOFFREY EVANS M.A. M.D. (CANTAB) F.R.C.P. 1886—1951

THE sudden death on August 30th of Dr. Geoffrey Evans in his sixty-fifth year, a few days after a fall at his home in Worcestershire, came as a shock to his many friends. One of the great personalities of the Hospital, he combined a cheerful and humorous nature with a most conscientious and painstaking method. There can be few Bart.'s men who have not learnt something from him about the handling of patients, for at this he was an artist.



Arthur Geoffrey Evans was the only surviving son of Patrick F. Evans, a former Recorder of Newcastle - under - Lyme. He was born in 1886 and was educated at Charterhouse and Cambridge. He was an Exhibitioner of Trinity College, where he took a First Class in both parts of the Natural Science Tripos. He also found time to cox the 1st Trinity Boat. He came to St. Bartholomew's in 1909 with a senior entrance scholarship and in 1912 he qualified and won the Brackenbury scholarship in medicine. He then went for some months of postgraduate study under the Professor of Medicine at the Bürgerspital, Basle, and on his return, he distinguished himself as House Physician to the Garrod-Horder firm. In 1914 he obtained the Membership of the Royal College of Physicians and was awarded the Lawrence research scholarship. During the First World War he served as a temporary surgeon-lieutenant in the Royal Navy from 1914 to 1919. When he came back to civilian life, he was glad to be able to take up his uncompleted Lawrence research work and he busied himself in the study of renal diseases in the hospital pathological department. He took the Cambridge M.D. in 1921, winning the Horton Smith prize for his thesis.

After serving for two years as Chief Assistant to Dr. Drysdale he was in 1921 appointed Assistant Director of the new Medical Professorial Unit at Bart.'s under the direction of Professor (now Sir Francis) Fraser. In 1929 he became Assistant Physician, first to Sir Walter Langdon Brown and then to Lord Horder; in 1936 he became full Physician to the Hospital. For two years after the First World War he had been Assistant Physician to the Metropolitan Hospital, but otherwise his hospital time was devoted entirely to his parent hospital. During the Second World War he regularly visited the Bart.'s units at Cell Barnes and Hill End. On reaching the then age limit of 60 in 1946 he retired from the full staff but continued in an Emeritus capacity for a further two years until the advent of the National Health Service. From the day of its introduction he gave up his hospital work but remained extremely busy in consulting practice. Because of the maturity and independence of his judgment, his opinion was sought even more than previously.

He took an active part in the work of the Royal College of Physicians. He was elected to the Fellowship in 1922 and later served on the Council and as an Examiner. He was Goulstonian lecturer in 1923 and on this occasion he described his original work on the nature and histology of arteriosclerosis.

He published further work in this field and his Lumleian lecture in 1943 was also on "Arteriosclerotic Disease."

In addition to his work on arteriosclerosis he made a special study of renal disease and he was co-author, with the late Sir Girling Ball, of "Diseases of the Kidney." He was also interested in arthritis and such homely matters as constipation, sleep, relaxation and correct posture. He paid great attention to the psychological aspect of physical disease and dealt with this in an essentially practical way. In his presidential address to the section of medicine of the Royal Society of Medicine in 1943, he spoke in detail on mental health. He had an orderly mind and latterly he had devoted much of his time and energy to collecting and editing the material for his last and comprehensive work "Medical Treatment: Principles and their Application," published in 1950.

In his medical interests, Geoffrey Evans was close to the general practitioner and many of them have cause to be grateful to him for his counsel. In 1925 he became Chairman of the St. Pancras Division of the B.M.A. and one of the last medical meetings at which he spoke—with characteristic humour—was that of the section of general practice at the Royal Society of Medicine.

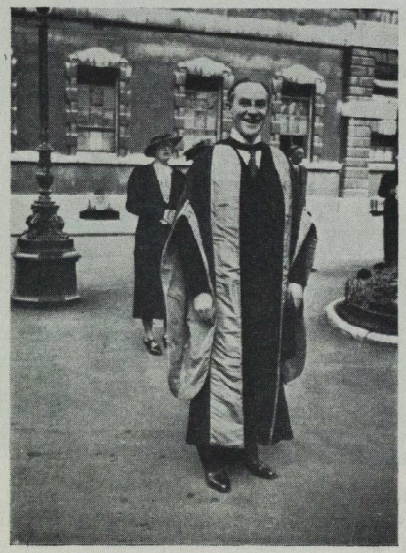
He excelled as an organiser and was an ideal Chairman of medical committees on account of his fairness, understanding and authority. He did much work for the Medical College at Bart.'s and he also served as Chairman of the Emergency Bed Service Committee of the King Edward's Hospital Fund for London. The development of the National Health Service was foreign to his nature but his criticisms were broad and constructive.

Geoffrey Evans had a strong religious instinct but he was never remote or sentimental. He held high honours in Masonry and was treasurer of his hospital Lodge. When he was able to go to Harpley House, his country home at Clifton-on-Teme in Worcestershire, he read the Sunday lessons in church and took a close interest in the welfare of his tenants and other villagers. He was a true countryman and he enjoyed visiting his local farms. No record of the life of Geoffrey Evans would be complete without reference to his supremely happy home amongst his family. In 1917 he married Ermine Mary Kyffin, only child of Sir Francis Taylor (later Lord Maenan), and they had one son and three daughters. To them we offer our sincere sympathy in their loss. A service of praise and thanksgiving for his life and work was held at the Church of St. Bartholomew-the-Great on September 12th in the presence of a large number of friends and colleagues.

There was nobody quite like Geoffrey Evans. Quick in movement as in thought, slight of build but very erect, dressed in a short black coat and striped trousers, with pince-nez and bowler hat, he was an unmistakeable figure; indeed he emphasized the importance to a doctor of consistency of appearance. His boots were always beautifully polished and on occasion he would trace the outline of one on a blue-board to demonstrate the principles of proper footwear construction. The white coat had a symbolic importance for him and he would stress to students the power and protection it afforded, since it enabled one to say things to patients that they would not accept in any other circumstances. When once a student appeared on a ward-round in rather loud plus-fours, Geoffrey made no comment until the end, when he spoke in general terms about the importance of looking like a doctor. "I was called out last Sunday," he said, and then—as if an afterthought—"but I wasn't in a knickerbocker suit." It was a gentle reproof.

His bowler hat was as significant as his white coat and sometimes it was difficult to keep a straight face when, in the course of changing in the cloak-room before or after a round, he would continue a serious conversation wearing both together. After flying to India to see a patient in Baroda, he remarked that he had even worn his bowler hat—riding an elephant. There was only one other such hat in the country, he had been told, and that was used for amateur theatricals. In St. Petersburg during the First World War he had acquired a fur-lined coat which he often wore in the winter.

The impact of his personality was always a stimulating experience. He was particularly helpful and encouraging to younger men, taking a real interest in their work and problems. He was always accessible for advice. His vigour was astonishing and he never seemed to be off sick. At first sight he might look a trifle stern, but when he began to talk, his vivacious enthusiasm, and his twinkling eyes showed something of his humanity. Although well known for the emphasis and clarity of his diction and for his somewhat dramatic style of humour, it was his thoroughness and gentleness with patients and, above all, his kindness which impressed one. He enjoyed provoking laughter but never at anybody's expense, for he had the most scrupulous regard for people's feelings. He never spoke in irritation or impatience and his sudden, gay laugh, followed by an expansive smile and raised eyebrows, often eased a difficult situation.



Taken at the opening of the King George V Buildings, 1936.

His regard for detail and his understanding care of his patients is illustrated by the following extract from a letter which he wrote, while on holiday, to a very new House Physician:

"Remember to pay especial attention to:

(a) those patients who are very sick and regular attention to those who are dying;

(b) all in whom the diagnosis is not established;

(c) especially any patient who is 'difficult' or disgruntled: it is important to listen to every complaint and to make no reply or observation of any kind until you have heard the other side of the story."

His lists of diagnostic questions to patients were famous. They usually began with an enquiry into any past history of "tonsillitis, quinsies, sore throats, glands in the neck, asthma, hay fever, bronchitis, pleurisy, pneumonia" and proceeded with grim determination through the alimentary system, ending with "typhoid, dysentery or yellow jaundice." A rather surprising one on trauma ended" . . . Have yer fallen on yer back, fractured yer skull, dislocated yer spine, broken yer neck—*much*?" He had his own form of shorthand, in which, for example, the rather voluble account of a patient, previously wealthy, who now had serious money troubles, might be summarised as "O/£ s. d., ↓ b4."

He always had an interest in the hospital Amateur Dramatic Society and was for a time its President. In his student days he had occasionally taken part in its activities and when he appeared in a performance of "Beauty and the Barge" by W. W. Jacobs in 1913, this Journal observed that "Mr. Geoffrey Evans was becomingly meek as Mrs. Smedley." He understood the power of words, and his dramatic talent was not always meek, for he once, as a young man, accepted the challenge of a Marble Arch orator to step into his place on the platform.

He enlivened any gathering and he was a generous host, sometimes entertaining the whole of his firm to dinner at Mansfield Street. At one time he organised regular monthly evening meetings of the junior staff of his firm; on these occasions refreshment was provided and each person presented a summary of recent medical publications.

He was a great humanist and, although nobody kept more up-to-date in medical advances, it was the approach to the patient that he most successfully taught to students on the wards. He wrote a small leaflet, some of which may be quoted as it represented well his attitude.

> "People come to us for help. They come for health and strength. . . . There is an emotional or nervous aspect to all disease. We doctors must be able to treat this. The basic weaknesses of human nature are fear, self-pity and self-indulgence. Tennyson wrote in 'Oenone':—
>
> Self-reverence, self-knowledge, self-control,
> 'These three alone lead life to sovereign power.'
>
> As medical students you can already contribute to your patients' recovery on this super-sensuous level. You will contribute to their self-reverence by treating them with respect and understanding, and by giving them their due in admiration for such fortitude (for instance) as they show in suffering. You will be able to give them self-knowledge by giving them simple information on physiological principles as is well within your knowledge and directly applicable to their sensations. You can give them self-control simply by having yourselves under perfect control, control so perfect that you are not (for instance) irritated by an irritating remark. If a man has no money he cannot give it away. It is the same with these super-sensuous things. . . ."

He believed in "atmosphere" and in the power to create it. He rightly felt that the attitude of the Sisters and Nurses and the whole firm was an important factor in the treatment of patients in the ward. He regarded affection and understanding as alternatives to a cold analytical or intellectual approach.

During the last War he refused to leave London and he worked harder than ever. He lost sleep but kept all his appointments. One afternoon he travelled up to Lincolnshire and back, without any hesitation, in order to talk informally to a group of R.A.F. medical officers. Somehow he found time to write frequent letters and in one he said:—

> "This war goes on and on and some people seem to be much occupied in waiting for it to end. . . . My mind turns to Charles Darwin who spent 4½ years in the Beagle working hard all the time and when he got home put 'Natural Selection' before the world. I feel that a war like this (and the last was just the same) puts us all into a sort of Beagle. It just upsets some people and blunts their purpose. It stimulates others to concentrated effort. Anyway, it's a voyage which may end unexpectedly suddenly. Then life ashore begins again and it will be a question as to what use has been made of the long voyage."

At the end of it all, he wrote from holiday in Worcestershire:—

> "I am enjoying a country life and am concerning myself with the sale of apples, timber and firewood. . . . There is a prospect of more feeding stuff and the talk is of keeping more pigs and poultry. . . . Peace is as exciting as war and it's fun being a primary producer and having this personal interest in the markets for primary products."

"It's fun, yer know!" was a comment he often made of many aspects of life, and whatever his hand found to do, he did it with his might. He died at the height of his powers and many will recall with affection his generosity, his buoyant enthusiasm and his kindliness.

E.C.O.J.

SISTER LUKE

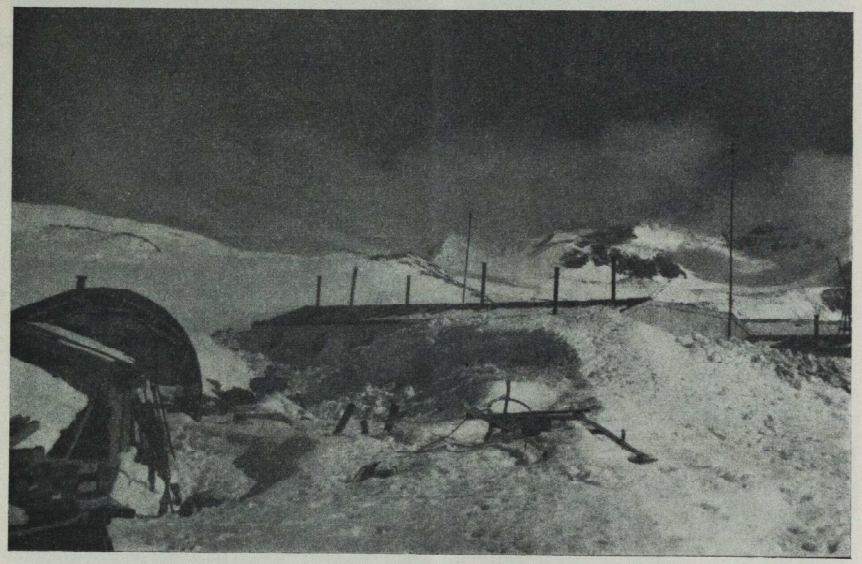
Constance Pank first came to St. Bartholomew's Hospital on June 19th, 1935, and her death on September 19th, 1951, was a loss and a grief to everyone here. She passed her senior examination in October, 1938, with first class honours, and became a sister on August 1st, 1941. In 1945 she went to Luke Ward, and it is for her work here that she is best known. The outstanding qualities that she showed were integrity and kindliness; although her judgment was shrewd and her sense of humour keen, she never used either to hurt. Her ward was happy, and student nurses loved to go there. What we shall best remember about her probably is the great courage and courtesy she showed in her last days. She knew the nature of the complaint that occasioned her two major operations, and in the spring learned that her time left was short. She was grateful that she was able to continue in her ward the work that she loved till within a few weeks of her death. During this final stage those who were with her often felt that it was not we who sustained and comforted her, but she who by her fortitude and greatheartedness helped us. We sympathise with her parents in their sorrow, which is shared by everyone here who knew her.

THE FALKLAND ISLANDS DEPENDENCIES SURVEY

(*Junior Registrar to the Department of Obstretrics and Gynaecology*)

By J. D. ANDREW.

IT is only for the past hundred years or so that active interest has been taken in what lies at the bottom of the world. That inveterate explorer Captain Cook it is true had penetrated into the southern pack ice as early as 1773, but it was not until 1820 that Edward Bransfield, R.N., in the brig Williams actually sited that portion of the Antarctic mainland subsequently called Trinity Land. Thereby he confirmed the long suspected presence of an Antarctic continent.



The Base huts at Hope Bay

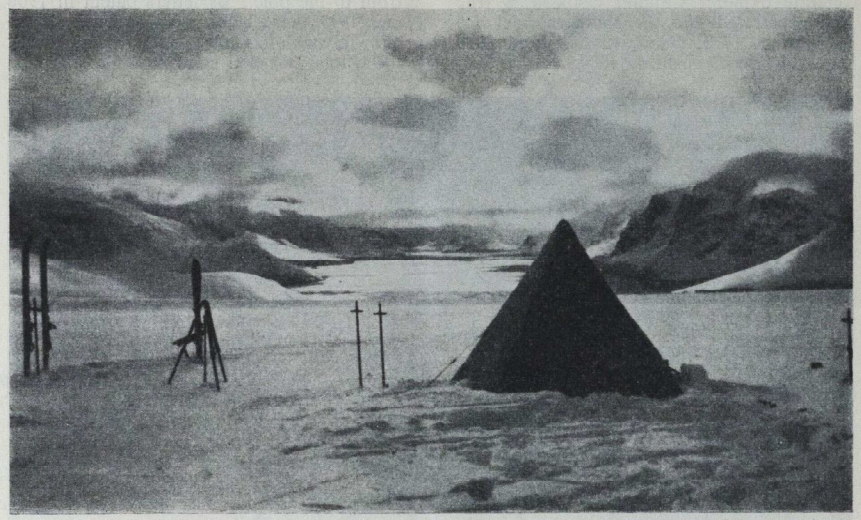
From that time onwards knowledge of the Antarctic seas and mainland has rapidly accumulated, both as a result of commercial enterprise in search of whales and seals and by reason of scientific interests and of discovery for its own sake. Such names as Weddell, Nordenskjold, Ross, Scott and Shackleton to recall just a few are linked inseparably with these activities.

The Falkland Islands Dependencies comprise in the main the South Shetlands, South Georgia, South Sandwich and South Orkney Islands and Graham Land together with that sector of the mainland which depends therefrom to the pole. By letters patent in 1908 and 1917 these lands were annexed to the Crown, which has subsequently administered the whole area and controlled all work and research.

In 1943 His Majesty's Government decided to dispatch an expedition to the dependencies, known as "Operation Tabarin," primarily to maintain British Sovereignty but also to pursue a scientific programme in which meteorology then bulked very largely. The summer of 1943-44 saw Lt. Cdr. J. W. S. Marr, R.N.V.R., establish two bases on islands near Graham Land, and in the subsequent year a further base was built at Hope Bay on the northern tip of the Graham Land peninsula. The activities of the expedition dignified now by the name of The Falkland Islands Dependencies Survey were greatly increased in

1945, and an ambitious programme of scientific survey in all its branches was embarked upon.

In October of 1946 I was so fortunate as to join the expedition as a relief M.O. to the Hope Bay base under the command of Surg. Cdr. E. W. Bingham of B.G.L.E. and Green-



A typical camp site

land Arctic Air Route fame. After a month of the most hectic introduction to expeditionary ways gathering and inspecting clothes and equipment for dogs sledges, tents and many other items and arranging scientific programmes of one sort and another, I finally left England in the grey dawn of a November morning to commence Antarctic life, of all things in a Dakota aircraft.

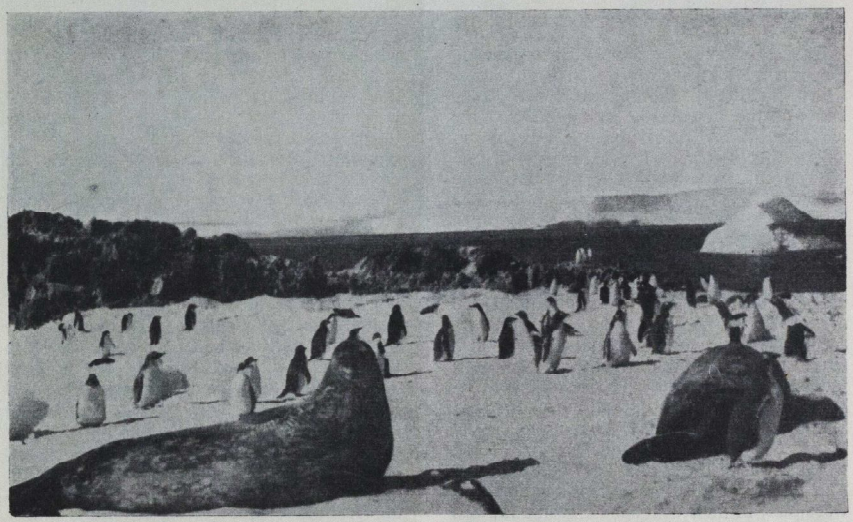
Some six weeks later our party of some 30 odd people culled from such diverse places as the Navy, the British Museum, The Long Range Desert Group the S.A.S., hospitals, schools and sheep farms were busy acting as stevedores in Port Stanley, the capital and only large port of the Falkland Islands. We had left England in the throes of a major dock strike and felt ourselves at home in a similar atmosphere in the Falklands. These islands are not unlike the Western Isles of Scotland, but across them there sweep frequent storms, so that the Spanish name Islas Malvinas, the isles of the bad winds, is singularly appropriate. It was with mixed feelings that we finally sailed from that little cluster of wooden buildings nestling in the inner reaches of the port which proved to be our last link with civilisation for some 18 months.

The expedition 'fleet' comprised three vessels, the R.M.S. Fitzroy of 1500 tons carrying most of the personnel and some stores; the M.V. Trepassey a wooden built sealing vessel of some 300 tons from the Labrador coast, equipped with sail and Diesel engines, carrying stores and dogs; and the R.R.S. William Scoresby with more personnel, including myself. The Trepassey was our 'ice breaker' and Captain Sheperd was a man of considerable experience in ice and had been in these latitudes only a year previously. At that time his ship the "Eagle" had her bows crushed in a blizzard by two large tabular icebergs. He and his crew had then sailed her, badly holed, and in a near sinking condition, across the Drake Passage through the stormies seas in the world to Port Stanley.

So it came about that at 2.0 a.m. on the morning of January 12th I found myself standing on a ship's deck which was white

with frozen spray, while silvery festoons of ice coated the rigging. Around us were loose floes of ice stretching away from the ship on all sides, here and there interspersed with larger bergy bits rising some ten to twenty feet out of the crystal blue water. In between ran channels covered with a loose scum of brash ice through which we were picking our way. On our starboard bow lay a tabular iceberg some five miles in length and away on our port side lay the snow covered Graham Land coast with Hope Bay coming into view ahead. The surface of the bay was covered with loose pack ice as we entered through which groups of penguins were porpoising their way to the rookery.

Hope Bay was one of the two sledging bases situated on the Graham Land peninsula; 600 miles to the south-west lay the other at Marguerite Bay. Our nearest base was at Deception Island, some 120 miles



Adelie penguins and Woddell seals

away, across the Bransfield straits which are navigable for some two to three months only during the year. The rest of the year the ice is packed too thickly to get through. There were eight of us at the Hope Bay base, two surveyors, a wireless operator, a meteorologist who is at present working with the Norwegian-British-Swedish expedition in Queen Maud Land, a geologist from the British Museum, a naval lieutenant, a rugged Falkland islander and myself as medical officer.

The base was built on the eastern shore of the bay at the head of which was a large glacier descending from the inland plateau. Down this there blows a perpetual wind, rising frequently to gale force, which lifts the surface of the bay in spindrift during the summer and, in winter, blots out its frozen surface in an impenetrable storm of drifting snow which seethes across our little encampment with a continuous roar, rendering audible speech well nigh impossible.

Our hut, however, was well built to withstand this battering; made of tongue and grooved timber, it had two walls with an intervening diaphragm of aluminium foil which served to reflect the heat. The main supports were sunk in concrete set in the rock surface, and the roof was further protected by steel hawsers held down on either side by large boulders. Inside we had a spacious living room with cabins for each man opening off it. In addition, there were a wireless room, meteorological office, surveyors office, laboratory, kitchen, medical

bay, bosuns store and carpenters shop. Lighting was chiefly by means of paraffin lamps and intermittently by battery-run electric lamps. Anthracite stoves kept the hut warmed to an average temperature of between 45 to 50°F., but, during the night, the stoves often went out and it was not unusual to find icicles hanging above one's bunk in the morning.

Each man took a turn for a week as cook and household chores were on a daily rota in which all joined. These included digging out sacks of coal from our dump, and bringing in blocks of fresh clean snow for our water supply. Our diet was mainly of tinned foods supplemented when possible by fresh seal or penguin meat, penguins' eggs and occasionally fish (Notothenia), known locally as 'Mouth Almighty.' Our diet was supplemented throughout the year by 50 mgms. of vitamin C daily and, in winter, to this was added vitamin A 9,000 I.U., and vitamin D 1,800 I.U. daily. The ascorbic acid was probably the only necessary one of these three.

The early weeks were spent in organising the base for the year's work. All our stores which had to be man-handled out of the boats up the ice-covered rocks and over the ice edge, were divided into two lots, one of which was left untouched throughout the year in case we should not be relieved the following spring. This, incidentally, is a fate which has since befallen the most southern base.

Our meteorologist was busy taking three-hourly weather observations. Wind velocities of over 100 m.p.h. were frequent and one of 130 m.p.h. was recorded. Daily recordings of the sea temperature were also made and, in suitable weather, "Met Balloons" were released. The results were relayed by the wireless operator back to Port Stanley three times a day, for inclusion in the South Atlantic reports and forecast. The wireless was also our only link with the other four bases. The surveyors and the geologist were busy in their own spheres while the rest of us looked after the dogs and prepared the sledges for our coming journeys.

Our dogs we had bought from the Esquimaux in Labrador and brought down with us. They were fed at the base on some five lbs. of seal meat or a penguin every other day. Out sledging, they had one lb. of dog pemmican daily. Most were trained and responded to the Esquimaux words of command 'Uk'—right, 'Illiyar'—left, etc. They had, however, to be organised in teams of seven to ten. Each dog was attached by a specially fitted harness to a rope trace and thereby to the sledge. They were arranged in pairs, two at 12 ft., two at 18 ft., etc., with a single dog in the lead. A 35 foot leather whip was used to control and guide recalcitrant members of the team with which at first more harm was done to ourselves than the dogs. Such painful experiences soon produced a higher degree of accuracy.

Numerous sledging journeys were made during the course of the year and some of us spent nearly six months 'in the field.' The journeys were largely exploratory across unmapped, untrodden territory, through which we had to find our way by compass bearing and sledge wheel traverse. The survey work occupied most of our time on these trips, but our geologist was busy too and delighted in his numerous fossil discoveries. Collections of lichens and other local flora were also made.

We travelled with two men to a sledge which carried our tent, sleeping bags, ice axes, snow shovel, skis and ration boxes for dog and man. A fully loaded ten-dog sledge weighed some 1,200 lbs. Food on these journeys was carried in 50 lbs. ration boxes, containing sufficient for two men for ten days, approximately 27 ozs. per man per day. The rations consisted mostly of pemmican, a greasy chocolate-like substance with a Bovril flavour; Quaker oats, chocolate, biscuits, milk powder and cocoa were also included. Under the rigours of sledging life, this did not suffice to meet our appetites and the "smallness" of meals in particular used to trouble us until we had been some weeks in the field. We used to long for a good "blow out" to quell the hunger pangs and for something to chew. I regret to record that my first reaction, on sighting an Emperor penguin after a prolonged sledge journey, was not a purely scientific interest, but a rapid consideration of the possibilities of dividing it equally between four hungry men.

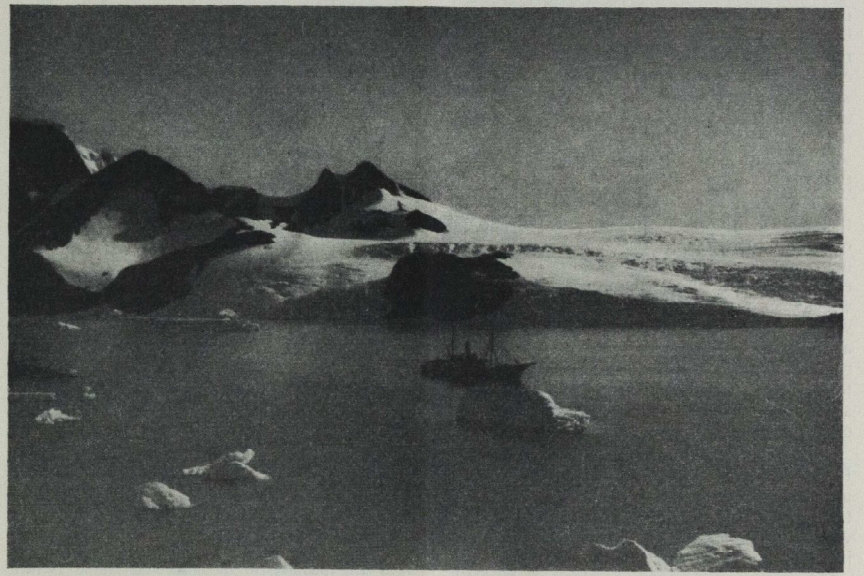
Our travels brought us often into contact with colonies of penguins. Of these the Adelie penguin was probably the commonest but Gentoo and Ring penguins were also seen. The Adelie is a small bird some 18" high, with a glossy black covering of closely interlocking feathers on his back, and a glittering white breast. In November, he

arrives at his breeding place by a process of hitch-hiking on the floes of the pack ice which encircles the continent. Groups can be seen "porpoising" through the water or making their way to the rookery, usually a low lying ridge of shale with easy access to the sea.

The nest is nothing more than a hollowed out mound of small stones which are piled up around the female. At this stage the clamour of a penguin rookery begins to be rivalled by its smell, both of which can be appreciated a mile or two away and neither are easily forgotten. The eggs, usually two in number, are bluish green in colour and about twice the size of a hen's egg. Both birds incubate them like a hen, thus bringing the egg in contact with a warm patch of bare skin on the abdomen.

The downy grey chicks hatch out a month later and are fed with food regurgitated from the parents' stomachs. They eat a variety of shrimp called Krill and occasionally small fish. As they grow up the down disappears and is replaced by a plumage rather duller than that of the parent birds for the first year. Once clad in this garb, groups of the young birds move off together to the sea and so put to the pack ice for the winter.

Travelling in the Antarctic is not always a matter of discomfort as is popularly supposed. There were days of bright sunshine, when, with a lightly loaded sledge, one could sit on top and bask in the sun rays, while the dogs pulled one merrily along at a steady 4 m.p.h. over a hard flat snow surface on level sea ice. The brief panting of the dogs, the padding of their paws on the snow and the musical note of the sledge runners sliding crisply across the sastrugi were the only sounds to break the vast stillness that we entered each day.



The relief ship arrives

For mile upon mile, we journeyed down the eastern coast of the peninsula. The line of the plateau comprising its central feature was broken here and there by a jagged peak which caught the rays of the low lying sun and was suffused in a rose pink glow, changing to a deep purple in the shadows of the rock, while from the white snow surface the sun was reflected in a myriad scintillant points of light. Such moments brought with

them a tranquillity of mind and a joy that was almost painful.

Travel was not always so, however, and though our fastest journey of 58 miles in 18 hours was of this nature, our slowest one of 200 yards in a whole day's travel speaks for itself. A hard surface makes for good progress, but in crevassed country or in soft snow where sledge and ski sink deep in to above the knee and the dogs plough through it at chest level, the reverse obtains. A blizzard superimposed on this makes life really uncomfortable. Even one's face gets covered in a mask of ice and the eye lashes stick together, while, if one has been so unwise as to let one's beard grow long, this may well freeze solid to the front of the Anarak and give a painful half hour or so thawing it out.

Under such circumstances, one is glad at the end of the day to put up the tent, span out and feed the dogs, and, with the demands of one's stomach somewhat quietened by a meal of pemmican, to creep wearily into one's sleeping bag. Outside the winds may blow and the snow silt up around the tent, but the weary sledger can relax in peace and comparative comfort temporarily oblivious of the fury of the storm and of the hours of digging that will ensue on the morrow.

Our health during the year was excellent. Frostbite and snow-blindness, troubles usually linked with polar life, were avoided by taking suitable precautions. In general, it was only carelessness which resulted in such injuries. Sometimes, however, when things went wrong on a sledge journey, it proved unavoidable and most of us suffered from frostbite in a minor degree at some stage. Two mild cases of snow blindness also occurred. Among other things, I had to treat a first degree Pott's fracture some fractured ribs and a fractured humerus, all of which healed well but required a little heart searching in the absence of the skilled X-ray examination to which I had been accustomed at Bart's. Temporary stoppings for dental caries proved a fruitful source of employment, the more so as they had frequently to be repeated. I was much troubled, on first arrival, to find one of the members of a small base suffering from advanced carcinoma of the stomach, from which he subsequently died soon after his return.

Early in 1947, I was moved to Deception Island to re-build a meteorological base there. Exalted to Magisterial status, I also had to administer an area somewhat larger than Wales for the Crown in the face of numerous invasions by sundry South American States. With the only available support to be found in the flying of a wind-torn Union Jack, this situation demanded a lively sense of humour.

From many points of view, I was very sorry to leave when my term of office came to a close. It was, however, with no little surprise that I handed over my medical duties to Dr. J. M. Roberts who had been my immediate successor on the Pink firm at Bart's. This had been an experience unique in its possibilities wherein I had seen much that, for most, lies hidden, and had learned something of tolerance and of many other things whose value time is still proving.

I am indebted to the Falkland Island Dependencies Survey for permission to publish these photographs and to the Falcon Press for their kindness in lending the blocks.

The twenty-sixth congress of anaesthetists was held in London during the early part of September, and was the first congress to be held in England since 1926. It was organised by the International Anaesthesia Research Society and the International College of Anaesthetists assisted by a Committee of British Anaesthetists. These gatherings are always associated with the name of an outstanding anaesthetist, and on this occasion it was held in memory of Dr. H. Edmund G. Boyle, for many years anaesthetist to this Hospital. "Cockie" Boyle was well-known to many Bart.'s men and his gas-oxygen machine was a familiar sight in the operating theatres. It says much for his placid temperament that he could watch a small spirit lamp burning furtively on the machine within a yard of the ether bottle. This lamp prevented the gas valves from freezing and was, of course, extremely dangerous, yet "Cockie" never set fire to his machine, though others were not so fortunate.

Dr. I. W. Magill was Honorary President of the Congress, which was opened by the Rt. Hon. Sir John Anderson. In the afternoon there was a visit to Bart.'s, where the visitors gathered in the Great Hall for tea.

An Exhibition had been arranged by Dr. Witteridge, who gave a short talk on the history of the archives and plate of the Hospital. Mr. A. Charles King demonstrated his collection of early apparatus and Boyle's machines. This was followed by a visit to St. Bartholomew's the Great, which proved of particular interest to overseas visitors. The writer congratulates Mr. C. Langton Hewer upon the excellence of his arrangements. Later in the afternoon the opening addresses were given at the British Medical Association, where a reception was held later in the evening, delegates being received by Sir Henry Cohen. For the next few days the visitors were busy attending the London Hospitals and B.M.A. House, where there were scientific sessions. On Tuesday members and their wives were invited to the Royal College of Surgeons for tea, which was followed by the Hewitt Lecture given by Dr. Ralph Tovell of Hartford, Connecticut. He chose as a title "New Horizons in Anaesthesiology." Sir Cecil Wakeley then welcomed Dr. Harold Griffith and Dr. Ralph Tovell as Fellows of the Faculty of Anaesthesia of the Royal College of Surgeons. The company then adjourned to the library for sherry and cocktails. From this moment any atmosphere of formality quickly disappeared, and everybody was looking forward to the next part of the evening—a Dinner held in the Grand Hall of Lincoln's Inn. The guest of Honour was the Dowager Marchioness of Reading. The excellence of the dinner organised by Dr. Ronald Jarman was only exceeded by the witty speeches of Lady Reading and Dr. Vernon Hall, Dean of King's College Hospital.

On Wednesday evening there was a reception at the Royal College of Physicians, at which academic dress was worn. The visitors and their wives were received by the President, Dr. W. Russell Brain and the Censors.

On Thursday, after a visit during the morning to the renovated tomb of Dr. John Snow, at the Brompton Cemetery, there were two receptions; the first being at the Ciba Foundation, where our own ever-youthful Lord Horder welcomed the visitors and their wives. After refreshment the Party adjourned to the Royal Society of Medicine, where they were welcomed by Lord Webb-Johnson.

F. T. E.

STEPPING STONES IN THE HISTORY OF ANAESTHESIA *

By JOHN L. THORNTON, *Librarian*

THE literature of anaesthesia is vast and complicated, and any exhibition of books on the subject must be selective. In this demonstration only books in the College Library were shown, and gaps were thus caused by the lack of certain important items. All the books mentioned here by title were exhibited, and most of the personalities mentioned in the texts linking the items were represented by biographical information, portraits, *etc*

Early reference to the use of various substances to produce insensibility to pain are numerous, hemp, wine, madragora, opium and other agents being employed. E. S. Ellis in his *Ancient anodynes, primitive anaesthesia and allied conditions*, 1946 quotes references to anaesthesia from the earliest times, to form an interesting volume. In the sixteenth century Valerius Cordus (1515-1544) described the synthesis of ether (1540), and in 1562 William Bullein (1500?-1576) published the first English book containing mention of an anaesthetic agent. This was his *Bulwarke of defence againste all sicknes, sornes, and wounds*, of which we possess the 1579 edition. On folio 42 this contains a description of the use of the mandrake as an anaesthetic.

Prominent events of the eighteenth century connected with the development of anaesthesia include the discovery by Sir Humphry Davy (1788-1829) of the analgesic effects of nitrous oxide. This had been discovered in 1772 by Joseph Priestley, who also discovered oxygen. Volume three of Davy's *Collected works*, 1839, contains his researches on nitrous oxide; John Davy compiled the *Memoirs of the life of Sir Humphry Davy*, 2 vols., 1836, and F. F. Cartwright has detailed Davy's contribution to anæsthesia (*Proc. Roy. Soc. Med.*, 43 1950, pp. 571-578).

One of the most important figures in the history of anaesthesia was Henry Hill Hickman (1800-1830) who, during a very brief life-time, conducted a series of experiments on animals following the administration of carbon dioxide gas. The centenary of the

* Based on a demonstration to the Annual Congress of Anæsthetists held in honour of Dr. H. Edmund G. Boyle, at a meeting held in the Great Hall on September 3, 1951.

death of Hickman was celebrated by the Wellcome Historical Medical Museum with the publication of an interesting volume entitled *Henry Hill Hickman centenary exhibition,* 1830-1930 [*etc.*], 1930, giving details of his life and experiments.

It is necessary to mention here the independent discovery of chloroform in 1831 by Samuel Guthrie, Eugène Soubeiran and Justus von Liebig. This was to play an important part in the future development of anaesthesia.

Among the important figures featuring in the early days of anaesthesia in the United States we must mention Crawford Williamson Long (1815-1878) (F. L. Taylor, *Ann. Med.Hist.,* 7, 1925, pp. 267-296, 394-424); Horace Wells (1815-1848) (W. H. Archer, *Bull. Hist. Med.,* 7, 1939, pp. 1140-1169; Amer. Dental Assoc. *Horace Wells, dentist; father of surgical anaesthesia* [*etc.*], 1948); and William T. G. Morton (1819-1868) (J. B. Robinson, *Bull. School Med. Univ. Maryland,* 31, 1947, pp. 120-124; and G. B. Roth, *Ann. Med. Hist.,* N.S.4, 1932, pp. 390-397). Much was written to prove or disprove the title of certain of these investigators to be first in the field, and a few of the contemporary tracts were exhibited. Recent investigations into the history of the subject fail finally to settle the problem, but offer fascinating descriptions of the early stages in the development of anaesthesia.

In Great Britain, Robert Liston operated in 1846 on patients under ether (see F. W. Cook, The first operation under ether in Europe—the story of three days. *Univ. Coll. Hosp. Mag.,* Christmas No., 1946, pp. 119-132). In the following year Sir James Young Simpson (1811-1870) introduced the use of ether in midwifery, shortly afterwards to employ chloroform in similar cases. We house several of Sir James' pamphlets on the subject, including one dated Feb. 28, 1847, which he sent to James Matthews Duncan with a note in the author's handwriting. Volume two of Sir James Young Simpson's *Works,* 1871 contains his writings on anaesthesia, and H. Laing Gordon's *Sir James Young Simpson and chloroform,* 1888, contains biographical information.

John Snow (1813-1858) was the first specialist anaesthetist in this country. He published a book on ether, administered chloroform to Queen Victoria, recognised the anaesthetic properties of amylene, and was the author of *On chloroform and other anaesthetics,* published posthumously in 1858. (J. L. Thornton, *Anaesthesia,* 5, 1950, pp. 129-135).

Others followed the examples of these pioneers, and the controversies aroused by their discoveries resulted in the production of an extensive literature. This is recorded in the standard histories of the subject. A selection of the books on anaesthesia published during the present century was exhibited. Contrasting strongly with the simple materials used a century ago, and with the elementary methods of administration, we find therein the results of the researches of scientists extending over a period of one hundred years. Among the books displayed were: H. Edmund G. Boyle's *Practical anaesthetics,* 1907; 2nd ed., 1911; and the third edition, written in collaboration with C. Langton Hewer, 1923: N. A. Gillespie's *Endotracheal anaesthesia,* 1941: R. C. Adams' *Intravenous anaesthesia,* 1944: John Adriani's *Chemistry of anaesthesia,* 1946: R. R. Macintosh and W. W. Mushin's *Physics for the anaesthetist,* 1946: A. R. McIntyre's fascinating, encylopaedic *Curare: its history, nature, and clinical use,* 1947: C. Langton Hewer's *Recent advances in anaesthesia and analgesia,* one of the most popular of the series, being now in its sixth edition, 1948: and Frankis T. Evans' *Modern practice in anaesthesia,* 1949, presenting a conspectus of present day anaesthesia.

The centenary of the introduction of surgical anæsthesia was celebrated in 1946. Several books, and numerous articles in periodicals were published to mark the event, and a selection of those displayed follows: special anaesthesia numbers of the *Journal of the History of Medicine and Allied Sciences* (October, 1946), and the *British Medical Bulletin,* (Vol. 4, ii, 1946): Thomas E. Keys' *The history of surgical anesthesia,* 1945, a remarkable chronological survey by the scholarly librarian of the Mayo Clinic: Barbara M. Duncum's *The development of inhalation anaesthesia,* 1947, a major contribution, well documented and adequately illustrated as a worthy publication of the Wellcome Historical Medical Museum: Victor Robinson's *Victory over pain,* 1947, having a more popular appeal: Frankis T. Evans' Cantor Lectures (*J. Roy. Soc. Arts,* 96, 1948, pp. 703-741): and yet another contribution from Bart.'s, Charles F. Hadfield's article on H. Edmund G. Boyle (1875-1941) (*Brit.J. Anaesthesia,* 22, 1950, pp. 107-117), in whose honour the Congress was held.

Stepping-stones are merely those which rise above their fellows, and are thus more noticeable in a rough, general survey. But they are supported by less obvious figures, whose work may be of equal importance to that of the more prominent in stature. Outstanding figures in the early history of anaesthesia are numerous, but we honour all who have contributed, in however humble a manner, to the alleviation of pain.

CORRESPONDENCE

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

Mr. Birdwood has chosen a profession which is unique in the degree of responsibility it can provide. That responsibility is not limited to the minor techniques of medicine; these he will inevitably and quickly acquire at no greater cost than a little embarrassment to himself. His real responsibility is surely of quite a different order, for medicine is not synonymous with dressing wounds, giving injections, or even such mild excitements as the excision of a sebaceous cyst.

But we should not be saying this to a graduate of an ancient University. He cannot have forgotten that old seats of learning teach more important things than techniques. It is unreasonable to expect a philosopher to teach you household hints.

Mr. Birdwood rightly says that "the clinical training period should be spent in acquiring skills." But he puts the narrowest possible interpretation on this truth.

The essential skills of medicine are hard to define; as we see it they are surely the diagnostic skill and the many skills embodied in just being a doctor. These this hospital can and does teach him. He is failing in his responsibility both to himself and his patients if, preoccupied with detailed techniques, he fails to profit from her true teachings.

It is of course necesssary to acquire these techniques at some stage. If he really wishes to acquire them before qualification, and if he really thinks that as a junior houseman he will be "expected to be perfect in these things" (in fact, a thing unique!) he had better take Sir William Osler's advice and "wander."

We have found these things feasible. He may lance and stitch, tap chests and dropsical bellies, and perform lumbar punctures; he may pass a sigmoidoscope and spend any spare time practising surgical knots at an L.C.C. hospital.

Many G.Ps. would welcome him to help in their evening surgeries. There must be a local T.B. Clinic where he could induce pneumothoraces.

And, when at last he reaches his fireside and pulls out his dictionary, one word he won't have to look up will be "initiative."

Yours, etc.,

IAN TAIT.
JOHN STEVENS.

September 19, 1951.
Abernethian Room.

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

I read with great interest Mr. G. F. B. Birdwood's letter in the September number of the *Journal.* Whether at the present time his complaints are justified I am not in a position to form an opinion though I have an uncomfortable feeling that they may not be without some slight foundation. Others better qualified to do so will no doubt contribute their views.

But I think that it might interest Mr. Birdwood, and possibly many others, to know that whatever justice there may or may not be in his criticisms today, they would have been entirely without reason when I entered the Hospital as a clinical student almost exactly fifty years ago.

Firstly, as regards the patients and the notes. Every clerk or dresser was expected to know all about his particular patients. It was his duty to obtain from each a full history and to make a thorough physical examination. The results so achieved were embodied by him in very full notes, and these notes he was made to read out aloud to the Visiting Physician or Surgeon on the first full round. In addition to this the adequacy of the notes was the particular charge of the Medical and Surgical Registrars. Any deficiency discovered by the Registrar was indicated by a small square of blue paper pinned prominently on the front of the notes. The student then knew that he was due for a severe admonition. It was commonly said then, and since, that the somewhat incisive

manner of speech characteristic of one of our Consulting Surgeons was acquired by him, when Surgical Registrar, as effective in dealing with such delinquents. In the Surgical wards the dresser did, with the exception of a few special cases reserved to himself by the House Surgeon, all the dressings, with usually a junior nurse standing by to hand him necessary lotions and dressings and to act as chaperon in the female wards. The nurses did no dressings themselves. In fact, any complaint there was was very different from Mr. Birdwood's. It was said that the practical instruction received by nurses in Teaching Hospitals was very inadequate because they never had the opportunity of doing dressings which were their particular province in other hospitals.

In the operating theatre again the dresser of the case was always on the floor of the theatre ready to act as a third assistant or in any other way required. One of the dressers also was appointed to "do strings" which meant dealing with ligatures, needles, etc., as required by the surgeon. All this resulted in a really practical training which was commenced and even exceeded before the dresser reached the wards. In the old surgery under the close surpervision of the Junior House Surgeon the surgery dressers themselves performed a large proportion of the minor operations.

The above sketch is a very brief account of the methods used in training a clerk or dresser when I was a student. It resulted in bringing him into close personal contact with his patient (to, I hope, the advantage of both), trusting him with no small amount of responsibility, and giving him a very fair opportunity of acquiring some degree of practical medical and surgical skill.

If conditions of teaching have so changed as to abolish these advantages—and I have only Mr. Birdwood's so far unsupported statements to suggest it—many may feel that there is possibly "something rotten in the State of Denmark."

Yours sincerely,

CHARLES F. HADFIELD

Esher.

September 18, 1951.

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

Sir,

Although clerking his patients at Bart's may be optional for my husband, at least it has the advantage of enabling me to make housework compulsory for him.

I return home in the evenings to find the flat spotlessly clean, and view with dismay Mr. Birdwood's suggestion that he should be compelled to be in the wards in the mornings!!

In order not to vitiate my husband's chances of getting a house job at Bart's, I must regretfully sign myself—

UXOR SCHOLARIS.

October 1, 1951.
Kensington.

SWEENY TODD "POLISHED OFF?"

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

Sir,

I read with due dismay your Editorial, *October*, I am only sorry that the writer had, quite unnecessarily, to draw upon fiction to point his moral.

"Mr. S. Todd," with his Hairdressing Saloon, has had his run. He never lived at Bell Yard, or even in that wine-cellar nearby in Fleet Street, that used to contain, for display to the morbid at a small charge, his original chair, complete with tilting mechanism. He was but a figment of the imagination of the writers of the first "penny dreadfuls."

I am, etc.,

PETER JAMES.

Tottenham, N.15.
October 5, 1951.

I must confess myself a little disappointed to hear that the story of "The Demon Barber of Fleet Street" is a myth. It seems a great pity to abandon one of London's best stories and Festival attractions. Can no one find a way of refuting Mr. James? I have been able to find this interesting information. The house that stood on the site of the "Saloon" was once Mrs. Salmon's Waxworks; it was taken down in 1880, when Fleet Street was being widened, and a large number of human remains, which took some hours to clear, were found in the cellar. At one time there was certainly a pie shop at this corner; it is mentioned in *David Copperfield*, and was famed for its "Spotted Covey."

EDITOR

MATTER FOR THE JOURNAL

Matter for publication should be handed to the Editor typed and ready for press at least one whole month before it is due to appear in the Journal.

EXAMINATION RESULTS

UNIVERSITY OF OXFORD

2nd B.M. Examination — **Long Vacation, 1951**

Forensic Medicine and Public Health

Campbell, E. D. R.
Havard, C. W. H.
Smith, M. A.
Cradock-Watson, J. E.
Macartney, B. W. M.
Feldberg, E.
Rant, C. M.

Special and Clinical Pathology

Brooks, J. M. H.
Davies, M. J. A.
Rant, C. M.
Campbell, E. D. R.
Feldberg, E.
Smith, M. A.
Cradock-Watson, J. E.
Havard, C. W. H.

CONJOINT BOARD

First Examination — **September, 1951**

Anatomy

Farrar, J. F.
Menage, J. A.

Pharmacology

Brown, I. P.
Brown, J.
Caplan, J.
Carrick, D. J. F. L.
Castell, E. O.
Clark-Wilson, L. J.
McKerrow, M. B.
Mears, M. F.
Theobald, G. I.

SPORT

RUGBY CLUB

v. **OLD WHITGIFTIANS** at Croydon. September 22.

Result: Lost 6-11.

Bart.'s lost their first game of the season, by two tries to a goal, a penalty goal and a try. They were slow in settling and were unlucky to lose Kneebone early on with an injured ankle.

O.W.'s scored first from a penalty and their first try came from a cross kick, which bounced perfectly for Turner, their right wing, to gather and finish the movement with a well controlled run. After this Bart.'s whirled back into their opponents' half and pressed hard. Heeling from the loose was good and from one such scrum the ball reached the backs where Davies by a clever change of direction and the forwards by some snappy interpassing, were instrumental in scoring. Mears touching down. The kick failed. Bart.'s were now in the O.W.'s half for long periods, but a further try came from a run by Turner, to make the half-time score 3-11.

Knipe's good hooking enabled the Bart.'s backs to have a good share of the ball in the second half, but the halves were not quite combining and opportunities were missed. O.W.'s lost their centre, Coleman, injured, which balanced the teams again, but although play was in O.W.'s territory almost constantly, Bart.'s could not quite score.

At last Murphy scored after a determined dash on the blind side. Bart.'s fought hard to the end, and Jones, whose jumping in the line-outs was exemplary, Havard, Ross, Fitzgerald, and Cuthbert were outstanding in a pack all of whom played and lasted very well. Avery, Murphy, Davies and Corbet, who had to combine full back with right wing for most of the game, were most on form in the backs.

Criticisms must be made of bad tackling and poor throwing-in, and of lack of jumping in the line-outs and slow rallying in the loose, but the game was hard fought and remarkably free of penalties, and the keeness evident in all the players augurs well for a successful season.

BOAT CLUB

During July the club took advantage of an invitation by the Danish A.R.A. and sent an experienced crew to row in the international regatta at Copenhagen.

Races took place five abreast on a lake north of the city, and although we rowed well our previous training of only three weeks was insufficient, and we were not fit enough to hold our opponents over the long 2,000 metre course.

However in a race of Henley standard we did well to be placed third.

After the regatta our generous hosts entertained us lavishly and we look forward to further expeditions in future.

The crew, which was beaten by Silkeborg Rowing Club and the Danish Students Rowing Club consisted of:—

Bow: G. S. Banwell
2: R. G. D. Nevill.
3: J. D. Salmon
4: F. R. Spink
5: J. M. Jones
6: D. H. Black
7: J. W. B. Palmer
Stroke: R. J. Knight
Cox: P. A. Clark

BOOK REVIEWS

THE MEDICAL WORKS OF HIPPOCRATES, translated by John Chadwick and W. N. Mann. Blackwell, 1950, pp vii+301. Price 20s.

At no time have the works of Hippocrates been so neglected by the medical profession as at present. While lip-service is paid to Hippocrates as "father of medicine" it is not generally recognised just how greatly the Hippocratic writings have influenced not only medical ethics but also the foundations of scientific medicine. This new translation—the combined work of a classical scholar and a physician—will go far towards meeting the needs of the medical reader. Such a reader cannot be expected to know any Greek or indeed to be acquainted with ancient history or culture. In this edition no such knowledge is assumed.

The task of presenting the Corpus Hippocraticum to the modern medical world is essentially one of selection. This book represents a scholarly attempt to select those books of the Corpus that bear most clearly the stamp "Hippocratic." The vast bulk of the so-called "philosophical" works have been omitted; so have the purely practical surgical treatises. Of the remainder a selection has been made which includes *Epidemics I* and *II, Regimen in Acute Diseases, Aphorisms, The Sacred Disease, Airs Waters and Places* and several others. These books preserve a unity of approach which mark them as the work, if not of one writer, at least of one tradition.

One small but noteworthy point about the book is the supplementary index, by means of which the reader may link the diseases of the present day with their description in Greek times.

This is a book which we welcome enthusiastically. It is well produced; its price is reasonable, and it richly deserves a place on every student's bookshelf.

TEXTBOOK OF OBSTETRICS, by John F. Cunningham. First Edition, 1951. William Heinemann Medical Books, Ltd., pp. X+499, illustrations 297. Price 40s.

The author has followed a well-recognised pattern of presentation of his subject. Some influence of the American schools can be seen, as in the chapter on Uterine Displacements. In general, the book is easy to read, though, in parts, it has the texture of lecture notes; this is noticeable in the treatment of the Vitamins and of Acute Infectious Diseases complicating pregnancy.

Students in this country would do well to bear in mind that there are marked differences of opinion between obstetricians of the English schools and those of Dublin. The author's views on rectal as opposed to vaginal examinations in labour, the use of colpotomy in the diagnosis of ectopic pregnancy and symphysitomy would here be regarded somewhat askance. His presentation of puerperal infection, however, is a lucid one. A surprising feature is the scant reference to the use of radiology in the obstetric field.

Conformation of the obstetric methods practised with the ethical standards of the Roman Catholic Church, mentioned in the preface, appear limited in the text to the consideration of the licity of therapeutic abortion and to baptism. He has a fondness for referring to sundry signs and manœuvres by the names of the initiators, the multiplicity of which tends to confuse rather than clarify. The text is abundantly illustrated but the diagrams are frequently so small that their clarity is lost.

A book that can hardly be described as a work of reference for the student, but one worth dipping into as an alternative to the standard works.

A SYNOPSIS OF ANAESTHESIA, by J. Alfred Lee. 2nd Edition, 1950, John Wright, pp. iii + 354, illus. 66. Price 15s.

This book, when first published four years ago, made a useful addition to the library of Synopses. The new edition takes full account of the numerous recent changes in anaesthetic practice.

Although of small compass the book deals exhaustively with its subject, containing more information than is to be found in many of the larger works, and certainly more than is required by the anaesthetic clerk. It fulfils, however, the needs of the anaesthetist revising for both parts of the Diploma in Anaesthetics, and for others it provides a readily accessible source of reference. It is not suggested that it should take the place of standard text-books for those fresh to the subject.

It is well set out in the tabulated form common to the books in this series; it is clearly written, and the illustrations are good and plentiful.

MEDICINE IN BRITAIN, by H. Clegg. 4th Edition, 1951. Longmans, Green, pp. 60. Price 2s.

This attractive booklet by the Editor of the B.M.J. is a mine of information on British medicine. All our major medical institutions are described. I should thoroughly recommend all students to acquire a copy; the cost is low and the quality of the contents high. The purchaser will no longer be in doubt as to just what the General Medical Council does, as to what the Lister Institute is, or how mental defectives get certified. I did not fail to find the answer to anything I looked up.

AIDS TO PHARMACEUTICAL CALCULATIONS, by Mary E. Bolton. Third edition, 1951. Baillière, Tindall & Cox, pp. viii + 96, 4 illustrations. Price 6s.

This book is of little value to a medical student at Bart's, where we are spared this type of calculation; but would be of use to anyone faced with making up and standardising drugs for the first time. Though full of facts, the lay-out makes it difficult to get a rapid grasp of the subjects in each chapter. The book could surely omit the chapters on logarithms and the use of the slide-rule.

THE BIOCHEMICAL APPROACH TO BIOLOGICAL ORGANISATION (Inaugural lecture at U.C. London), by Professor E. Baldwin. Lewis, 1951, pp. 20. Price 3s. 6d.

Professor Baldwin's inaugural lecture is characteristic of him and worthy of the attention of the student. Its content is well summarised in the last paragraph—" . . . it is only by the systematic application of biochemistry to every branch of biology that we can hope to discover the fundamental laws that govern the activities of living things."

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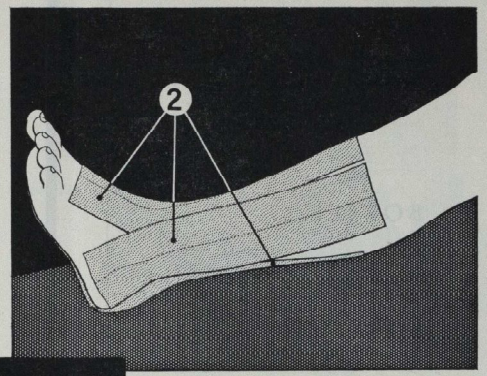

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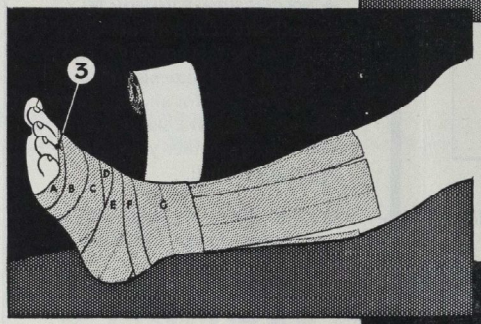
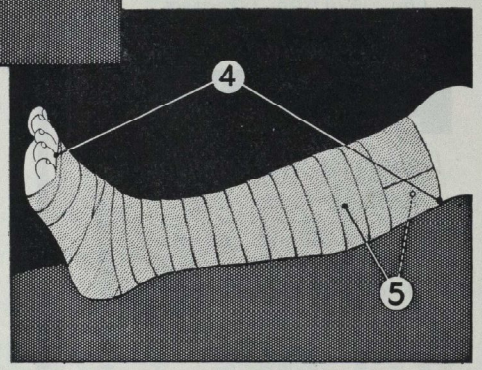


3 Commencing at the webs of the toes, take two or three turns around the foot, dependent upon its length, and bandage around ankle, enclosing heel as illustrated.*

4 Leg should be *covered* from webs of toes to a point just below the bend of the knee.



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6 No creases.

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* *Note bandaging may be made from toes upwards or knee downwards as desired.*

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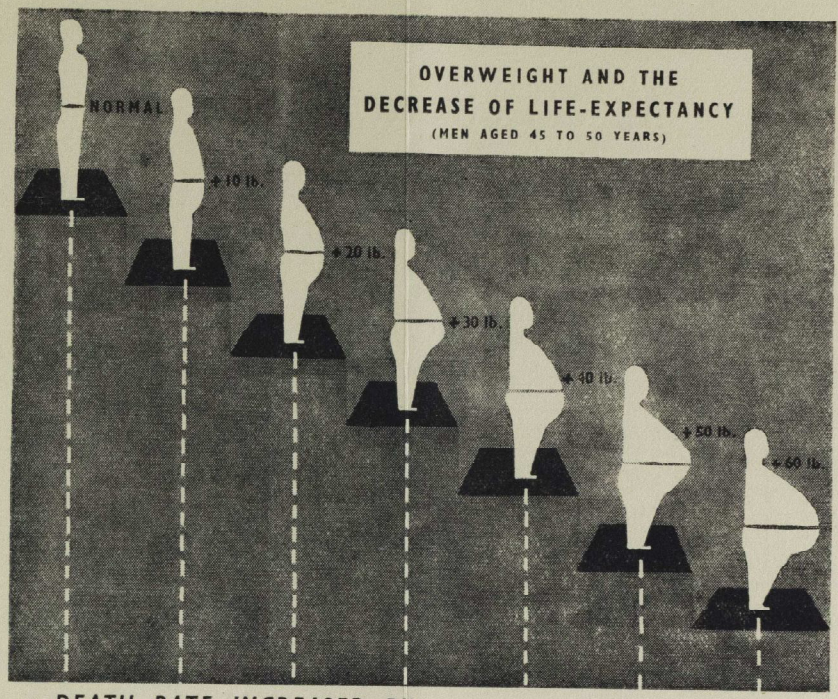

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SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

DECEMBER 1951

VOL. L V

No. 12

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Editor: A. N. GRIFFITH. *Manager:* E. A. BOYSE.
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December, 1951

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Four-day old culture of a per-nasal swab on Bordet-Gengou medium. Colonies shown include *H. pertussis*, a coliform and *N. catarrhalis*

References:
1. Gray, J. D. Lancet, 1:150, 1950
2. Macrae, I. Lancet, 1:400, 1950

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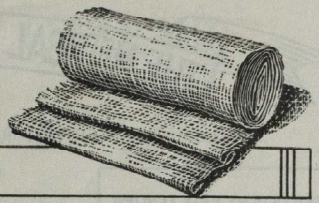

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ST. BARTHOLOMEW'S

HOSPITAL JOURNAL

Vol. LV DECEMBER, 1951 No. 12

THE 'ENGLISH' CHRISTMAS

UCH is England. There is probably nothing less English in England than our Christmas, of which we are so proud. Amongst all the customs and the traditional fare that makes this festival something special for us, there is scarcely any feature, which we can call wholly English. Our Christmas, like our Blood, is attractive because of the variety of its origin, and like our Blood it forms so strong a tincture that no matter in what dilution it still remains purely English.

The three chief charms of the English Christmas are its gaiety, its welcome, and its traditional customs. Each of these has been absorbed from a different festival: the Roman *Saturnalia. All Souls Day*, and the Teutonic *Yule-tide*, each of which is characterised by one of these qualities.

But first, why celebrate Christmas at all? and why was December 25 chosen? There is no suggestion in the gospels that Christ's Nativity should be made a special day in the calendar. In fact, we know that nothing was made of this day until the fourth century, and all the evidence we have points to the remarkable conclusion that this festival was pirated from the Mithraic Faith, one of the most formidable rivals to the Early Christian Church. The Nativity of the Sun had been celebrated at the winter solstice, from which the winter days grew longer. In the Julian Calendar this was reckoned to take place on December 25. Mithras, the Syrian Sun-god, celebrated his nativity upon this same day, which was given over to great and splendid festivities, in which the Christians were tempted to join. For the Nativity of Christ, which had been attributed to January 6 was not thought to call for any special celebrations. Therefore the Christian elders cunningly declared that this event would now be celebrated, and on December 25 too, January 6 being reserved for the Feast of the Epiphany. This move merely increased the antagonism between two religions which already shared many similar doctrines such as the humble Virgin birth, the legend of the Shepherds and of the Adoration. Such tactics were nothing new to the Christian Church, which had already seen to it that the death of Christ and the Resurrection of the Redeemer was observed at an identical time to the Greek cult of Adonis, and had arranged to celebrate the Assumption of the Virgin in the ides of August at the same time as the Feast of Diana.

The *Saturnalia* was a feast of the Romans, celebrated from December 17 to 24. It was a time of general merry-making when shops and schools were closed, distinctions of rank were lain aside so that the slaves sat at table with their masters and at times were even served by them. There was an air of utmost freedom, licence and forgiveness, unknown at other times. Gifts were exchanged, gambling allowed, and punishments forgotten. Much of this spirit of merriness is retained within our celebrations: the fancy dress, mummers plays, feasts and presents, especially for children.

All Souls Day, Hallowe'en, and the *Mundus Patet* of the Roman Catholic Church, when the souls of the departed return, and evil spirits are abroad, have left

their stamp on the English Christmas. These occasions are a time of welcome for all, lest spirits returning in the guise of a stranger be turned away. Homes are cleaned and prepared, fatted animals are slaughtered, there is brewing, baking and special cookery. In some parts of Norway and Sweden food of the living is actually laid out in expectation for a visit from such spirits, whilst the family is at Church, on Christmas Eve: and many of the stay-at-homes can tell you how they have seen spectral figures taking their fill. If satisfied, they will intercede for the fortune of the family and the farm's fertility.

The *Yule-tide* customs are widespread over Europe, from Iceland to Greece. In the sixth century A.D. Procopius described the "Thule" ceremony of the return of the sun after forty days of darkness. In Southern Scandinavia, a very similar ceremony, the *Hoggunott*, in which candles played a large part, was held at the darkest time of the year. Amongst the great Icelandic Sagas we can read of sacrifices made "for a good cron" and "for the year's good luck and for peace." The custom of the Yule log has a similar significance and is associated with the safety of the household and a promising harvest. In the valley of the Seig, a heavy oaken log is placed in the bottom of the grate, which must last the year. Elsewhere the *Christbrand* is placed on the fire during thunderstorms. In Provence, the *Tréfoir* is said to protect from thunder and sorcery. In other places its ashes are scattered over the fields, or the charred remains used to fashion a tip for the ploughshare, which will bestow fertility on the farmland. In England we retain our own charms: threepences, horseshoes, and buttons to be found in the Christmas pudding, which prognosticate good fortune, or a chance of marriage for the girls.

Other Yuletide customs seem more sinister, such as the Valkyries of the god Odin, who are heard hunting the souls of the warriors in the passing of birds and the roaring of the storm, whilst other monsters of the nether regions roam the earth.* But later, people became less credulous and such creatures became but figures of fun, who brought gifts for children, a privilege taken on in other parts by St. Nicholas or Santa Claus.

Some customs are surprisingly modern. The first Christmas tree arrived in England in about 1850, a year or two before the first Christmas card. Christmas trees were unknown even in Germany before the seventeenth century.

But of customs that are wholly English we have only traditional entertainments such as the Nativity plays, the mummers, and the English pantomime. There are games, too, such as snapdragon (which is facetiously illustrated in the capital beginning this editorial), sword dancing, and the excellent ceremony of the Boar's Head, which has almost died out, save in Oxford, that home of lost causes. In Queen's College Hall, the Boar's Head, traditionally decorated and with an orange between its teeth, is borne into the Hall on a silver platter by three scouts to the sound of trumpets and the singing of the carol:—

Caput afri differo
Reddens laudes Domino.
The Boar's Head in hand bear I
With garlands gay and rosemary
I pray you all sing merrily:
Qui estis in convivio.

Such festivities were presided over by the *Lord of Misrule* (in Scotland he was named the *Abbott of Unreason*, a post forbidden in 1555 by Act of Parliament). But the oldest and the most popular of all Christmas customs is that of promiscuous kissing under the mistletoe, which is said to be of Druidical origin. It is certainly the only one of our customs which has "taken on" abroad, where it is understood to be very popular; and the only one to justify the phrase "The English Christmas."

*In Iceland, twelve small and hideous gnomes, the *Jólarsveinar*, come out of the sea to chastise lazy children and to take the Christmas pickings. They appear one by one, day by day, until they are all present for Christmas night. They similarly disappear until the last leaves on Twelfth night. Their names are too good to be omitted: Scrap-snatcher, Pot-licker, Peat-pedlar, *Skyr*-gobbler, Muck-bundle, Dung-taster, Doorway-sniffer, Window-peeper, Candle-nipper, Cat-tweaker, Bandy-legs and the Undooer of Shoelaces.

In this issue we should like to wish all our readers a happy Christmas and a peaceful and successful New Year. We have tried to make this edition seasonable, and a little festive with a few lighter articles, and one or two competitions for which we shall be very pleased to receive entries. There will be considerable prizes!

We are publishing the history of a selection of the hospital ward names in this issue; more will follow from time to time. "Work in Progress" is a new series in which various activities in and around the hospital will be discussed. The first of these is a description of a tour of the new buildings in Charterhouse by two critics, who prefer to remain anonymous in their pseudonyms Burbank and Bleistein.

Handel's Samson

In May of this year the United Hospitals Festival Choir made its debut with a very fine performance of Mendelssohn's Elijah. Many commented on the beautiful tone of the singing. Everyone who enjoyed the performance will be glad to hear that the choir, which includes Housemen, Nurses, Physiotherapists and Students from Bart.'s, will be singing again on December 13 in the Westminster Central Hall. Handel's Samson will be conducted by the choirmaster, Colin Ratcliffe and accompanied by Reginald Jaques and his orchestra. Proceeds are to be given to the British Students' Tuberculosis Fund. Enquiries about tickets should be made to J. Pittman, Esq. (Chairman of the Choir), or to other members of the choir.

Pathognomic?

A subject that should repay study is the comparative anatomy of mythological men. Gnomes are well-known to be hypopituitary dwarfs or achondroplasiacs, depending on whether they are of good or bad intent. The Christmas men or "Jólasveinan" mentioned in the Editorial footnote were described as having round feet and a cloven back—spina bifida and tallipes equinovarus surely? Pan, in medieval paintings, is depicted with a tuft of hair on his sacrum and the feet of a goat: the spina bifida is occult, and, as Pan is a deity, the feet are more serviceable than talipes. An idle thought, perhaps, but it is not truly so far-fetched! Deformity, even in England, only recently ceased to be holy, and is still mysterious.

More about mead

Following several notes on mead that have appeared recently in the Journal (see September and October numbers), The Meadmakers of The Mead House, Gulval, Penzance, have kindly sent us a number of samples of mead to try. We enjoyed mead, possibly this is due to some atavistic streak in our character, and we can strongly recommend it to anyone who wants something original this Christmas. Of the many different meads, we would recommend Metheglin as an excellent clean clear table mead. Mead aperitif has richness and Hippocras individuality, though as a dessert mead perhaps Sack Mead is the choicest.

Further Syllabubs

As a result of an alimentary editorial of a month or two ago, we have had a number of enquiries about Syllabubs, when and what they were; it being even suggested that they might be figment of the Editorial imagination. However, for disbelievers and connoisseurs here is a recipe culled from a XVIIth Century Cookery Book:

Chrystmass Sillybubbs:

> "Take a quart of Creame and half a pound of Sugar and a pint of Sack and Renish together and about half a pint of strong Beer, and when it up to a froth save some of the Froth on a Sive to top ym, then fill the glass half full with that which is not whipt much, and fill it up with the whipt, and top them with that on ye Sive. No Whytes of Eggs mentioned in ye Sillybubb which I think ought to be in."

We agree!

An Academic Bird

A week or two ago the hospital was honoured by a visit by a Black Redstart, this small bird which is a considerable rarity in England was seen in the Square. Although fairly common on the Continent, the Black Redstart has only come to England in recent years, where it has settled only in places connected with Cloth and Silk: Ely Cathedral, King's College in Cambridge, Lincoln's Inn Fields, The Law Courts and St. Paul's. Last year one nested by the window of the offices of the Third Programme in Broadcasting House. If this attractive little bird is now to honour the Medical Profession, let us hope that it makes its home at Bart.'s.

We should like to congratulate:

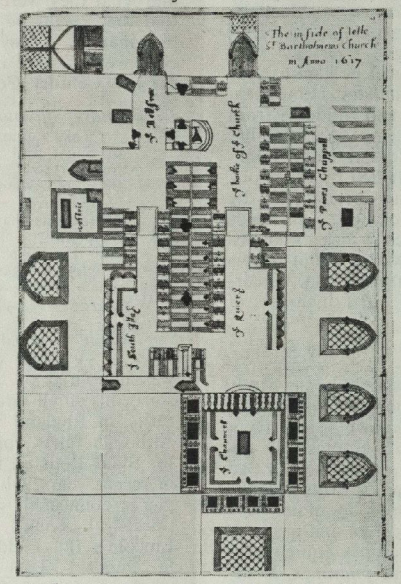
Mr. H. B. Stallard who has been awarded the William MacKenzie medal "for original work in ophthalmology of outstanding merit." He has also been made an Officer of the Order of St. John of Jerusalem.

Professor K. J. Franklin, who has recently been elected a Fellow of the Royal Society of Arts.

THE PARISH CHURCH OF ST. BARTHOLMEW THE LESS

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

THE parish of St. Bartholomew the Less was created by Henry VIII at the time of his re-foundation of the Hospital. References in earlier times to a parish of this name relate to that of St. Bartholomew by the Exchange in Broad Street Ward of the City. The Hospital at its foundation by Rahere was situated outside the walls of the City and outside the bounds of any of the City wards. It was only during the fourteenth century that the creation of Farringdon Ward Without brought it within the jurisdiction of the City. The mediaeval records show that the lands immediately surrounding the hospital buildings were considered to be within the parish of St. Sepulchre and it is therefore largely from this parish that the parish of St. Bartholomew the Less or of St. Bartholomew the Hospital (as it is sometimes called) was made. Today its extent is not quite coterminous with the Hospital site as by modern additions (i.e. nineteenth and twentieth century) the Hospital has incorporated within its bounds lands from the present parishes of St. Sepulchre and of St. Botolph without Aldersgate.



A plan of the interior of St. Bartholomew the Less, 1617.

During the Middle Ages, as now, the Hospital was in the diocese of the Bishop of London, to whom appeal was made in cases of difficulty or dispute. It was also under the direct protection of the Pope. Though Rahere died without fulfilling his intention of obtaining personally from the Apostolic See confirmation and protection for his double foundation of Priory and Hospital, shortly after his death in 1144, three of the canons went to Rome and secured three grants from the Popes Anastasius IV (1153-4), Adrian IV (the Englishman, Nicholas Breakspear, 1154-9), and Alexander III (1159-81), whereby "they rendered this church glorious with this triple dowry and defended it against hostile attacks as it were with an impenetrable shield." Of these, the Bull of Alexander III still remains in the Hospital archives. It is couched in general terms but confirms the Hospital in its possessions existing and to come and pronounces anathema against any man who should dare to infringe this protection. It is from this same Bull that we learn that a chapel was part of the original buildings of the Hospital. It is called "the chapel which is beside your house." Pope Lucius III, Alexander's successor, confirmed in 1183 the Hospital's right to its own chaplain ministering in its own church, and granted it further the permission to celebrate the divine offices even during a general interdict, provided that the offices were said in a low voice behind closed doors and no bells rung.

Alan was Master of the Hospital at this time, and he was still Master in 1208 when the country was laid under a General Interdict as a result of King John's quarrel with the Pope. In 1184 Lucius III issued another Bull in the Hospital's favour. In this he gave the brethren permission to move their oratory to a more convenient site. When the new chapel was built it was to be consecrated by the Bishop of London and it was to have a cemetery for the burial of the brethren, of the members of the household

and of the poor of the Hospital. Though it has been assumed that this permission refers to the foundation and building of the existing church of St. Bartholomew the Less, there is no proof of this and the evidence of the bricks and mortar of the present church proclaim it otherwise. Where this chapel was, whether it was built and consecrated by the Bishop of London at the end of the twelfth century, we do not know, though perhaps documents may yet be found to give us further information. The Hospital itself possesses no record.

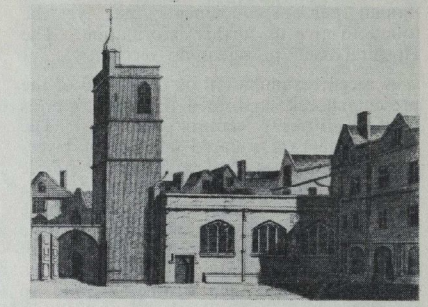
A recent examination of the fabric of the present church confirmed that the tower is built of fifteenth century masonry. The large stones are squared and set in layers and the interstices filled with smaller rubble masonry. Here and there large flints of a type found also in the Priory Church have been incorporated, and may indicate the utilisation in the fifteenth century of materials quarried from an earlier building. Where the stones have weathered away on the SW corner of the Tower they have been replaced by squared stones of the nineteenth century. The whole of this masonry was exposed in 1936 when the outer covering of plaster laid over the Tower was removed. At the same time the nineteenth century door-way which formed the main entrance to the Church was removed, the remains of the fifteenth century doorway were restored and completed in modern materials. There is an original holy water stoupe to the South of this doorway. The other in the centre of the West wall, once beside the main entrance to the church, is a restoration dating from 1936. [The part built into the wall is alone original.] The wall of the west end of the church contains fifteenth century masonry near the Tower and a considerable quantity of Tudor brick to the right and left of the present window. The stone course at the base of the wall is nineteenth century. The rest of the brick in the wall and the window itself date also from the nineteenth century. A vertical line which clearly marks the end of the Tudor brick near the North end of this wall seems to suggest that this was the limit of the northerly extent of the earlier church. A deep horizontal groove at the level of the base of the present window suggests the presence at some time, either of the roof of a penthouse above the church entrance, or the floor of a building against the church wall. The former seems the more probable explanation though I have found no documentary evidence for either. The South side of the Tower shows two doorways, both blocked up. Their relation to each other is such that it seems probable that they were not both in use at the same time. The one at ground level is filled with Tudor brick and its bond suggests English workmanship of the early part of the seventeenth century. The higher one is apparently filled outside with later brick and as it has been covered inside with plaster and paint does not reveal the date of its blocking. Its origin and use also are obscure. At some time it seems as though it may have led to a gallery in the Tower and presumably communicated with the first floor of an adjacent building. There are no traces of stairs leading to it. The doorway at ground level once led into the Cloister of the old Hospital, as is proved by reference to the various seventeenth century plans in our possession. These plans do not show any communication with an adjacent building at first floor level, so that the purpose of the higher door remains conjectural. The rest of the exterior of the church is of nineteenth century workmanship. It is made of brick and Bath stone of a type used in the eighteenth century hospital buildings, and dates from 1825.

Inside, the four pillars forming the base of the Tower, though unusual in design and even clumsy, are of fifteenth century work. The rest of the church dates from 1825. Its present interior decoration was carried out to the designs of Lord Mottistone. The windows which replace those damaged during the blitz, are the work of Mr. Hugh Easton.

The appearance of the mediaeval church can be conjectured from a print of its exterior made at the end of the seventeenth century (the Henry VIII Gateway into Smithfield built in 1702 is not depicted), and from a plan of the interior dated 1617. The entrance to the church was through either of the two doors at the west end. The main west door, now obliterated, but visible in the masonry of the exterior, led directly into the body of the church and was in a direct line with the high altar. The christening pews stood to the right of this entrance beside the still existing fifteenth century pillar and the font was on a raised platform on the north side of the north-east Tower pillar. To the North side of the body of

the church lay the Poors Chapel, extending northwards towards Smithfield and eastwards as far as the entry to the choir. The chancel depicted in the 1617 plan, is very obviously that of a post-Reformation church, but the position of the altar had doubtless remained unchanged from earlier times. It is not identical with the position of the present altar, but to the north of it. Though difficult to interpret, it seems as though the pulpit was situated between the choir and the South aisle. The roof of the main part of the church is shown in the print as vaulted, but no traces remain in the Tower masonry of the responds. The vestry, shown in the plan on the South side of the church, is not there in the print. The door remains in both, but a window seems to have been added to match the other two in the South wall. The sculptures on the outside of the South wall, between the second and third windows, are those which are now preserved inside the ante-chapel on the west and north walls.

Entries in the Hospital's *Journals* record continuous minor repairs to the church over many years, but these repairs did not prevent the church from falling into a ruinous condition by the eighteenth century. Characteristic of these minor repairs is an entry for January 13, 1679: "Whereas upon view lately made of the church of little St. Bartholomew belonging to the Hospital, the pavement and roof thereof are found to be much out of repair, it is thereupon thought fit and ordered that the same shall be decently repaired and beautified at the charge of this house in the next convenient season of the year ensuing." In May 1679 the roof of the Poors Chapel was renewed. The steeple was 'done with finishing for the preservation of the same' in May 1701. In 1718 the pavement of the church was defective and an order was made for its amending with purbeck stone at 8d. per foot. The roof was defective again in 1715 and had to be retiled. On March 31, 1722, an agreement was made with a painter to paint the ceiling of the south aisle in pearl colour at 5d. a yard, and plasterer's work all over the church was ordered at the same time. Further orders for repairs were given in February 1743 and a screen with folding doors was ordered to be made at the entrance into the south aisle from under the steeple. The glass of the church was under consideration in May of the same year. A glazier was ordered to new glaze the parish church with the best crown glass at 8d. per foot and to be allowed 1½d. per foot for all the old glass. At the same time it was "ordered that a piece of painting in glass representing King Henry the Eighth, the Founder of this Hospital, delivering the charter of this Hospital to the Governors,



The Exterior of the church, before 1702.

which was formerly in the window of the old Hall, be now placed in the West window of this parish church and that the same be repaired and be secured with a wire frame on the outside of the window." But this was not to be. The new Administrative Block was now completed and four days after this decision another superseeded it: May 19, 1743, "Upon reading the last minutes, the Governors upon further consideration resolved that the picture of King Henry the Eighth painted on glass be put up and fixed in the middle window of the Great Court Room opposite to the middle chimney, as the most proper place." Mr. Price, a painter on glass, was to be given ten guineas to repair this window and add a border to make it the proper size for the window where it was to be placed. At the same time it was agreed with him for a guinea a piece to repair with stained glass and proper colours the King's arms, the City's arms and the Hospital's arms which were to be then replaced in the east window of the church along with the arms of Sir William Stewart, the late President of the Hospital. Four coats of arms of ancient Governors of the Hospital which were formerly in the window of the old hall, were to be set up in the west window of the church.

It was on April 9, 1788, that the Vicar, Dr. Kettilby, spoke before a House Committee of the extreme bad repair of the church. The Hospital Surveyor, Mr. George Dance, was introduced to view the building. In June following, Dance produced a plan for repairs and improvements, "but as they amounted to £1,000 and upwards the Committee thought it of too much consequence to determine on immediately." On February 11, 1789, "Mr. Dance, the surveyor, having produced a plan for the repairs, alteration and improvement of the church and likewise an estimate of the expense thereof amounting to £1,200 the same was approved of and ordered to be carried into execution as soon as a Faculty could be obtained for that purpose." Between 1789 and 1791 Dance completely wrecked the interior of the old church leaving only the walls and the Tower standing. He cut away and destroyed nearly all the ancient monuments in the church, so great was his contempt for Gothic architecture. Within the denuded shell he built a wooden octagon. The print of approximately 1810 shows the exterior appearance of Dance's church.

The Exterior of Dance's reconstruction, about 1810.

Although he estimated an expenditure of £1,200 the total of the monies spent in time and materials amounted to £584 12s. 0d No sooner was Dance's reconstruction finished than dry rot attacked the timbers. Already, in January, 1801, a deputation of the parishioners with Dr. Kettilby attended a House Committee of the Governors to report the very cold and damp state of the church. In February, Mr. Hall, the Hospital Surveyor, informed the House Committee that he had found the church cold and damp and that dry rot was making alarming progress therein. He ordered the installation of a stove costing £50, but the Governors thought that braziers containing charcoal fires would answer the same purpose and cost less. So they tried them, but the dry rot continued. More repairs were ordered and carried out in 1811. By June, 1821, it was obvious that vigorous action would have to be taken if the entire church were not to fall down. Once more a deputation of the parishioners attended a House Committee and the Hospital Surveyor was bidden to report on the church. He made his report in August and advised the Governors to let the matter stand over till the following spring. On July 18, 1822, his report was read at a House Committee and his estimate for repairs costing £860 was approved. But in September the House Committee itself went to view the Church, when it appeared to them "that all the main timbers of the building were very much affected by the dry rot, so much so that the Surveyor stated it as his opinion that it would not be advisable to undertake any repair of them."

A General Court of Governors was summoned for November at which the Surveyor presented a plan and estimate for rebuilding the entire church, and a Committee was appointed to discuss the matter and report their opinion. This report was made on December 17, 1822, and was as follows: After maturely considering the ruinous state of the church, it was their opinion that the present church should be kept up and the decayed timbers in the piers should be replaced by masonry, brickwork or some imperishable material. But an amendment was moved and carried at this same meeting to the effect that as the dry rot had been innoculated into the timbers of the roof as well as the piers, no repair was to take place but the whole church, excepting the Tower, was to be pulled down and rebuilt. But still the Governors could not make up their minds. In February, 1823, another General Court reversed this decision thinking it "more advisable to maintain and repair the present church than to take down the same and erect a new one on a reduced scale of accommodation." Repairs calculated entirely to remove the decayed timbers and replace them with stone or iron and to

ventilate the church more effectually and render it thoroughly warm and commodious were to be undertaken by the Surveyor, Mr. Hardwick. His plan was approved in March and contracts for the work were entered upon on April 8. But by April 23, when the repairs were beginning, Mr. Hardwick reported to the Treasurer at a General Court that the chief part of the walls of the church were so defective that they must be taken down. On April 30, it was decided that all the external walls with the exception of the south west wall and the Tower should be demolished and the new church, such as it appears today was begun. Dance's octagon was preserved but made now in stone and the chancel and the whole church was made new. The Poors Chapel disappeared. What happened to the vaults of the ancient church is a matter for some conjecture. In March, 1823, Hardwick had been instructed to prepare a plan of the existing vaults and a new plan for constructing a vault or vaults. But nothing further is heard of this subject. It is therefore to be presumed that the ancient vaults still exist under the present church. Excavations undertaken in the early part of this year at the north east corner of the nave and chancel apse revealed only a nineteenth century brick vault, the tomb of Diana Clarissa Latham, the wife of Dr. Peter Mere Latham, interred there in 1825. (Her memorial tablet is affixed to the wall above the pulpit.) Further digging close to the apse revealed human bones. This was only to be expected as the church stood within its own cemetery which had been in use for several hundred years. Explorations inside the church have also been fruitless. The reason why the floor of the nave and of the ante-chapel should be approximately 2ft. 6ins. above ground level is not known but it is hoped that in due course the explanation may be found.

Of the monuments of the ancient church very few remain. In the ante-chapel, the canopied tomb below the west window is partly of fifteenth century workmanship. The Purbeck marble slab beneath the canopy may be of an earlier date and be derived from another tomb. The inscribed stone of black marble comes from yet a different place. It once marked the grave of Elizabeth, the wife of the surgeon John Freke, who was buried in the Poors Chapel, November 19, 1741. John Freke himself was buried in the same tomb November 12, 1756, but no memorial commemorates him. Let into the floor near this composite tomb is a ledger stone with two brass effigies and an inscription, defaced at the Reformation. It once marked the grave of William Markeby and Alice, his wife, who lived within the Hospital Close, who died July 11, 1439. The tomb is mentioned among the monuments in this church listed by Stowe. On the South wall of the church near the pulpit, is a monument to the Lady Anne, wife of Sir Thomas Bodley. She died in Sir Thomas Bodley's London house, (on the site of the present South block of the Hospital) and was buried June 12, 1611. Sir Thomas Bodley received permission from the Governors to set up this monument to her on January 12, 1612. Below this, a stone inscribed with Latin verses commemorated the churchwarden William Hone who died 1575. Opposite, on the north wall is the kneeling figure of Robert Barlthrope, serjeant surgeon to Queen Elizabeth, who died December 9, 1951. The other monuments on the walls all date from after the 1825 restoration and there is nothing else of interest remaining from the mediaeval church.

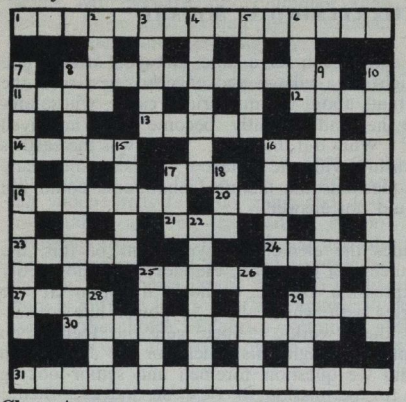
DR. PEACOCK

It is with great regret that we have to announce the death, on October 14, 1951, of Albert Peacock, M.B., B.S., M.Sc., lecturer in Anatomy at Charterhouse from 1946 to 1948.

This kind and genial man will be well remembered by all his pupils. Who, indeed, can forget his inimitable brand of rapid-fire catechism, his enormous dissecting forceps, his "it's that simple you can't go wrong"? On his return from Australia in 1949, Dr. Peacock went to the London Hospital (where he qualified in 1927), and it was there that he died at the age of 46. We offer our deepest sympathy to his wife.

A CHRISTMAS CROSSWORD

Set by OPISTHOTONOS



Clues Across

1. What! One wrong tea. A sober thought. (2, 3, 5, 5).
8. But does it stir the *female* heart? (6, 2, 3).
11. Fate never wounds more deep the gen'rous heart.
    Than when a blockhead's insult points the ——" *Samuel Johnson* (4).
12. Classically, being with mother goes to the head. (4).
13. Put it down—we include decay. (5).
14. 21 across, when the leaves fall. (3).
16. A cord means nothing to the young girl. (5).
17. They got together after a tea-party. (3).
19. Book to be read in public transport? (7).
20. The skull and other bones are connected with it. (7).
21. Woman, never here today. (3).
23. 150, this is where 2 & 25 down are heard. (5).
24. The last word in R.A.F. aspirations. (5).
25. No cravats for the followers of King James. (5).
27. A dish to be found in a little street we must return to. (4).
29. A small number on the river. (4).
30. Christmas any year, particularly 1951. (7, 4).
31. Answer to this is to get plastered. (4, 2, 4, 4).

Clues Down

2. The start of an old woodwind. (4).
3. If grass, no weeds. (5).
4. Death, we see, is the end of these nervous afflictions. (7).
5. The weapon with the French end. (5).
6. Six in the present era are covetous. (4).
7. Cell that does all the grind, O spare me! O curse upon it! (11).
8. Belsen poker may cause this. (6, 5).
9. Broken ends, four in before, Noun. (11).
10. Conservative treatment may be needed here. (6, 5).
15. In head I bleed. (5). 16. Grub. (5).
17. How funny it would be the morning before. (3).
18. Highest in a century. (3).
22. (7).
25. Christian (?) name of national leaders. (5).
26. Butt a beaten Frenchman. (5).
28. Sea-bird. (4).
29. The last word. (4).

The Solution appears on page 280.

THE NEW BARTSMAN AND NATION

Set by ENOCH SOAMES

Prizes totalling three guineas will be offered for the best printable descriptions of a professional visit to a case of any of the following conditions: St. Anthony's Fire, St. Vitus' Dance, drowning in a butt of Malmsey Wine, and the after-effects of a Surfeit of Lampreys, as by any of the following: Dr. John H. Watson, Dr. W. G. Grace, The Radio Doctor, Chaucer's "Doctour of Phisyke" and Dr. Samuel Johnson.

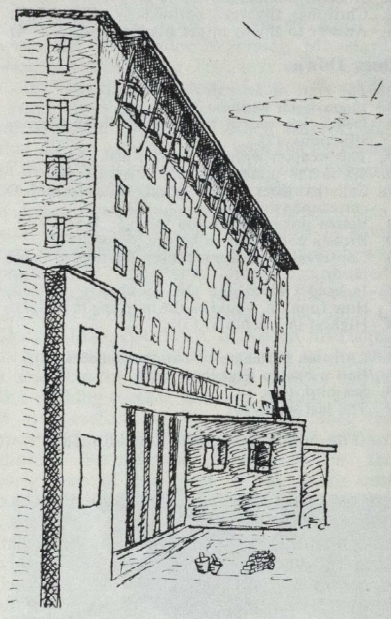
Entries which may be in verse or prose should be limited to 200 words, and addressed to *Enoch Soames*, c/o the Editor, St. Bartholomew's Hospital Journal. Anyone is welcome to enter, be they from the hospital or not. Closing date December 27th, 1951.

Overheard on the South Bank:

"Wasn't Naunton just a bit too radical?"

WORK IN PROGRESS

THE NEW COLLEGE HALL CHARTERHOUSE SQUARE

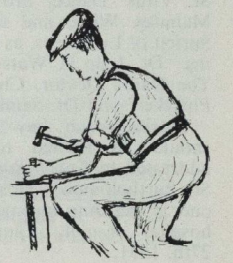


LONG ago Joseph K., a land surveyor, arrived late one night in a village and eagerly questioned the inhabitants about the mysterious castle, whose employee he had recently become*. Who lived there? What did they do? What was the castle's relationship with the village? These and many other questions the taciturn inhabitants could not or would not answer.

Besides the elementary symbolism of this, the main theme of the book, the story is undoubtedly an expression of the author's irritation at the mysteries with which those in power like to surround their works. Such were our feelings on attempting to begin this article for the Journal: in vain did we question foremen and senior-looking clerks for permission to view or, indeed, whence we could obtain such permission; invariably were we passed on to some slightly higher official, with no more positive final result.

The impasse was finally overcome by someone advising us to consult the College Secretary. Within a moment of being shewn into his office, we had not only been accorded full permission to see all we wanted, but were also infected with his enthusiasm for this project and the replanning of the Preclinical site as a whole. We should like to take this opportunity of thanking him for his wholehearted co-operation, without which this would not have been possible.

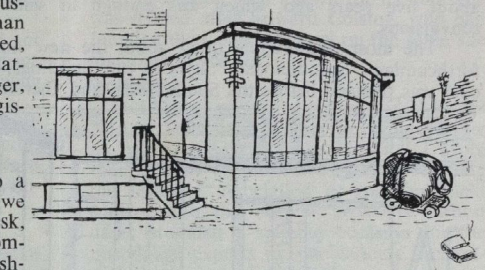
At the present moment it is best to commence the hostel Grand Tour at the top of the building, for here the rooms are structurally complete and most of them have furniture in as well. The first thing that strikes one about these rooms is their good design: windows which fit, built-in wardrobes, flush-fitting solid doors, the absence of picture rails and many other small details, which tell one whether the architect has ever done any housework himself. The colour schemes also derive from the cerebrum and have not merely "occurred." The ceiling is painted in the same light colour as the side walls, while the richer colouring of the wall facing the window provides contrast and gives an air of warmth and intimacy.



The conventional fireplace is replaced by an electric filament which will supplement the warmth from the central heating and is placed at last, thank heavens, in the correct position under the window. It is flanked by bookshelves and cupboards cunningly tailored to hold most sizes of bottle. An upper shelf, waist-high, extends the length of the wall, and requires only the presence of a simple ornament (chosen with discerning taste) such as a vase of the T'ang Dynasty, to give character and distinction to the room. Above, a large cork panel is inset into the wall. This intriguing

* This reference is apparently to "The Castle," by one Franz Kafka.

feature is destined for pin-ups, though, this being the ladies' floor, beards and moustaches will perhaps be commoner than shapely limbs and inviting lips. Indeed, one can spend an interesting time speculating on the ladies' choice . . . . . Granger, Kaye, or one of those fascinating Registrars?



Movable furniture has been kept to a minimum; a bed (for whose comfort we can vouch) bedside table, chair and desk, coffee-table and an exquisitely accommodating armchair. The desk has a washable composition top, and will be provided with an Anglepoise lamp. A house telephone will be included in every room, though whether there is a direct line to the bar remains to be discovered. Considerable imagination has been used in the choice of fabrics—feminine chintzes for the top floor and subdued pastel colours to accord with the tastes of the sterner sex.

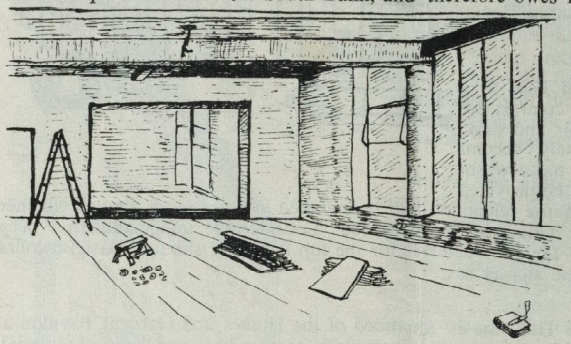
Constantly in the College Hall one is reminded of the Homes and Gardens Pavilion at the Festival of Britain Exhibition—in the furniture, with its pure lines and sense of material, in the bathrooms whose cheerful lemon yellow tiles will surprise those who associate such places with the subterranean gloom of those at our Ancient Universities. As on the South Bank, one is constantly being intrigued and delighted: the sense of light and air, the deep shaft, intended not for a Prisoner of Zenda, but as a short cut for dirty linen. On the other five floors the rooms and equipment, with a single concession to the male, are no different from those described. It is the State Rooms on the ground floor which will provide the spaciousness and grandeur, so necessary for the sense of gracious living. On entering through the wide doorway one is straightforth plunged into the centre of affairs. On the one side swing doors lead into the refectory, one end of which can be shut off if desired: facing one there are the lifts and stairs to the upper floors and on the right, visitors' rooms, the bar, the reading room and a recreation room. This last is lofty and well lit from three sides by tall windows. Next door, on a slightly higher level is a music room, which, by the baroque contrivance of a sound-proof screen descending into the floor, becomes a concert platform for the recreation room.

One could ramble on through pages of *The Journal* about the individual features of this hostel—the caretaker's flat and drying rooms, the unforeseen embarrassments due to the placing of showers and changing rooms on opposite sides of the main service corridor, the sinister tunnel which connects the hostel with the dissecting room—but such was not our commission, which was merely to sample the prescription with the aid of a critical dipstick.

Here we must say that, in our opinion, the outside appearance of the Hostel is undistinguished, to say the least, and that this has probably arisen through internal considerations entirely dictating the external form. From the front especially it is monotonously regular, and this feature is even more emphasised by the irritating double number of windows on the first floor. Admittedly these are intended to soften the transition from the upper storeys to the row of tall French windows on the ground floor, which, however, look like shopfronts at the base of a block of flats. Having unburdened ourselves thus far, it must in fairness be said that we are judging an uncompleted building and that this is to be the first instalment of a replanned Preclinical unit, where similar buildings on the other three sides may give the square an air of gracious formality. And the present external form, however undistinguished, is

vastly superior to the artist's conception of a hostel block, as portrayed in the prospectus of about five years ago, which was enough to send any sensitive architectural soul into convulsions.

The most encouraging thing about the new hostel is the ubiquitous acceptance of the forthcoming "Scandinavian" style of our buildings, furniture, and textile patterns; this moreover was planned before the South Bank, and therefore owes no inspiration to Sir Gerald or Mr. Casson. For this we must congratulate the Dean and his Committee, and suggest that they open the new College Hall with a bang and not the traditional whimper by inviting the architectural correspondents to view and write about this enlightened patronage of Good Taste. And may our still small voices be heard from the other side for a similar revolution against our betiled squalor.



BURBANK AND BLEISTEIN.

THE WARD NAMES OF ST. BARTHOLOMEW'S HOSPITAL

By G. W. MIDDLETON

THE ward names of the hospital have been the subject of at least two previous articles in the Journal. In November, 1896, an article was published by F. A. Howard Clarke entitled "The Nomenclature of Some of the Wards," and in December, 1897, there was printed the inaugural address to the Abernethian Society's 103rd session, delivered by John Langton, F.R.C.S. His subject was "Some of those after whom the wards are named." He described the wards as being named after Scriptural persons and divine gifts, official positions and persons, benefactors and members of the staff. This still holds good today, but many of the names of his time have temporarily disappeared due to re-building or re-naming. For example, of the ward names in the block originally built by James Gibbs on the site of the present King George V Building, only that of *Rahere* remains. The others included *Kings and Queens, Soldiers and Sailors, President, Treasurer and Radcliffe.*

The ward names used at present, date from *Rahere* in the twelfth century to *Bowlby, Butlin* and *Waring* in the twentieth.

Many of the names which are not now in use, commemorate famous personages in the life of St. Bartholomew's Hospital, for example: *Pitcairn* (Physician and Treasurer), *Lucas* (President), *Stanley* (Surgeon), *Harley* (President), *Darker* (Treasurer), and *Sitwell* (Auditor). There were also Scriptural personalities such as Matthew, John and Mark, as well as others like Hope and Charity.

Kenton

Benjamin Kenton (1719—1800), was born in Whitechapel and educated at Sir John Cass School. In his youth, he was apprenticed to the landlord of the "*Angel and Crown*" at Whitechapel and later moved to the "*Crown and Magpie*" in Aldgate. The owner of this inn had allowed the Magpie half of the sign to decay, and altered the name to "*The Crown.*" As a result of his parsimony the prosperity of his inn lessened, and Kenton was lucky to buy it up at a very reasonable price. Business prospered and Kenton came to acquire great wealth. Ships' captains held a high opinion of his wisdom from the fact that when they were dining upstairs, he, although never present in the room, always knew when the candles required snuffing. His explanation that he kept a contemporaneous candle in the bar in no way diminished their appreciation of his ability.

Kenton also discovered a method of bottling ale so that it could make the voyage to India round the Cape without blowing the cork out of the bottle.

He bequeathed £5,000 to Bart.'s, of which his friend Thomas Harley was the Treasurer.

[Harley gave his name to the ward opposite Kenton which is now the Physiotherapy Department.]

Colston

Edward Colston (1636—1721), was one of Bristol's most munificent merchants trading with the East Indies. He had made a large fortune in trading and sugar refining and he was very generous to charities. For three years he was Tory M.P. for Bristol, but left there in 1689 and lived for the rest of his life in Mortlake, Surrey.

His father, William Colston, who was also a Bristol merchant and an ardent Royalist, was removed from office of Alderman in 1645 by order of the House of Parliament. After this he moved to London and so he sent his son, Edward, to Christ's Hospital. In 1902, one and a half acres of land on site of Christ's Hospital were bought for the present Out-Patients and R.S.Q. The Colston Hall in Bristol, well known for its concerts, was named after Edward Colston, who had founded the Colston School on the same site many years before.

Smithfield

In 1923 a special collection and sale was held in Smithfield Market to commemorate the octo-centenary of the Hospital. More than £10,000 was raised. This gift, recalling the intimate association of the Smithfield traders with the hospital from its earliest days, provided a suitable occasion for the hospital to express its indebtedness. Accordingly the name Smithfield was associated with one of the wards, and on July 26, 1923, the ward formerly known as "John" was renamed Smithfield.

Smithfield or Smoothfield was originally an open space outside the walls of the hospital used for tournaments, jousts and other assemblies including Bartholomew Fair, which was held there from the reign of Henry I till 1855. It was also the site of torture for Ecclesiastical offences: such as death by boiling and burning at the stake. The Scottish Patriot, Sir William Wallace, was hung drawn and quartered there on St. Bartholomew's Eve, 1305.

WINTER THEME

By E. A. J. ALMENT

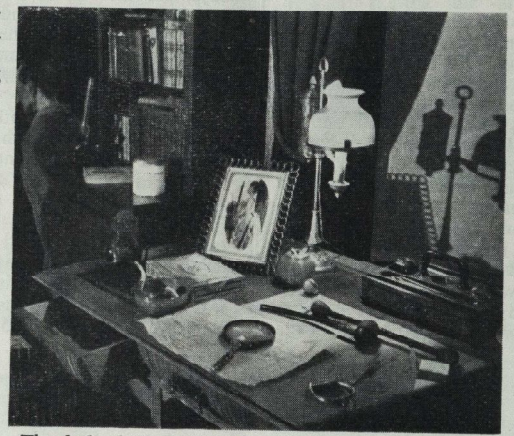
Out of the north
Borne down the path
Faint on the air
Like arctic bells
Over the sea-fret,
Sliding through creek;
Dark in the lee of pale night-searching moon:
Trickling sluice, hiss of salting grass;
Sweep down great whispering pinions
Suddenly stilled as they turn,
Idly swinging in unison
Then strike earth
and cry: the
geese are
in.

behind the creeping cold
of bleak October wind
the rising clangour comes
rung in a steely sky
silver-fingered tide
mist-filled mud gulley

SOME OBSERVATIONS ON SHERLOCK HOLMES AND DR. WATSON AT BARTS

"It is of course a trifle but there is nothing so important as trifles."[1]

Dr. Watson[2] passed his examination for the Doctorate of the University of London in 1878, of this we have canonic proof,[3] and from this date we are left to deduce the year of his entry to St. Bartholomew's Hospital. Unfortunately, the records of these early days are far from complete, and they are no longer held by the College Office. But, by "reasoning analytically," we may accept this date as 1873 with a fair measure of certainty.



The desk of Sherlock Holmes. Amongst the handcuffs pipes and other litter, the framed picture of "The Woman" may be seen.

The young Watson must have cut a conspicuous character amongst his fellow students. He was never one of the typical Public School men, despite his spending some years at such an institution with "Tadpole" Phelps, but throughout his life he retained the determination and zest, born of the wild and country upbringing of his childhood at Ballarat, in Australia. Though his academic record was never brilliant, he stood out on account of his prowess at Rugger. He had certainly played three-quarter for Blackheath, and he could well recall a match played at Richmond.[4] Unfortunately, we have no record that he played for the hospital. It is interesting to note, and perhaps not without significance, that after the installation of the Hospital Cup in 1875, it was not until 1881 that Bart's were to carry it back to Smithfield;[5] although Watson could not have been in that victorious team, his coaching in the previous years undoubtedly contributed to the victory. Besides his outside interests, which were chiefly boxing and horse racing, Watson showed himself able and steady at his work, and once he had qualified, obtained a House job. Most likely this was that of Dr. Samuel Gee, one of the first men in this hospital to be interested in nervous disorders,[6] and from this appointment dates Watson's interest in neurology. He had become well versed in the literature of the rising school of French Psychologists' and, to quote his biographer, "The learned and highly specialised monograph by Percy Trevelyan on certain obscure nervous disorders, though something of a burden to its publishers, had not escaped the eye of the careful Watson."[8] When Holmes interrupted the newly-wed Watson at breakfast just before the affair of the *Stockbrokers Clerk*, the article in the B.M.J. which Dr. Watson had propped up against the marmalade was on Hemiplegia by John Abercrombie.[9] Later in life he returned to study, possibly with a view to taking the

References to the Holmes and Watson canon are to be found in the two volume edition published by John Murray.

[1] *The Man with the Twisted Lip*, p. 140.
[2] Dr. Watson, however, preferred to be called Dr. John H. Watson. Compare his own inscription on the flyleaf of *The Study in Scarlet*, and also the legend upon his tin dispatch-box.
[3] *A Study in Scarlet*, p. 5.
[4] *The Sussex Vampire*, p. 82.
[5] *Barts in Hospital Rugby Football*, by R. C. D. Newill, *St. Bartholomew's Hospital Journal*, June, 1951, Vol. LV, No. 6, p. 132.
[6] In 1880, Dr. Samuel Gee wrote a significant paper on "Mental Disease." See the *St. Bart. Hosp. Reports*, Vol. XVI, 1880, pp. 27-46.
[7] *The Six Napoleons*, p. 742.
[8] See *Dr. Watson*, by S. C. Roberts, London, Faber, 1931, p. 11, and also *The Resident Patient*, p. 460.
[9] It is, unfortunately, impossible to summarise in a short article this complicated deduction.

Fellowship. Whenever "dangerous thoughts" came into his head,—Watson was thinking of the smile and the deep rich voice of Miss Morstan,—he would give up reading Winwood Reade's *Martyrdom of Man* and "plunge furiously" into the latest treatise on pathology.[10]

As soon as he left Bart's, Watson turned from the humdrum life of the G.P. to the camaraderie of the regimental mess.[11] He attended the Army course at Netley, and was soon attached to the Fifth Northumberland Fusiliers, whom he joined at Kandahar. This is no place to dwell on that fatal battle of Maiwand, the courage of Murray his orderly, the ghastly journey to the base hospital at Peshawar, though the matter of the Jezail bullet is worthy of a small digression. In view of the claims of several critics to have found an inconsistency in the site of the bullet wound, I would ask you to examine the facts. With the same enthusiasm that has prompted some to postulate a deutero-Watson, others have put forward a hypothesis of multiple wounds, and even inaccuracies on the part of our chronicler. So, let us look into this carefully. Here are the relevant passages:

(a) . . . I was struck on the shoulder by a Jezail bullet, which shattered the bone and grazed the subclavian artery . . . I was removed to the base hospital at Peshawar. Here I rallied, and had already improved so far as to be able to walk about the wards and even to bask a little on the veranda, when I was struck down by Enteric Fever, that curse of our Indian possessions.
A Study in Scarlet, pp. 5 and 6.

(b) . . . I made no remark but sat nursing my wounded leg. I had had a Jezail bullet through it some time before, and, though it did not prevent me from walking, it ached wearily at every change in the weather. *The Sign of Four*, p. 146.

(c) ". . . and a six mile limp for a half pay officer with a damaged tendo Achillis." *The Sign of Four*, p. 202.

(d) I had remained indoors all day, for the weather had taken a sudden turn to rain, with high autumnal winds, and the Jezail bullet which I had brought back in one of my limbs, as a relic of my Afghan campaign, throbbed with dull persistency. With my body in one easy chair and my legs upon another . . . I lay listless. *The Noble Batchelor*, p. 225.

(e) "What was I, an army surgeon with a weak leg and a weaker banking account . . . ?" *The Sign of Four*, p. 158.

(f) "Are you game for a six-mile trudge, Watson?"
"Certainly," I answered.
"Your leg will stand it?"
"Oh yes." *The Sign of Four*, p. 195.

(g) *Holmes*: "It is cocaine, a seven per cent solution. Would you care to try it?"
Watson: "No indeed, my constitution has not yet got over the Afghan campaign." *The Sign of Four*, p. 144.

Let us examine these *seriatim*:

Taking (a) this would seem categorical, and to leave little room for doubt, but within a short while our suspicions are aroused by (b), where, with almost equal certainty, Watson records the bullet passed through the leg. An old medical aphorism says "Diagnose not two, where one will do," so let us search around for an explanation of this dichotomy. The protagonists of a crural bullet may point to the damaged Tendo Achillis (c); had such an injury been sustained, the field surgeon would certainly have extracted the bullet, there being no structures liable to damage around the tendon, and the operation a simple one. But evidently the bullet was not removed, see (d), in which the bullet, wherever it was, *throbbed with a dull persistency*. But suppose the bullet lay in the scapular or axillary region, it would be a daring and a foolish man to undertake the operation. Remember there were no X-ray photographs or special facilities. If the correct site be the scapular region; how then are (e) and (f) explained? Let us now study (a) *in extenso*. Watson was soon *able to walk about the ward and bask a little on the veranda*. Now at this time there was only one effective treatment for a damaged limb and this was rest. John Hilton's lectures '*Rest and Pain*'[12] were at this time influencing medical opinion. I would remind you there was no such thing as "ambulatory treatment" then. The Thomas's Splint was not introduced for front-line casualties until the 1914 to 1918 war. We can therefore assume, with some measure of certainty, that up to this point there had been no damage to the leg. But note what follows. Watson is struck down with Enteric Fever, his life was "despaired of," and before his resilient constitution recovered, he was shipped home on the *Orontes* in a weak and emaciated state and invalided from the Army. Now a rocky convalescence from Enteric fever is insufficient grounds to discharge a man from the Army, clearly there must have been more to it than this. Indeed there was, and we have not far to look, only, in fact, to his leg. In these days it is well known amongst the Medical Profession that the Typhoid state is associated with a tendency for the blood to clot.[13] This most frequently occurs in the plexus of veins within the soleus muscle and the gastronemius, and spreads up the leg. This complication is favoured by the High Fowler Position[14]

[10] *The Sign of Four*, p. 158.
[11] Vide S. C. Roberts *Op cit.* p. 11.

[12] "*On the influence of mechanical and physiological rest in the treatment of accidents and surgical diseases, and the diagnostic value of pain*," by John Hilton, F.R.S., F.R.C.S., published, in 1863, by Bell and Daldy, 186, Fleet Street.
[13] *Modern Practice in Infectious Fevers*, Vol. I, p. 362, by H. Stanley Banks.
[14] George Ryerson Fowler, American Surgeon, 1848-1906.

in which, as like as not, Watson was nursed, for this position was then coming into vogue. This thrombosis left its legacy of intermittent claudication. Now compare (a), (b), (c), (d) and (e), see that they fit in to this hypothesis, but not (e), I shall return to this later in my argument.

I wish first to re-examine (d). The weather had certainly been wet. Holmes had remarked as much when he felt Lestrade's pea-jacket. Watson's listlessness sprang not from the weather. If it had, he could have dispelled it by plunging into his treatise on Pathology, nor did it come from the old "bullet wound," which might have been treated with a mustard plaster, but instead it was due to the surrender of his batchelordom and the coming yoke of matrimony, (" It was a few weeks before my marriage.") At any rate it was not long before his troubles were forgotten amongst a brace of woodcock, a pate-de-fois-gras pie and the contents of some ancient and cobwebby bottles, and therefore his listlessness seems to be of a more functional than an organic origin. Watson in fact gives us a clue that his trouble is not local but constitutional in (g).

Now save for the anachronism of (c), all has been plausibly explained, if indeed any explanation were necessary. (This recent trend in gaining quick recognition as a critic of the Holmes-Watson texts by pointing out cheap inconsistencies, which cannot be justified, should be abhorred). The damaged *Tendo Achillis*, was clearly more than a thrombosis. I would suggest, in fact, that Watson had had the operation known as tenotomy, in which the *Tendo Achillis* is divised. This gave him relief from pain, but left him with a weak leg and a limp which did not prevent him undertaking a *six mile trudge*. The last piece of the jigsaw is thus completed the part confirming the whole.

No one was more anxious to speak of his war experiences than Watson, who would endeavour to cheer and amuse Miss Morstan with some reminiscences of his adventures in Afghanistan, but he does not care to describe the bloodier battles where he saw his own comrades hacked to pieces at Maiwand, and likewise spares us details that might distress by modestly passing off the tenotomy operation as just another Jezail bullet.

"Thin as a lath, and brown as a nut," as he later said, Watson naturally gravitated to London, "that great cess-pool into which all the loungers and idlers of the Empire are irresistibly drained."[15] Worried by his "meaningless existence," he was standing one day in a brown study at the Criterion Bar, when someone tapped him on the shoulder. Turning round Watson saw young Stamford, who had been a dresser under him at Bart.'s. At once they took a Hansom to the "Holborn Restaurant." As they talked over their lunch, Watson gradually turned the conversation from reminiscences of contemporaries at Bart.'s, to his most pressing need —lodgings. Stamford mentioned an acquaintance of his who was also looking for digs. Watson jumped at the idea of sharing, though Stamford was more cautious. "You might not care for him as a constant companion," he replied, looking "rather strangely" over his wineglass. But Watson insisted and an introduction was promised. This was to be one of the most remarkable literary meetings ever, save perhaps that of Boswell and Johnson in the back parlour of the book shop kept by Tom Davies in Great Russel Street, Covent Garden, two meetings which show a remarkable resemblance.[16]

As they made their way down Holborn towards St. Bartholomew's Hospital, Stamford told Watson a little more about his friend's peculiarities. They turned into Giltspur Street, and passed down a narrow lane (to be identified with Windmill Court) and through a side door. It was familiar ground to Watson, and he needed no guiding up the "bleak stone staircase" and along the "corridor with its dun coloured doors to the Chemical Laboratory" then, as now, "lined and littered with countless bottles."[17] There was only one student in the room, bending over a table, test-tube in hand. He was absorbed in some work.

"Dr. Watson, Mr. Sherlock Holmes"

"How are you? You have been to Afghanistan, I perceive"

"How on earth do you know that?"

Such was that memorable introduction.

Stamford brought up the question of "diggings." Holmes was delighted and mentioned a small suite in Baker Street.[18] Together they summed up their shortcomings and vices. Holmes listed "Strong

[15] *A Study in Scarlet*, p. 6.

[16] For further comparisons between these meetings, see the original description by Boswell, and that by Watson: *A Study in Scarlet*, pp. 6-13. For further references read both *Dr. Watson* and *Dr. Johnson* by their biographer Mr. S. C. Roberts.

[17] Much of this has been changed since Watson's day, in particular the internal decoration. The "dun colour" has been abandoned and only last year (1950-1) the whole block has been redecorated in green and cream. The arch referred to seems to have been done away with during structural alterations.

[18] It is not proposed to re-open the thorny problem and vexed question of the actual site of these rooms. Interested readers should refer to the writings of Dr. Grey Chandler Briggs of St. Louis, Dr. Maurice Campbell's *Sherlock Holmes and Dr. Watson: a medical digression*, Vincent Starrett's *The Private Life of Sherlock Holmes*, a recent and prolonged correspondence in *The Times*, on April 7, 16, 17, and 21, 1951, and also a collection of theories abstracted for the recent exhibition at Abbey House.

tobacco, a liability to depression, experiments with chemicals and playing the violin." Watson confessed to "Ship's tobacco, a bull-pup, and an objection to row."

"Oh, that's all right," Holmes cried with a merry laugh, "I think we may consider the thing as settled." They agreed to visit Baker Street together the very next day.

"Very piquant" observed Watson to Stamford after they left the laboratory.

Thus it is to the honour of St. Bartholomew's Hospital that not only Dr. Watson was a "Bart's man," but also that Holmes had some association with the hospital, though his position was ill-defined: "Working in the Chemical Laboratory," "not a medical student," "though well up in anatomy, he is a first class chemist." Now Augustus Mattiesson was the lecturer in Chemistry at Bart.'s from 1870 onwards. Sir Normon Moore recalls that he had two

A view of the fireside and Holmes' chemical corner at "221B."

These illustrations are reproduced from two Daguerrotypes now in the possession of the niece of Mrs. Hudson.

The sharing was a success from the start, and thereafter they lived on and off together for many years. Holmes never objected to Watson's choice of tobacco, and he would have had little enough reason considering his own revolting habit of smoking all yesterday's compounded dottles in the after-breakfast pipe, but he may have felt very different over the matter of the bull-pup, for no more is heard of it, which is "strange treatment," and perhaps in this the bull-pup may be compared with the "dog in the night-time." It will be recalled that Holmes' past experience with bull terriers had not been altogether happy (vide *The Gloria Scott* p. 375) "Such . . (good) . . hounds have a way sooner or later of biting the hand that feeds them" Holmes later remarks with some bitterness.

private pupils,[19] one was Moore himself, the other he does not name though he does give us some information about him. He had been in Strasbourg during the Franco-Prussian War (1870-71) when a shell passed through his house. Mattiesson was interested in Opium and together they had investigated its alkaloids. He was a constant and eager experimenter. The likeness between this student and Holmes becomes more and more apparent, and we may, in fact, conclude they were the same person. If this be accepted, his position at Bart.'s is accounted for, his absence from Britain during the Franco-Prussian War explained,[20] as is his useful knowledge of

[19] Vide "*The History of St. Bartholomew's Hospital*," by Sir Norman Moore, Vol. II, pp. 816 and 817.

German, for it will be remembered that he was happy to quote Goethe quite glibly.[21]

Holmes was the most modest of men and on the whole made little account of his discoveries and researches.[22] For him the pursuit of knowledge was its own reward. "It is my business to know things, it is my trade." "I am brain, Watson, the rest of me is just appendix." "All other men are specialists, but his specialism was omniscience."[23]

His research on the distinction of ante-mortem and post-mortem bruising which he did not elect to publish may have seemed bizarre to some, but nevertheless, it was more profound than the work of Christison.[24 25] Similarly, the blood test, upon which he was working in the Chemical Laboratory, when disturbed by Stamford and Watson, detected blood at a dilution of $1:10^6$, and on his own statement superseded the old guiacum test "which was clumsy and uncertain."[26] Though never published it was clearly an oxidation test of the same type as the later benxidene test, and until the introduction of the Spectroscope it would have remained our most reliable test. Thus from the retiring personality of Sherlock Holmes, little of his glory was reflected on his Alma Mater.

Dr. Watson, however, in this, as in everything else, was a complete contrast. Watson was a typical product of the Hospital at the latter half of the last century: frank, honest and industrious, a systematic observer, a comforter and friend.[27] His ability to describe what he saw and felt in clear, vivid English during his later life, arose from his patient note-taking as a student e.g. the clear description of the twisted lip of Mr. Neville St. Clair,[28] and his ability as diagnostician came from his work at the bedside and in the ward. Holmes poses Watson a clinical problem: "the muscles are in a state of extreme contraction, far exceeding the usual *rigor mortis*. Coupled with this distortion of the face, this Hippocratic smile or *risus sardonicus*, as the old writers called it. What conclusions would it suggest to your mind?"

"Death from some powerful vegetable alkaloid, some strychnine-like substance which would produce tetanus."[29] It is the student Watson who speaks, he is back at the bedside answering the questions of his chief.

Yet again Watson succeeds in making the correct diagnosis. "Put your hand here." Mr. Jefferson Hope indicated his chest with his manacled hands. I become at once conscious of an extraordinary throbbing and commotion which was going on inside . . . In the silence of the room I could hear a dull humming and buzzing noise.

"Why," I cried, "you have an aortic aneurism."

"That's what they call it."[30]

[20] In this there is no inconsistency with the chronology of Holmes' College Career, which has been worked out so exhaustively by Miss Dorothy Sayers. It does, in fact, lend weight to her theory. Holmes must have gone straight "up" after getting back from the continent to be in time for the Christmas term. See "Holmes' College Career" *Unpopular Opinions*, by Dorothy L. Sayers, London, Victor Gollancz, 1946, pp. 134-147.

[21] "'Wir sind gewohnt dass die Menschen verhohnen was sie nicht verstehen' Goethe is always pithy," *Sign of Four*, p. 192.

[22] But compare "'too bad!' cried Holmes, 'my old friend here will tell you . . . that I can never resist a dramatic situation.'" *The Mazarin Stone*, p. 1158. Se also the denouements at the conclusion of such cases as *Silver Blaze*, p. 329, *The Naval Treaty*, p. 531, *The Six Napoleons*, p. 760.

[23] Holmes did, however, entertain a few odd ideas, take for example his opinions on evolution. He quotes, or rather misquotes, Darwin on the influence of music on primitive man, see *A Study in Scarlet*, p. 46, and *The Descent of Man and Selection in relation to Sex*, John Murray, 1871, Vol. II, Chap. 19, p. 334. For a fuller discussion of this see *Sherlock Holmes and Music*, by Guy Warrack, Faber, 1947, p. 23 and p. 24. But compare these with his later views on the discovery of the antecedents of criminals by studying the form of their hands, which he claims is inherited, from such trades as: slaters, sailors, cork-cutters, compositors, weavers and diamond polishers. In this he clearly adopts the standpoint of a Lamarkist. See *The Sign of Four*, p. 147.

[24] See *Taylor's Principles and Practice of Medical Jurisprudence*, Churchill, 10th edition, Vol. I, p. 301 *et seq.*

[25] Sir Robert Christison, who aided in bringing to book Burke and Hare in 1823, published his brief researches a few years before Holmes: *Murder by Strangling, with some remarks on the Effects of External Violence on the Human Body soon after death*: No. IV of cases and obs. in *Med. Jurisp. Ed. Med. and Surg. Jour.*, 1829, pp. 229-250.

[26] *A Study in Scarlet*, p. 11.

[27] But compare Holmes' attitude to his clients, "The status of my client is of less importance to me than the interest of his case." *The Noble Batchelor*, p. 225.

[28] *The Man with the Twisted Lip*, p. 145.

[29] *The Sign of Four*, p. 187.

[30] *Ibidem*, p. 122.

Watson never overrated himself, even when Holmes, who was at the time dying from a rare tropical disease, turned upon his own friend to say "after all you are only a general practitioner with very limited experience and mediocre qualifications," he kept his dignity and admitted he had never heard of Tapanuli fever or the Black Formosa Corruption.[31 32] Watson was not one for these curiosities of medicine, he would keep his feet on the ground[33] and when diagnosis was in doubt he would wait to see if the condition would improve by itself. Failing improvement by orthodox therapy he would prescribe a Turkish Bath.[34]

Unfortunately a description of the complete medical career of Dr. Watson and notes on his more interesting cases must wait for a further paper at a later date. This is no place to study the changing fortunes in Watson's varying practices at Baker Street, Paddington and Kensington, though it may be mentioned that towards the end of his life he was able to purchase a "not inconsiderable practice," and finally settle in a house in Queen Anne Street. There is no evidence to show that this house is not the one at present occupied by a member of the consultant staff of this hospital, it is a happy thought that this house has remained so long in the hands of a Bart.'s man.

This has been a special year for Sherlock Holmes and Dr. Watson. Many of us have been able to visit the exhibition in Abbey House, by which, we have, this year, honoured them. But I was distressed to find no reference to the Hospital, at which the great men did part of their training. It was sad and shameful that St. Bartholomew's Hospital did not contribute a single relic. Surely some of his dresser's notes might have been unearthed in the Registry giving palpable proof of his ability as an observer, and a chance for interesting speculation upon his calligraphy, no sample of which is now extant.

I have diligently searched the library catalogue and the Athenæ collection for Holmes' *Monologue on Malingering*, a handy book for the medical man, but there is no record in this hospital of any of Holmes' published works.[35] Perhaps his researches into the *Early English Chartists* or *Studies of the Chaldean Roots in the Cornish Language* are outside the scope of the library, and the *Monograph on the polyphonic motets of Lassus*, which was printed for private circulation only, may now be unobtainable.[36] But surely that small, sleek, leather-bound edition of Holmes' last published work, over which he has lavished his years of retirement on the South Downs, *The Practical Handbook of Bee Culture, with Some Observations on the Segregation of the Queen*, would be a fitting memorial to Watson and Holmes, who are little enough remembered at their old Hospital.

[31] *The Dying Detective*, p. 1004.

[32] I should like to express my thanks to the librarian of the Hospital for Tropical Diseases, who has been most helpful in aiding my search for these rare conditions. Up to this point I have found no reference to them in any of the standard textbooks or monographs.

[33] "If I have one quality on earth it is commonsense." *The Hound of the Baskervilles*, p. 380.

[34] "A turkish bath is what we call an alternative in medicine—a fresh starting point, a cleanser of the system." *Lady Francis Carfax*, p. 1018.

[35] For a complete list of Holmes publications see *Doctor Watson* by S. C. Roberts, *Op. Cit.* Appendix A, pp. 31 and 32.

[36] The reason why it is now unobtainable has been exposed with distressing lucidity by Guy Warrack, vide *Sherlock Holmes and Music*, Faber & Faber, 1947, pp. 48-53.

BIRTH

The birth is announced of a daughter (Valerie) to Mr. Arthur Wint and his wife, Norma, on November 3, 1951, in Elizabeth Ward.

DEATH

The death is announced of Edward James Deck, M.R.C.S., L.R.C.P., of "Inveravon," Mudeford, Christchurch, Hants, at the age of 79. He qualified from St. Bartholomew's Hospital in 1896.

ENGAGEMENT

The engagement has been announced between Mr. G. I. (Bob) Verney, younger son of Prof. E. B. Verney, F.R.S., of Cambridge, and Miss D. F. Theobald, a member of the Nursing staff of the Hospital and elder daughter of Mr. G. W. Theobald, F.R.C.O.G., of Bradford.

MARRIAGE

The marriage took place at St. Augustine's Church, Ipswich, on September 29, 1951, between Ian F. Eastwood and Miss Pamela Carter, a member of the nursing staff of St. Bartholomew's Hospital.

THE STATE OF THE PRIVATE MAD-HOUSES

By M. J. CLARKE-WILLIAMS

" Mad I call it ; for to define true Madnesse
What is't, but to be nothing else but mad."—Shakespeare.

ON February 21 a number of years ago, a report was presented to the House of Commons by a select committee headed by Mr. Townsend, M.P. It is not possible to say for which constituency this worthy gentleman was Member, for there were no fewer than seven of that name in the House at the time. Amongst these seven were a Privy Councillor, an Admiral and two " Honourables." This select committee had been appointed " to inquire into the state of the private mad-houses in this kingdom." They decided to confine themselves to two main points: firstly—" the manner of admitting persons into houses now kept for the reception of lunatics," and secondly—" the treatment of them during their confinement."

Now that the hugger-mugger of the Hustings has been settled and the petty Party polemics are over, for the time being, it may prove refreshing to examine this non-Party report. It was presented in the days when the Legislature went leisurely to work, for it was seldom that it met more than eight times in the month! There were no Hansard staff then to report the proceedings verbatim, indeed reporting within the House was illegal. Thus are we dependent on accounts, set down partly with the aid of the prodigious memory of the authors and partly by means of their ever-flowing invention. The reports that we are about to study cannot therefore be taken in any way as wholly accurate, but they are all that exist today!

Select Committees—Royal Commissions, Working Parites, call them what you will—did not take the enormous time and labour that they do nowadays. This committee investigated the cases of only four ladies, each of whom had been an inmate of some private mad-house. In addition to these ladies only a dozen or so other witnesses were called, amongst whom were Doctor Battie and Doctor Monro, " two very eminent physicians, distinguished by their knowledge and their practice in cases of lunacy." [Dr. Battie the psychologist, might have stepped straight out of a pack of " Happy Families!"]

Let us take one of the four cases as illustrative of them all, for all had similar tales to tell.

> The next complainant was Mrs. Hawley, who represented her case as follows:—That, being on the fifth of September invited by her mother and husband to go upon a party of pleasure to Turnham Green, she was by them carried to a mad-house at Chelsea, kept by Turlington. That upon her being carried into the house she kneeled down and exhorted the keeper to let her go ; who refused her upon the authority of her mother directing him to keep her confined. That she was kept up night and day in a chamber locked and barricadoed; refused the use of pen and paper ; no notice permitted to be carried to any relation or friend ; and treated with severity.
>
> That during the whole time she was never visited by her mother, nor ever desired to take any medicines whatever ; and that she continued under confinement in the said home 'till the fourth of October, when she was in persuance of a writ of Habeas Corpus granted by Lord Mansfield, carried before his Lordship who discharged her.

Fortunately for Mrs. Hawley she had had the foresight to tell a friend Mr. La Fortune about the invitation, and he was called to give evidence before the committee. He said that " on the day of her confinement, she had dined at his house and that she then told him that she had received an affectionate letter from her mother desiring her to go with her upon a party to Turnham Green." He had advised her not to go and she had asked that if she was gone more than two days he should initiate enquiries. He it was that applied to Lord Mansfield for the writ of Habeas Corpus.

Other witnesses were called to prove this story which was typical of these cases investigated. All four ladies claimed that they were incarcerated by request of their relatives and that they had no access to the outside world and received no medical treatment whatever.

The two mad-house owners concerned in the enquiry, Mr. Turlington and Mr. Miles, were then called. Mr. Turlington excused himself by saying that he left the management of his house to his agent, Mr. King. He was asked " what instructions he gave to Mr. King in respect to the admission of persons?" He avowed that the rule was general, to admit all persons who were brought; and that, though the house was intended for the reception of lunatics, other persons were admitted as lodgers; that no physicians attended the house; that no register of persons was kept—but he denied in general the severities charged upon the house by other witnesses and expressly asserted that chains were never used.

Mr. King, his agent, on being called " said he had been in the wool trade but for six years past had been employed by Mr. Turlington to keep his mad-house." He confirmed what his employer had said and admitted that their diet and apartments were according to the allowance they paid which varied from twenty to sixty pounds a year. He " acknowledged it was the established order of the house that no letters should be sent by any of the persons confined to their friends or relations." Mr. King " frankly confessed that out of the whole number of persons whom he had confined he had never admitted one as a lunatic, during the six years he had been intrusted with the superintendency of the house." When asked if he ever refused anybody if they could pay, he answered " No."

The two eminent physicians were called next. " Doctor Battie gave it as his opinion that the private mad-houses require some better regulations; that the admission of persons brought as lunatics is too loose, and too much, at large, depending upon persons not competent judges; and that frequent visitation is necessary for the inspection of lodging, diet, cleanliness and treatment." Both doctors quoted cases from their own experience of sane persons being confined in private mad-houses and Doctor Monro reiterated Doctor Battie's suggestions for the improvement of these asylums.

" The committee being sensible from these few cases of the great abuses of private mad-houses and that Turlington's house was in no degree a selected case, declared it their opinion that the present state of the private mad-houses in this kingdom required the interposition of the Legislature."

Whereupon the House of Commons resolved to have a Bill brought in for the regulation of private mad-houses. And the year that this enquiry was held was 1763.

A SHORT HISTORY OF ST. BARTHOLOMEW'S HOSPITAL ALPINE CLUB

By P. KNIPE

ON November 24, 1930, fifty-six people gathered for dinner at Ye Olde Cocke Tavern, and to inaugurate the Bart.'s Alpine Club. For some time, individuals at the hospital had wanted some organisation to link their climbing into some form of unity with that of other hospital members. As a result of this impromptu gathering, the club was born.

The late Prof. Gask took the chair and after a " royal get-together," a committee was formed with several distinguished climbers such as Dr. C. Warren, Dr. Finzi and Mr. Bedford Russell as its members. It is of interest to note that the club at that time had two distinct sections, a climbing and a skiing section. Mr. Bedford Russell as the vice-president (Skiing Section) pointed out that these were mutually dependent for skiing is as essential to the skilled (and otherwise) climber as the yacht to the yachtsman. Climbing has been a sport for many years, though skiing has only been popular since the first world war. Nevertheless, Procopius writes in 500 A.D. of the Lapps using two flat pieces of wood strapped to their feet as a means of transport over snow country: a long piece on one foot for gliding over the surface, and a short one on the other foot to act as a means of propulsion. Similar skis have been in use in the Lake District for some hundreds of years, and they are mentioned in Lorna Doone as being used in Devon.

Unfortunately, the skiing section of the club has not yet been revived. There is certainly a place for it if there are any enthusiastic skiers in the hospital.

From its inauguration until 1939, the club flourished. It is mentioned in many of the old Bart.'s journals and to read of the days when one could go by rail to Bettwsyloedd for 38s. return, and stay in the hotel at Capel Curig for 16s. per day inclusive makes one very envious. Though the accounts are rather sporadic, it would appear that the

Club was well supported, for in 1936 they had three separate meets at Helyg in N. Wales.

The original intention was for the club to hold an annual meet abroad. Whether or not this was carried out I am unable to find out, but certainly members did frequently go abroad on their own expeditions, for accounts are found of climbing in the Pyrennees, Austria, the Himalayas and even some highly original work in Greenland! Another group visited some unusual and little-known areas in the Balkans in 1937.

The meetings in London continued, and Dr. C. Warren no doubt kept the attendances at a high figure by his lectures on Mt. Everest. He was medical officer to three expeditions to Everest between the wars, and his excellent article on the 1938 expedition in the Bart.'s journal gives some idea of the medical as well as the purely technical difficulties of such an expedition. In 1937 Prof. Gask retired from the chair and Dr. Finzi was elected in his place.

During the second world war the club, like so many others, lapsed before the sterner jobs of wartime. During these years, the minute books of the club together with all the records of the meets were tragically lost in the blitz. It is because of this that the detailed records of its pre-war activities are so difficult to trace and record in this article. However in 1946, the ambition of Dr. J. Gask materialised and a number of people met at Diviani's to reform the club. Dr. Finzi retired and the new president Dr. Cullinan was elected.

In November of that year a meet was arranged at Helyg in N. Wales. Between that time and spring of 1950 further meets in N. Wales and Skye have been held and a number of meetings arranged. During this period the membership was only in the twenties, and with difficulties of petrol rationing, rising costs and the small number of keen members, the club again lapsed for nearly a year.

In March of 1951, largely due to the efforts of Dr. Cullinan and Dr. G. W. Marsh, a further meeting was held after a modified publicity campaign had been tried. It was felt that a number of people were very keen on the sport but were ignorant of the existence of a club. I feel that this was proved both at that meeting and at the meet which followed.

On May 17, at 8 p.m., ten members left Bart.'s taunted by various ribald comments from non-climbing brethren about the condition of their dress. We motored up the A.6 to Helyg in N. Wales. It has been said that "for the beginner who aims at being a true mountaineer the only place within easy reach to learn the craft is the Alps." More particularly since the war, climbing and climbers have become split into two different sections. Those who can still afford the luxury of being climbers in all senses, equally at home on rock, snow and ice, in home and in foreign lands; and those who must be content with or who prefer rock-climbing for its own sake. As Geoffrey W. Young said "a man who knows rocks and their structure and can climb them with understanding is potentially a mountaineer."

On the night we left Bart.'s for Wales, we "potential" mountaineers were more than satisfied at the prospect of getting to grips with rock alone. North Wales is the nearest climbing ground to London, and although not thoroughly explored till the late 1800's, when the Lake District was already well known to climbers, it has never lacked in popularity since.

At 3.30 a.m. on the Friday morning, we arrived a the Climbers' Club hut at Helyg, and for those members who were new to climbing, it must have seemed an entrancing place. The moon was high and the broken lines of Tryfan stood out as though on guard over the silver valley. It seemed sacrilege that anything so strange as voices and car headlamps should defile it.

A few hours later a very sleepy party got up, and with a hot breakfast putting new life into us, we walked from Ilyn Ogwen up the path towards Cwm Idwal, that most lovely of hidden Welsh beauty spots. On a misty day, with the great black wall of Clogwyn Du split by the Twil Du (or Devil's Kitchen) looming over it, the legends of Cwm Idwal seem undeniable.

"A savage place! as holy and enchanted
As e'er beneath a waning moon was haunted
By woman wailing for her demon lover."

Just before reaching it we came to a low rocky bluff that stands out of the hillside—the Gribin. Here we split up into parties and spent a grand few hours climbing. Some of the beginners spent an amusing (?) time finding the truth in the saying "that men are unwise and curiously planned" by tackling the notorious Monolith Crack. There the inevitable happened and one of the party

managed to get himself well and truly jammed for some time. Some of us preferred the more open work on the face of the Gribin on the home climb.

The following day we motored up to Pen-y-pass and walked up to Llyn Llydau. While a couple of people walked round the Horseshoe, the rest of us set tracks for Llewedd. This is by far the finest rock face in Britain, almost 1,000 ft. of it, and certainly a place to be treated with respect. The rock strata are inclined in such a way that all the holds face down and out, and good technique is an essential.

Halfway up the Horned Crag route, the mist came down and the rain started. It was our first taste of bad weather that week-end. The thunder rolled round the valley with ear-splitting intensity and we were in no mood to waste time. On eventually reaching the summit the mist had cleared, but back at Capel Curig we drank our beer and swopped stories by candlelight, for the storm had fused the electricity cables to the area.

The Sunday was another day which began by being glorious. We scrambled about on the delightful but rather over-populated Milestone Buttress. This was really first rate fun, one party racing the other on those famous "bucket" holds, and the beginners amongst us felt really at home (probably for the first time!) on rocks. After lunch we wandered round to the east face of Tryfan, leaving the majority to return to Helyg and on to London. The rest spent an enjoyable though wet couple of hours doing the Gashed Crag route from Heather Terrace, and then raced back to Llyn Ogwen road and home to Helyg.

One party was then setting off rather reluctantly, and at about 6.30 p.m the rest of us looked around the newly cleaned hut, bade farewell to Tryfan, and set off on the long journey back. Altogether during the weekend climbs had been made on Llewedd, Tryfan East Face, Milestone Buttress, the Gribin, the Horseshoe, and several other complete or incomplete climbs done on the Glyders.

To encourage the would-be climber, who might be deterred by expense, I would like to point out that this last meet of the club, inclusive cost of the transport, food and accommodation, from the time we left Bart.'s on the Thursday till our return in the early hours of Monday, cost only £2 18s.—less in fact than the British Railways return fare! The other members would I feel sure agree with me that we certainly did ourselves well in every respect.

It is hoped that we can organise another meet in the early spring, and to those of you who would like to climb, or can already do so—or are at all interested in mountains and the pleasures they can give, may I assure you of a welcome into the club.

CORRESPONDENCE

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

Mr. E. F. Brook's letter in the *October* Journal referring to the ptomaine poisons of tainted and decaying meat, and Nansen's observation that they possibly caused scurvy, is of further interest in that Edward Wilson (this time at the South Pole with Scott), was of the opinion that scurvy could be prevented by eating fresh meat—seal or penguin. He also concluded that a similar condition to scurvy affecting the dogs of the Expedition was caused by "ptomaine poisons" in the fish they ate, which had been brought through the tropics. We now know that this was due, mainly, to infection by B.enteritidis.

Yours sincerely,
R. G. DANIELS.

Abernethian Room.

SWEENY TODD "POLISHED OFF?"

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

Sweeney Todd non-existent—what next! My grandfather, a clergyman, used to tell me how he had his beard trimmed by this barber with whom he was well pleased.

I am, Sir,
Your obedient servant,
JAS. EMBLETHORPE.

Orpington.

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

With your evidence of the finding of human remains beneath the site in Fleet Street (*see November Correspondence*) you have done little but embroider your myth. There is an obvious explanation—St. Dun-

stan's Church was very near, and its vaults ran some distance underground to either side. Surely, then, bones such as were found in the basement are likely to have come from the vaults, and it is unnecessary to postulate a "demon barber?" St. Dunstan's was demolished in 1913.

I am reminded of two other stories: Deloney's "Thomas of Reading," and the trial of "Sawney Bean" in Scotland in the 16th century. Compare them with the Todd legend.

I am, etc.,
PETER JAMES.

Tottenham, N.15.

I am afraid that I am no match for Mr. James' scholarship. However, I have now been able to trace the full story of the Sweeney Todd myth. As fiction, it first appeared in *Tell Tale*, a penny dreadful of 1823. It was entitled "A terrific story of the Rue de la Harpe, Paris." It described the shocking murder and mutilation of a gentleman, who was up from the country and spending a day or two "in town" by a fiend-like barber. The "casket of pearls," which he happened to be carrying was stolen and the barber disposed of the body to his paramour, a pie-maker, whose patties were the rage of Parisian Society. This fiction was based upon a crime, which did actually take place in the Fauberg St. Marcelle, in 1800, a record of which can be referred to in the *Archives of the Police* by Fouchée. When the case was fully investigated, three hundred mutilated bodies were found in the cellars of their premises. The barber and his mistress confessed to the crime and were executed, and it was declared that henceforth no building should again be raised upon this site.

This story was pirated by Thomas Prest from the *Tell Tale* account. He made a few additions, and the action of the story was moved nearer home to London, the pie-shop to Bell Yard, the barber's shop to Fleet Street. The title was now changed to "Sweeney Todd the Barber of Fleet Street and the String of Pearls." This version was published in 1840 by Lloyd. Two years later, a dramatic version was produced by Samuel Lane, at the Britania Saloon, Hoxton. This play had great popularity, one version being produced by the *Old Vic*. Tom Pinch makes mention of Todd's premises in *Martin Chuzzlewit*, and later reports telling of human remains have kept the myth of "Sweeney Todd the Barber of Fleet Street" alive, whereas such terrible tales as *Charley Wag* and the *Woman with the Yellow Hair*, are forgotten, and would be lost, but for the broad-mindedness of the curators of the British Museum Reading Room.

EDITOR.

To the Editor,
St. Bartholomew's Hospital.

Dear Sir,

"Your most interesting article by Dr. Boyd Neel reminded me of a story I once heard about the earliest days of his musical career. At the time of his first concert in London, when Boyd Neel was still practising in the East End of London, the Concert, like all the rehearsals, was squeezed in between the visits to his patients. After the performance the budding conductor travelled back to his Practice, and in the same evening delivered a mother of her baby. Dr. Boyd Neel is thus probably the only person ever to have conducted both a concert and a delivery on the same night, and certainly the only one to have made a success of both."

Yours, etc.,
(MRS.) EDMUND COOPER.

Bembridge, I.O.W.

MATTER FOR THE JOURNAL

Matter for publication in the Journal, should be handed to the Editor at least one month before it is due to be published. It should be typed and ready for the printers. Material for the So To Speak column is very welcome, especially if it has a suitable caption.

CROSSWORD SOLUTION

Across:— (1) on the water wagon; (8) bundle of His; (11) dart; (12) dura; (13) wrote; (14) naked; (16) lasso; (17) U.S.A. (19) omnibus; (20) corsair; (21) Eve; (23) Lille; (24) astra; (25) Jacob; (27) stew; (29) Avon; (30) present-time; (31) skin off your nose.

Down:— (2) haut; (3) widow; (4) tremors; (5) rifle; (6) avid; (7) odontoblast; (8) broken sleep; (9) substantive; (10) labour pains; (15) Dible; (16) larva; (17) use; (18) ace; (22) vacancy; (25) Josef; (26) battu; (28) wren; (29) amen.

EXAMINATION RESULTS

UNIVERSITY OF CAMBRIDGE

Examination in Pharmacology for Medical and Surgical Degrees

October, 1951

Daniels, R. G.
Gawne, E. F. D.
Nainby-Luxmoore, R. C.

CONJOINT BOARD

Final Examination — **October, 1951**

Pathology			
Arthur, B. K.	Davies, H. T.	Lockett, H. I.	Stevenson, K. M.
Cave, J. D. H.	Davies, P. E.	Manuel, J.	Thomas, B. D.
Channon, C. E.	Dodge, J. S.	Mercer, M. H.	Thomas, H. A. J.
Clappen, J. A.	Fitt, W. P.	Page, A. R. W.	Todd, J. N.
Cochrane, R. C.	Hill, F. A.	Stanford, R. M.	
Medicine			
Bowers, K. E. J.	Gobert-Jones, J. A.	Lumley, P. W.	Watson, L. P. E.
Evans, E. W.	Hall, M. C.	Scott, A. E. R.	Whittard, B. R.
Fallows, L. G.	Hooker, D.	Waddy, G. W.	
Surgery			
Bowers, K. E. J.	Fallows, L. G.	Goodspeed, A. H.	Waddy, G. W.
Butcher, R. H. G.	Gobert-Jones, J. A.	Sarma, V.	Whelan, N.
Midwifery			
Blake, A. S.	Fallows, L. G.	Johnson, R. J. R.	Watson, L. P. E.
Channon, C. E.	Goode, J. H.	O'Reilly, P. B. M.	
Evans, E. W.	Greenhalgh, G. P.	Sarma, V.	

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

Bowers, K. E. J.	Gobert-Jones, J. A.	Scott, A. E. R.	Whelan, N.
Evans, E. W.	Lumley, P. W.	Watson, L. P. E.	Whittard, B. R.
Fallows, L. G.			

SPORT VIEWS

RUGBY CLUB

v. Woodford at Chislehurst. **Saturday October 13. Result : Lost 9-16.**

It was a lovely dry sunny afternoon, and conditions were ideal for open football. Bart.'s started off in grand style and attacked consistently. After five minutes the scoring was opened with a penalty goal landed for the hospital by Davies. This was soon followed by a try by Thomas from a good opening made by Murphy. The try was not converted. Bart.'s maintained their attack, the forwards giving their backs an abundant share of the ball from the scrums, line-outs and to a less extent from the loose, and some of the backs made good use of it—especially Davies whose touch finding and attacking play were excellent. Before the end of the first half Tallock dived over the line from a line-out to make the half-time score 9-0 to Bart.'s.

In the second half Woodford set off with great vigour, and soon scored a try by their right wing three-quarter. Their onslaught then seemed stemmed and Bart.'s retaliated by pressing hard. Inside the Woodford twenty-five one of their centres intercepted a pass from the Bart.'s centre and supported by his wing ran the length of the field to score beneath the posts; the try was converted. Encouraged by this, Woodford maintained their pressure, when a mistake by a Bart.'s forward resulted in a further three points to Woodford from a penalty. Inspired by this, Woodford were able to add a further five points to their score before the end of the game by another goal.

It was an excellent game and there was much good football, and indeed, Bart.'s were unlucky to lose. Corbet played an excellent game at full back, and Davies was a tower of strength at fly-half. The forwards showed much improved form and definitely over-rode the Woodford pack.

Team : J. L. M. Corbet, A. D. M. Thomas; K. M. Clare; J. K. Murphy; J. T. Snow, M. J. A. Davies; A. Mackay; H. Cooper-Johnson, P. Knipe; C. W. H. Havard (Capt.); J. M. Tunes; A. W. Roche; L. Cohen; E. D. M. Shane; J. Tallack.

The Junior sides opened their season today, and all were victorious. The "A" beat Woodford "A" 6-3; the Extra "A" beat Woodford Extra "A" 9-0 and the "B" beat Woodford "B" 8-3.

v. Harlequin Wanderers, at Chislehurst, **Wednesday, October 24.**
Result : Won 19-8.

For once the bad luck which had been dogging the hospital team relented and St. Bart.'s won by the convincing margin of two goals, a dropped goal and two tries to a goal and a try.

The game opened with some rather scrappy mid-field forward play. After a quarter of an hour the play was just outside the Bart.'s twenty-five when from a good movement with all their outsiders taking part the Harlequins scored a try which they failed to convert.

Bart.'s then pressed and after a series of scrum and line-outs in the Harlequin twenty-five, they heeled from a loose maul and Havard was quickly on to their fly-half, took the ball from his hands and scored near the posts. The try was converted. Soon Bart.'s lead was further increased by A. A. M. Thomas who scored near the corner flag after a good run by J. M. Jones. At half-time Bart.'s were leading 8-3.

The second half began with an onslaught on the home line by the Harlequins and after a loose maul their fly-half ran hard across the field to send his wing over to score near the posts. The try was converted and the scores were equal.

Within two minutes of the restart Bart.'s heeled the ball from a scrum just outside their opponent's twenty-five and the ball passed down the line to Murphy who cross-kicked; Knipe was in position to gather the ball and passed to Roche who ran hard for the touch down in the corner. The kick failed.

Bart.'s continued to dominate the play, and it was only the nature of the score which was surprising when it came. As a result of a quick lead from a loose scrum, Davies was able to drop a neat goal. The final try was a brilliant solo effort by Davies who broke through in the mid-field, kicked over the full-back's head and won the race for the touch down between the posts—capping his fine run by converting his own try.

The forwards were playing together better than previously and Havard, Jones and Graham all did well. The outsiders also looked more dangerous than at any time this season. Davies being outstanding, and Murphy making several good openings, though never really making the most of them owing to a horrible tendency to slow down rather than increase his speed once through the gap.

The game was a great stimulator to both team and supporter, and much good football was played by both sides.

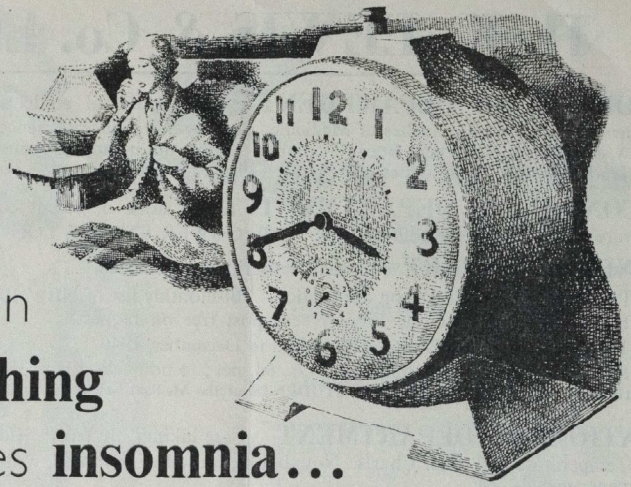
Teams : J. M. Kneebone; A. A. M. Thomas; K. A. Clare; J. E. Murphy; A. M. Lummiman; M. J. A. Davies; A. Mackay; A. J. Gray; P. Knipe; F. I. Macadam; J. M. Jones; D. W. Roche; J. Tallock; M. Graham; C. W. H. Havard (Capt.).

v. Kenilworth at Kenilworth, October 20.
Result Lost 0-3.

It was a disappointing ending to a hard-fought game to see the opposition stand-off half kick a drop-goal two minutes before the final whistle. A pointless draw would have been a fairer result in a game in which the standard of play never reached any great height, due probably to the extremely wet conditions of both ground and ball. It was most unfortunate that we lost Gawne within the first five minutes of the game, but great credit must go to the seven remaining forwards, who more than held their own, against a slightly heavier pack.

Nothing much can be said about the game itself except that both Lanniman and Roche nearly scored twice and our centres, when they got the ball, looked more dangerous than their opponents. Mackay at scrum-half played an extremely plucky game under adverse conditions, and Corbet at full-back extracted us from a few awkward situations by his sound kicking.

Team : J. L. M. Corbet; D. A. Lanniman; R. D. Bailey; J. K. Murphy; A. D. H. Thomas; M. J. A. Davies; A. Mackay; A. J. Gray; P. Knipe; F. I. Macadam; D. W. Roche; W. B. Castle; L. Cohen; E. D. F. Gawne; C. W. H. Havard (Capt.).



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