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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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April, 1953

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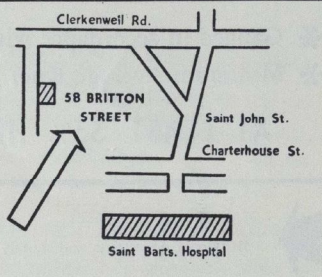

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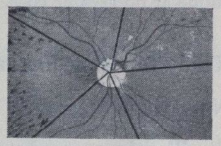

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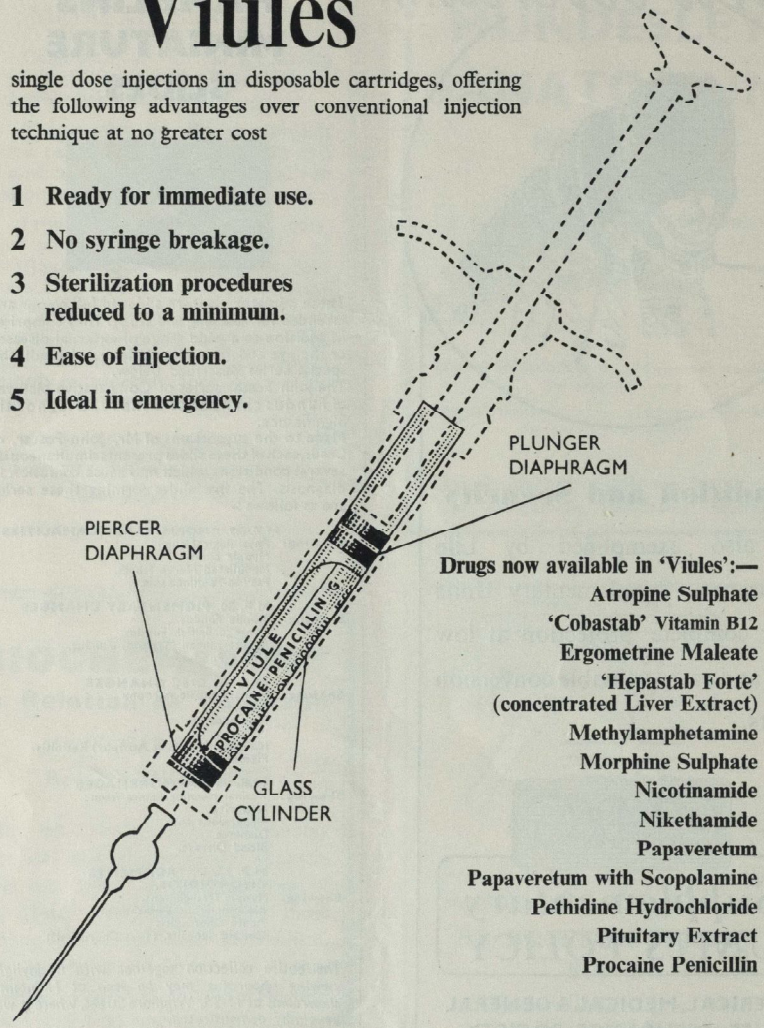

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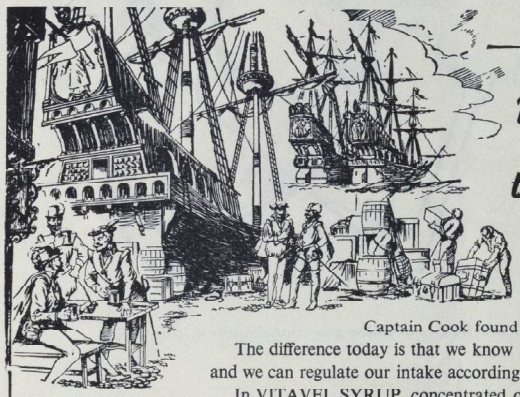

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HOSPITAL JOURNAL

Vol LVII APRIL, 1953 No. 4

AN OLD CHESTNUT

He will print them without a doubt, for he cares not what he puts into the Press.

The Merry Wives of Windsor.

Pity the poor leader writer. Told to write a seemingly terrible number of inches (called *ems* by the initiated), rejected by his readers for the rival claims of the advertisement opposite, or the savoury tit-bits of the gossip column following, his sole consolation are delusions of grandeur as he proudly thumps out the editorial *we* on his typewriter. We, also, never read these editorial articles until we came to write one of our own. Bogged down in our particular Slough of Despond, yclept Cliché, we came to realise too, that one's difficulties lay not only in a not unoriginal use of the English language, but also in a choice of subject.

It seems that there are four main classes of subject for this page. Firstly the Grand Slam or "HATE." Something is wrong in this rotten world, the stinking abscess of corruption cries out for drainage by the editorial sinus forceps. For half a page our writer examines the situation with the ruthlessness and thoroughness of the Sunday Press. At last the line of treatment is clear; to follow this is to regain the golden age of one's dreams. But who does? Do we sit less in armchairs, or look less at Television, or resolve not to emigrate? The only people who really benefit from this display of spleen are the writer's friends, if he has any by then, as this particular topic of conversation is, from that moment, "out."

Then there is the airy-fairy arty-crafty editorial, headed with quite inappropriate quotations. This variety is harmless. Thirdly, one can be ever-so-up-to-date in medicine itself and take a leaf out of the other journals by discussing latest trends, or that hardy perennial, medical education. "He who can, does: he who can't, teaches" said G.B.S., to which a wag added "and he who can do neither, talks about teaching." Strictly this may be true, but it would be unfair to our editor to rule this out of court as a topic for the month. Thankfully at the moment there are few new ideas about how we should be educated. We will leave the whitened bones of this subject, therefore, to be picked by a successor.

Lastly there is the *Journal* itself, and as it is our text for this month (do we see you all turning over?) we shall say little about its potentialities or relevance as a subject.

This month we publish an article on the first volume of the *Journal* and we hope, as part of the celebrations of our diamond jubilee, which falls due this year, to follow this with a more general survey of its history. The surprising thing on reading the older issues is to note their sense of continuity with those of the present day. The older journals, with qualified men for their editors, may have possessed a more adult tone, but

lacked, we like to think, some of the necessary irresponsibility and roughness of their undergraduate-sponsored successors. Present day editors may think they stamp their personality deeply on their issues—thus in the past few years it has not been difficult to detect admiration of Pope and Swift, Oscar Wilde and Bernard Shaw and of Sidney Smith on this page, and perhaps at this moment its tone seems desperately teutonic—but much of this impression is illusory. To a large extent the choice of articles is dependent on the contributions received at that particular moment, and moreover there is always the gently restraining influence of the Publication Committee, albeit catholic in its tastes.

In the past editors frequently bewailed the lack of contributions. Thus we find this page sometimes headed: "On the importance of becoming a contributor," or "Bricks without straw." Now, although the number of contributions from the student body is little if any larger than before, we somehow seem at the moment to be well supplied with all manner of contributions, and can even occasionally afford the dangerous luxury of rejecting one of these. The *Journal*, too, is larger than ever before, and thus it is that we can devote more space to the same number of articles; we like to think that our contributors really have the opportunity of getting to grips with their subjects, and do not, as seem so many contemporaries to do, merely skate over the surface of highly involved questions. We have often thought that many of these serious articles, both clinical and extra-medical, are well worth having in permanent form, and would suggest to a later editor the possibility of giving birth to a blue-stocking sister for "Round the Fountain."

One noticeable feature at the present day is the lack of any good humorous writing. We look back with envy on the not so distant times when articles from Alan Tois, Hogarth, G. Harverfordwest (pronounced Harvest), J. Mc. O., and Evelyn Tent appeared regularly every month. Since then no comparable writers have arisen within the hospital. We do still get articles in this genre, of course, but they lack the wit and sparkle, whimsy and inconsequence of the older writers; the modern battle-axe misses the target which the rapier always succeeded in hitting. But apart from this lack, however, the aims and contents of the *Journal* have changed little since its first editor laid them down.

It is not for us to say whether these fine ideals are still followed, but they certainly seem to us to represent a very worthy aim.

Looking through our untidy desk the other day we came across the artistic testament of a former editor, which is worth reprinting. *If the "Journal" ever acquires an office of its own again* (evidently this was written shortly after our forcible eviction from the College Office), *I suggest that the following mottoes should be printed on stiff boards and hung up at suitable points around the room.*"

"Above all, no enthusiasm."

"Every hospital gets the journal it deserves"; and

"There are things of more importance in heaven and on earth than the Bart's *Journal*—except to its Editor."

We cannot now recapture the undertones of psychological trauma which coloured the original *cri de coeur*, but it was evidently deeply felt, The writer was quite right in implying that we owe our life to criticism, especially the rough destructive variety. For example our recent change of cover design has, we hear by devious means, provoked growls from several eminent lions. But do they write and say just how bad it is? Eric Gill's beautiful, if unsuitable, engraving for the pre-war *Journal* provoked much heated and lively argument in these columns; it seems that one of the many enervating effects of the late war has been to make us all too polite and neutral—a most unhealthy state of affairs.

We must also have plenty of contributions, especially from our own ranks. Only by constant selection and survival of the fittest can we ever hope to be true to our original aims, or indeed to raise our standards and keep up to date. Whether this will change the character of the *Journal* is indeed doubtful, and desirably so, but it is the responsibility of all our readers to refute Wilde's half-truth "It is the unreadable that always occurs."

12th Decennial Club Dinner

The Coronation Year Dinner of the 12th Decennial Club will be held at the Naval and Military Club on Friday, May 15, at 7.15 for 8 p.m.

It is regretted that the fourth Friday after Easter, the usual date, is not available at the Naval and Military Club this year.

The Hospitals Cup Match

On another page the Sports Editor—a rowing man, incidentally—has written we know not what on the rugger match versus St. Mary's in the Hospitals Cup. His account is at the business end of the *Journal*. Here, up at the front, we dwell in a literary fool's paradise all of our own, and regard everything that may catch our fancy with the unreasoning eye of the inexpert.

Photo: The Times.

So whatever *he* may say, *we* tell you that we enjoyed this match immensely. The support from the Hospital was most encouraging, and the Charterhouse Band (appearing by courtesy of British Road Services) was suitably cacophonous at the right moments. And the game was rugged and robust. Scott-Brown lost his shorts (almost) within the first ten minutes, two men were on and off the field in the same time, and under the banner headline "Man in Crowd Reset Shoulder," the *Star* later told "the inside story of a touch-line drama" when Mr. Dickson Wright deftly reset Hackett's shoulder after an injury sustained while preventing a certain try. In next to no time, thirty-one panting, heaving chests were demonstrating that this is a game where vital capacity really does mean something, whatever the physiologists may say.

Especially did we enjoy watching the sound, safe defence work of Burrows at full-back, particularly valuable because, it must be confessed, a good seventy-five per cent. of the play was in the Bart.'s half. His achievement is the more remarkable because, though it would be untrue to infer that he was a stranger to rugger, nevertheless at one of the older universities it was in table-tennis (how nearly we called it ping-pong!) that he achieved most fame.

Reveille

As a sequel to a leading article in the *Journal* last year which dealt with the necessity of seeing hospital life through the patients' eyes (inspired, incidentally, by the warding of the then editor with a New Year syndrome) Dr. Malcolm Donaldson has sent us the Ministry of Health's memorandum on "The Reception and Welfare of In-Patients in Hospitals." It was Dr. Donaldson who persuaded the Medical Council to set up a sub-committee with the lamented Sir Holburt Waring as Chairman, to enquire into the

evil of disturbing patients in the very early hours of the morning. Eventually a rule was made that no patient was to be called before 6 a.m., except for therapeutic purposes.

This pamphlet shows an extraordinary humanity for matter enclosed between the familiar white covers of Her Majesty's Stationery Office. Among other matters it deals with reception arrangements, visiting hours, supply of books and newspapers, furnishings and food : matters which we may think of as trivial, but which are to the patient of equal, if not greater, importance than the progress and treatment of his malady. As it says in paragraph three of the book :

It is difficult for those who are familiar with hospital life to realise just how incomprehensible and alarming hospital appears to the outsider. It tends too easily to give him the impression that he has got into the grip of a monstrous machine the working of which he cannot understand and cannot influence.

We cannot believe that these thoughts will ever be inspired by a stay in Bart.'s However, it behoves us all to remember these wise words, and always to think of patients as people and not merely " the first duodenal on the left."

Hot-Diggity-Dawg !

One does not have to be an arrant Communist to look askance at some of the ideas, methods and customs which cross the Atlantic along with Marshall Aid and arms for N.A.T.O. Some of them take a little swallowing. There was, for instance, the little matter of Errol Flynn winning the war in Burma. The latest shock to the staid sensitive British system was an obviously imported advertising stunt.

Under the heading of " The Samba of the New Sausage " the London correspondent of the *Manchester Guardian*, recently described how, on the invitation of a publicity agent, he and two hundred colleagues got up early to go to a Bond Street night club for a *breakfast* party, to celebrate the liberation of the sausage, now 85 per cent. proof. This party had everything—Don Enrico's gipsy band, flood lights, a girl with a tiara and necklace of chipolatas, and, of course, sausages, bacon and egg for breakfast. It was all a bit over-powering even for that hard-bitten profession. As the correspondent wrote : " One does not need to be a fuddy-duddy to have a low tolerance for rumba music at 9.45 a.m."

There was even a vocalist with a topical song. It's too good to miss.

When you come down the stair,
Dance the sausage samba.
You'll forget your breakfast care,
Dance the sausage samba.
Farewell to old fried fish,
Dance the sausage samba.
Here's a good old breakfast dish,
Dance the sausage samba.

He was forgetting that the Englishman, so far from dancing at breakfast time, cannot even make polite conversation at that hour, and solves the problem and salves his conscience by reading the paper.

What has all this got to do with the medical profession ? Nothing—yet. But why should the sausage manufacturers have a monopoly of bright ideas ? Why should the clinician who has made a new discovery be confined to the technical press for his sober publicity ?

The physicians, conservative men for the most part, little given to the dramatics of life, might like to announce their new treatment by way of some poetry—an heroic ode, perhaps, or an epithalamion. The surgeons obviously would want something grander, with more punch to it. Howzabout an opera to launch a noo operation ? Libretto by G. L. Keynes. Or a musical comedy ? Theme song—sung by Cicely Courtneidge—" New Shunts for Old Veins." Lyrics by R. B. Price : plot, such as it ever need be, by Richard Gordon. Boy, it'll sendya !

Honoris Causa

A correspondent has kindly sent us the text of an address given by the Vice-Chancellor of the University of the Witwatersrand in presenting the degree of LL.D. (*Honoris Causa*) to the Minister of Health, Dr. Karl Bremer. Dr. Bremer was at Bart.'s from 1904-1908, and was an active member of the Rugger Club. After twenty years in general practice, he became an E.N.T. consultant and was President of the South African Medical and Dental Council for seven years. He was elected South African Minister of Health and Social Welfare in 1951. Since then, in the words of the Vice-Chancellor :

" He has already placed far-sighted measures on the Statute Book, after little more than a year and has piloted a bill through the House to legalise Post Mortem Examinations and the provision of material for grafting operations." Dr. Bremer is also taking a very active part in the Tuberculosis prevention campaign in South Africa. " It is, then, Mr. Chancellor, on one who has already rendered great services to the community, as a planner not deterred by temporary setbacks, as a man determined to improve the foundations on which the health of the community is based, that I request you to confer upon Karl Bremer the degree of Doctor of Laws *Honoris Causa.*"

Three Hospitals Orchestra

A Correspondent writes:

" Mr. Franz Osborn has been kind and brave enough to play with the orchestra at this concert . . ." So ran a line in the programme note explaining the formation of the orchestra. Perhaps this modesty was advisable, for no one can predict the outcome of a début of this sort : necessary, however, it certainly was not, for the success of the concert could have been foreseen after the first ten bars, and we, who, let it be admitted, had come prepared to tune down our critical faculties for the evening, relaxed our clenched jaws and prepared to enjoy ourselves. For this is what everybody—players and audience alike—did on this occasion and it must certainly augur well for the future success of the orchestra.

The concert opened with Haydn's *London* Symphony (No. 104 in D major). Mr. Norman del Mar gave this a conventional reading without mannerisms, though perhaps the tempo of the finale was a little exaggerated. Sibelius' *Scènes Historiques* had presumably been inserted in the programme for the pleasure it gave to the players and the opportunity to display each section of the orchestra, for there can have been little other justification for this third-rate piece of café music. An overture by Berlioz, such as *Le Corsaire*, would have shown up just as well the uniform excellence of all the departments of the orchestra, and would not have provoked so many yawns as the *langueurs* of the overrated Finn.

After the interval, Mr. Franz Osborn played Beethoven's Piano Concerto No. 3 in C minor, Op. 37, with the orchestra. In this country, with our classic tradition of Mozart concerto playing, we are apt to make our Beethoven too feminine and to neglect his more rugged aspects. No such charge can be laid at Mr. Osborn's door. He infused the piano part with the *Sturm und Drang* which rightfully belongs to it, but was not insensitive to the lyrical demands of the slow movement. The orchestra provided a sympathetic and well-balanced accompaniment, but it was in their last item that they were to reveal their full splendour. This was as exciting a performance of the *Meistersinger* overture as the writer can remember ever having heard. The subtlety of the phrasing and the unique final arrangement of the five themes in counterpoint were so well brought out on this occasion that he fully expected an unseen curtain to rise and the choir in St. Katherine's Church to begin their chorale on the last crashing chord.

We hope now that the orchestra has undergone this baptism of fire that they, with their conductor who is famous for similar work with the Chelsea Symphony Orchestra, will look into some of the by-ways of music and give us works by such neglected masters as d'Indy, Pfitzner and Janàcek. Certainly, on the basis of this night's attendance—though familiar Bart.'s faces were few and far between—they can always be sure of a large responsive audience. Let us hope that it may not be long before we at Bart.'s act as their hosts.

We understand that the orchestra still has need of more instrumentalists. Those interested should communicate with Miss Elizabeth Garrad, who is also the orchestra's librarian—Ed.

Consultations

" Yes, I know Sir Thomas, but I believe in looking at these things from all angles ! " In a letter to this month's *Journal* Professor Hadfield has set the scene of Dr. Geoffrey Evan's famous remark about the E.C.G. Medical and Surgical Consultations are, however, unknown to present-day Bart.'s men, although they are still a memory among our seniors. " The best show in town ! " is the description of one of them.

At these meetings, held every Thursday afternoon, at first in the wards and then because of their popularity in the Theatre, all the great men would gather with their assistants and housemen and attract a crowd of students, qualified Bart.'s men and often strangers. Surgical Consultations began at 1.30 ; the Orthopaedic surgeons could afford to wait, as their operating list would hardly last beyond tea time anyway ! Any surgeon with a difficult or interesting case would present it, inviting his colleagues to examine the patient. This done for all in the crowded theatre to see, the surgeon described his diagnosis and treatment and then each in order of seniority gave his opinion. Among the physicians, however, it was the hard lot

of the junior Assistant Physician to lead off.

In the early days of these meetings diagnostic aids were few and elementary. The E.C.G. was a later innovation. Diagnosis was usually difficult. The clinical experience of the older men enabled them to tower above the rest, for whom there were no path. reports or strips of film with which to challenge authority. We can irreverently guess, however, that they were not above attempting on occasions to confound each other ; in fact, with Professor Hadfield's help we have caught Sir Thomas Horder politely in the act.

Founded in the eighteen sixties, Consultations had changed little when they faded out between the wars. They grew up at a time when diagnosis, however hard, was becoming increasingly reasonable. A surgeon of 1888 remarks that in his student days " elsewhere " the surgeons consulted behind closed doors and gave no reasons for their conclusions. The system had the great merit of associating the consultants and the whole staff with the student body. The hospital in the students' eyes had its focus, it hung together and its character and quality were published from the housetops. When in recent years diagnosis became simplified by a host of new techniques and the great men were driven to specialisation, Consultations declined in value, and any remnants were obliterated by the war. We more than regret their passing. This is one of several things we hold against the E.C.G.

Bibliography

We have been sent a copy of a bibliographical check-list of the works of Philip Gosse, compiled by Raymond Lister, and adorned with a frontispiece—a silhouette of this distinguished son of Bart.'s. It came to us as rather a shock on reading the introductory note, to realise that Dr. Gosse did not embark on an author's career until well past forty. It is good news indeed that he has promised us an article for our special Coronation Diamond Jubilee number in June this year.

The check-list catalogues exhaustively Dr. Gosse's works, not a few of which, we are proud to see, are reprints from the Bart.'s Journal. We would commend to Paul Jennings' notice, should he ever be short of material for his weekly column, such intriguing entries as :

PHILIP GOSSE/GESCHIEDENIS/VAN DE/ZEEROVERIJ/ /ZEEROVERIJ IN DE OUDHEID/DE PIRATEN VAN DE/ BARBARIJSEKUST/ (*colophon*) /VRIJ-BUITER REEKS/I/MCMLII/ N. V. UITGEVERIJ W. P. VAN STOCKUM & ZOON/'—GRAVENHAGE.

or SOCIETY/for the SPREAD of STICKLEBACKS/in SUSSEX./ (*device*) 1932.

The Women's Guild Draw

We are looking forward to hearing on April 29, when the draw is made by the Lady Mayoress, that some poor wretched medical student eking out a solitary bachelor's existence in a room measuring 10 ft. by 8 ft. has won the first prize of an English Electric refrigerator. The situation will be similar to that of the farm labourer who won a large Humber in the motoring competition run last year by the *Daily Express*. However, we expect that English Electric will do the big thing and take the refrigerator in part exchange for a Canberra bomber.

Those who have not yet bought a ticket are urged to buy one (price 1s. 0d.) from the evil-looking people who sell them. Those who have already bought one should buy another. At various intervals throughout the year you are mulcted of your hard-earned shillings for causes far less worthy than this one, so don't begrudge them for the Women's Guild, to which patients and nurses alike have cause to be very grateful. Anyway, if you've no use for a fridge, there's always the case of champagne, or the six-guinea perm., or the *dîner à deux* at Kettner's, or a double ticket for the Coronation Ball. . . .

Bart.'s men who are out of reach of the " evil-looking people " may buy tickets until April 22 by application (with money!) to the Editor.

Congratulations

to Mr. Hume on his election to the Council of the University of London Senate. We believe with this appointment the hospital is unique in its large representation: the other two Bart.'s members are Dr. C. Harris and Mr. Tuckwell.

to Ian Tait on his engagement to Miss Janet Nye.

to Gordon A, Reed on his engagement to Miss C. Elizabeth Philips.

Contributor

Dr. Christopher Maddox qualified from Bart.'s in 1936 (M.B., B.Ch., Cambridge) and after having held Resident appointments he went out to Central China to work at the Henrietta Bird Memorial Hospital at Langchung, Szechwan, under the auspices of the China Inland Mission. At this hospital he and his wife worked continuously for many years and helped to train Chinese students and nurses ; more recently, in common with other English people, they were ordered to leave the country at short notice. Now Dr. and Mrs. Maddox are at Kampala, Uganda, and are finding it quite a different country as far as the climate is concerned, and probably in other ways as well. His article in this month's *Journal* is an interesting account of one of the many cases with which he dealt in China.

The Wessex Rahere Club

will hold its Spring Dinner at the Castle Hotel, Taunton, on Saturday, April 18th. Further details from the Hon. Secretary, Mr. A. Daunt Bateman of 3, The Circus, Bath.

View Day

will be on Wednesday, May 13th.

TYPHOID FEVER AND CHOLECYSTITIS

By CHRISTOPHER MADDOX, M.D.

ALTHOUGH cholecystitis is a definitely recognised complication of typhoid fever, it is perhaps not very generally recognised, nor is it frequently reported in the medical literature.

Cholecystitis is associated with typhoid fever in one of at least four ways :

1. Acute cholecystitis may develop as a complication during the course of typhoid fever. Since Gilbert and Girode first drew attention to this in 1890 (Ref. 1) it has been frequently noted, and reported mainly in the foreign literature. Like many other of the various complications of typhoid, the possibility needs only to be borne in mind for it to be recognised; but failure to recognise it may have grave consequences. (Ref. 2).

2. Acute cholecystitis may be the condition for which the patient seeks advice and is treated, the underlying typhoid infection being discovered at a later date. Rubenstein illustrates this with an account of a student nurse who developed typhoid fever. Enquiries to find the source of infection revealed that in the previous four weeks three patients had been treated for gall-bladder disease in the ward where the nurse worked, and that one of these who had had a cholecystectomy for acute cholecystitis had a positive Widal reaction and positive stool culture six weeks after operation. Review of the history and symptomatology made it clear that this patient had in fact had typhoid fever, with acute cholecystitis as a complication. (Ref. 3).

3. Acute cholecystitis may develop years after a typhoid infection which may or may not have been recognised at the time. (Ref. 4).

4. Chronic cholecystitis and cholelithiasis may be found in chronic typhoid carriers. (Ref. 3, 5).

The treatment of cases falling into groups three and four is on the usual lines for the inflammatory process, but their importance lies in their potential infectivity and the risk for nursing staff and others associated with their care.

Rubenstein finds that acute cholecystitis complicating typhoid is reported most commonly in children (Ref. 2). Other writers report that in such cases there is a high incidence of perforation of the gall-bladder—a serious eventuality. Thomas reported 39 out of 154 cases (Ref. 6), and Liège and Folliasson reported 16 out of 35 cases in children (Ref. 7). So, as with acute appendicitis, early recognition and early treatment is important in all cases, and especially so in children.

The following is reported as a case of acute cholecystitis complicating typhoid fever which was successfully treated by simple cholecystostomy.

CASE REPORT

L.Y.M. a Chinese male office worker, aged 28, was admitted to the Second North Szechwan Hospital on 20.7.51. He gave a history of two weeks' illness which he described as malaria, starting with fever on alternate days. He had been treated for malaria (probably with atebrin), and later went deaf. The fever continued; he developed a cough and some sputum, and marked constipation.

On admission the temperature was 102° F., pulse 88, respiration 24. Positive findings on examination: there was marked impairment in hearing—he could hear when addressed in a loud voice. He was not stuporose (nor at any time subsequently). In both lungs rhonchi could be heard scattered throughout. The spleen was markedly enlarged; there was some tenderness in the right hypochondrium. Blood examination showed R.B.C. 4,600,000. Hb. 98%. W.B.C. 7520/c.mm. Malarial parasites were not found. There was some albuminuria and a few granular casts were reported.

Progress: after admission the temperature fell to 95° which suggested a diagnosis of malaria, but this fall was probably due to aspirin (0.3 gm.). The next day the temperature rose again to 103.4° and continued to rise to 104° and a maximum of 105.2 on one occasion; there was one major remission in this period, again probably due to aspirin. The pulse rate ranged 90-110, and respirations were about 30. In repeated blood films parasites were not found; the white blood count was falling; Diazo reaction of the urine was negative; there were no facilities for blood or stool culture, or Widal reaction. Slight cough persisted without any more marked signs in the lungs. There was also some diarrhoea; the abdominal pain became more severe with distension and rigidity, more marked on the right side; at one time the possibility of typhoid perforation was considered.

Three days after admission, with a tentative diagnosis of typhoid fever based on the continued high fever and deteriorating general condition, the use of chloromycetin was advised. When this was started two days later the temperature had already fallen to 101–102°. A total of 9 grams chloromycetin was given in three and a half days. On the first day the temperature rose again to 104° and then fell to 100–101°. There was marked improvement in the general condition and the patient declared that he was well; hearing gradually returned to normal, appetite returned and was difficult to control.

For the next two and a half weeks the general condition continued to improve but swinging fever developed, being sub-normal every morning and rising to 101–103° every afternoon. Tenderness, rigidity, and a suggestion of a mass in the right hypochondrium, persisted. Repeated white blood counts were low, 3,250 to 4,850; moderate anaemia had developed—R.B.C. 2,770,000, Hb. 58%. Repeated examinations for the malarial parasite were negative and the empirical use of paludrine was without effect. 500,000 units of penicillin given in two and a half days had no effect. X-ray screening of the chest showed no abnormality except slightly diminished movement of the right diaphragm. Although the pain, tenderness and swelling of the right hypochondrium were definitely less, it was thought there must be some active lesion to maintain the fever; continued low white blood count did not support the diagnosis of a sub-phrenic abscess which was suggested on the supposition that there had earlier been a small perforation which healed itself. On a tentative diagnosis of cholecystitis or possibly sub-phrenic abscess, exploration was advised.

Operation, 17.8.51. Under general anaesthesia the right hypochondrium could be more accurately palpated and a smooth rounded tumour was felt. A two and a half inches obliquely transverse incision was made over the tumour and on opening the peritoneum a tense gall-bladder presented, surrounded by omentum and peritoneal adhesions. Aspiration produced thick dark dirty-green bile—a smear subsequently showed large numbers of short chain streptococci and gram-negative bacilli. The gall-bladder was drained and the wound closed in layers.

The day after operation the temperature rose again to 104.6° and the pulse increased to 110; thereafter temperature and pulse fell gradually to normal, and remained steady. On the second day the bile draining changed to clear amber colour. The drainage tube was removed on the tenth day and the biliary fistula healed spontaneously in a few days. Further convalescence was uneventful and the patient left hospital fully recovered about three weeks after operation, that is about seven weeks after admission and nine to ten weeks from falling ill.

DISCUSSION

Diagnosis. With limited laboratory facilities the diagnosis was not established beyond doubt. Malaria, or other parasitic infection can almost certainly be ruled out. Primary acute cholecystitis must be considered, but the clinical course, enlarged spleen, and low white blood count were not like acute cholecystitis as usually seen. Except for the absence of any stupor, the picture was averagely typical of enteric fever and the diagnosis of typhoid fever complicated by cholecystitis, seemed the most reasonable.

Treatment. In the literature it seems that cholecystectomy is the treatment of choice, when possible. But where this is not possible, cholecystostomy avoids the serious risk of perforation, though cholecystectomy may be necessary later to deal with a chronic carrier. (Ref. 2).

I have not found in the literature any account of the effect of antibiotics on such cases. Dr. Mao, who had used chloromycetin effectively in a number of cases of typhoid, said he had not found it of much effect in the complications. (Personal communication). In the case reported here there was no obvious effect. It may well be questioned whether dosage was adequate, but it should be noted that, largely for reasons of expense and supply difficulty, it is customary in inland China to use potent preparations in smaller doses than commonly used in England, and that these smaller doses seem equally effective. It would be interesting to know the experience of others in this type of case.

In the case reported, cholecystostomy led to a clinical cure, but it is impossible to discover whether the patient has become a chronic carrier.

SUMMARY

The association of typhoid fever and cholecystitis is briefly reviewed. A clinically diagnosed case of typhoid and acute cholecystitis is reported. Treatment by operation and chemotherapy is briefly discussed, and it is suggested that the role of chemotherapy in prevention and treatment of complications needs further investigation.

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SUB-CRANIAL LIPOMA

To H.W., who after two years' obscure nervous symptoms was brilliantly diagnosed, operated upon, and restored to health by a well-known London surgeon from "another place."

Your efforts to hoax all those medical blokes
Shewed a somewhat malign form of humour;
It is pleasant to find what you had on your mind
Was only an innocent tumour;
It is now common tattle that Ordeal by Battle
The blight on your brain has combated,
But I'll witness on oath this lipomatous growth
Proves you, not the doctors, the fathead!

R. B. PRICE.

BART'S IN 1893

As seen in the first volume of the "Journal."

We've a Paper, you know, at the Hospital now,
Only just lately it made its first bow;
Not before it was wanted, I think you'll allow.
For a tanner you can usually spot it.
It reads very well in a sort of a way,
And when made a bit brighter is likely to pay;
Just at present it's a little too h'm-h'm, they say,
D'you know what?
Scientific?
You've got it!

So ended the duet sung by Messrs. Gale and Birdseye at a concert given by the Smoking Concert Club in the French Room of the St. James' Restaurant, Piccadilly, on December 2, 1893. It was well received and an encore demanded, though whether the audience was approving the birth of the *Journal*, or supporting the complaint about its contents, no record remains.

Volume 1, Number 1, is dated October 14, 1893. It cost 6d., with an annual subscription of 5/-, was published from the Hospital and was printed by a firm with a long connection with Bart.'s, Adlard and Son, then of Bartholomew Close. The first editorial tells us something of its genesis, and shows that the *Journal* is closely linked with the foundation of the Amalgamated Clubs.

Apparently there had been an attempt in the 1870's to publish a monthly paper, which came to nothing. In 1885 a "serio-comic journal in manuscript" ran for six issues: then it, too, "deservedly retired into obscurity." In the summer of 1892 the Amalgamated Clubs were put upon what is substantially the present basis, replacing, for financial purposes, the hitherto autonomous students' clubs. They soon found their feet, showed a surplus of £200 in the first 12 months, and in May, 1893, decided to start the *Journal*. According to an article by Mr. (later Sir) Anthony Bowlby in November, 1893, the leading part in suggesting and organising the amalgamation was taken by W. M. Borcherds, who was to become the first Editor.

His first Editorial is capped by a quotation from the *Odes* of Horace, which was to linger on for many years.

Aequam memento rebus in arduis
*Servare mentem.**
Book ii, Ode iii.

He starts in a very matter-of-fact way: no sugary sentiment or declamation of high ideals for him. "The objects of the *Journal* are . . ." to record clinical and academic work and lectures done and delivered in the Hospital and not recorded elsewhere; to promote and extend the feeling of *esprit de corps* among past and present students; to keep up the interest of old students in the doings of those at the Hospital; and finally, and most hopefully, "to give publicity to anything original in the way of articles, verse, or drawings, and to act as a means by which those who write may learn to perfect themselves in that art, before they plunge into literary work in a wider sphere in after life."

He goes on to explain how the *Journal* came about and concludes humbly enough: "We ask the indulgence of our readers for any shortcomings in this, our first issue, with the promise that we will do all that we can to improve in the future. Our excuse is not want of time, but lack of experience."

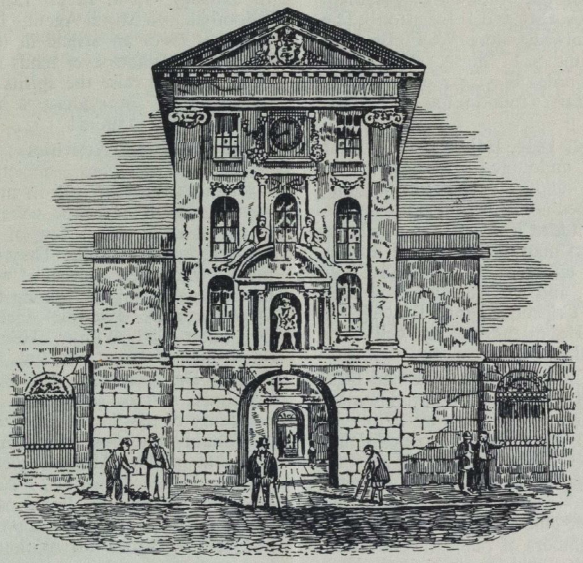
He need not have been so self-effacing, for the standard of the first twelve issues is surprisingly high, considering that he was starting an entirely new venture with no previous experience. The *Journal* was, perhaps, a little too "h'm-h'm," but then it still is, and will probably remain so. It is pleasant to record that while still in office the first Editor passed Conjoint and was well on the way to a Cambridge degree.

It would be interesting to review the activities of the personalities, clubs and societies of the Hospital as depicted in the first volume.

* The Ode to Dellius.

Brace thee, my friend, when times are hard
To shew a tranquil mind.

Why this lugubrious quotation was used to send the *Journal* on its way it is impossible to discover—unless there was more acrimony and difficulty over its beginning than the records reveal.



The Amalgamated Clubs

The founder clubs were the Athletic, Boxing, Cricket, Association Football, Rugby Football, Boating (*sic*) and Swimming, in association with the Abernethian Society. In May, 1893, the Lawn Tennis Club was admitted to the Amalgamation and in October came the *Journal*, which is thus the organ of the Students' Union, and not of the Hospital or the Medical College.

Today all students are compulsory members of the Amalgamation, and pay their life subscription without any option. But at the beginning membership was quite voluntary and Editorial encouragement was given from time to time, exhorting the laggards to join. The particular concern of the Clubs was the purchase of a new sports ground. With the help of the Medical College one was found at Winchmore Hill and there are repeated references to the problems arising out of its acquisition.

Then, as now, students shunned Annual General Meetings. One was held on October 11 and only 20 out of 300 members attended. Somewhat paradoxically the record has it that a vote of thanks to the retiring secretaries was "carried with acclamation." But then "the rest of the business was postponed for the want of a sufficient quorum."

The balance sheet for the year 1892-1893 is interesting. Income was £497, expenditure £332. Grants to Clubs totalled £159, including £40 for rugby, £37 for soccer, £26 for boxing, and £33 for athletics. The Boating Club, being in decline, received nothing. The balance sheet was audited and found correct by two junior members of the staff.

Sport

Our sporting record throughout the year was not one of much distinction, except in athletics. Bart.'s had held the United Hospitals Athletics Shield from 1885 to 1892, so that contemporaries "had come to look upon it as a permanent ornament to the Bart.'s Library. Guy's robbed us of it in 1892," but 1894 saw its recovery, "by the substantial margin of six wins and six seconds, to Guy's five wins and four seconds, St. Mary's taking the odd second." Three United Hospitals records were broken, two of them by Bart.'s men, A. Hay and J. Johnston. The other Bart.'s stalwarts were W. F. Bennett, C. V. Cornish and S. F. Smith. The Sports included a five miles bicycle race in which, it would seem, Bart.'s found it too undignified to compete.

In his August, 1894, Editorial the Editor exercised his undoubted prerogative to criticise all and sundry. "Even the winning of the shield does not wipe out the disgrace —for disgrace indeed it is—that in this large hospital, with so many students, we do not at present hold either of the Football Challenge Cups . . . and we are seldom, if ever visited, by the Cricket, Tennis, Rowing, or Rifle Cups." He might just as well have been writing today.

The Rugby Club seems to have had little enough excuse for its defeat by St. Thomas' in the first round of the Cup by 27-0. In November, 1893, the Editor was complaining that though several first-rate football players, who had distinguished themselves elsewhere, had entered the Hospital, they seemed to be playing for other clubs, "and do not intend to be active members of our own club until later on, when they will join in the cup ties." They presumably were soon reminded where their first loyalty lay. However, the Hospital did provide Blackheath with its captain, H. Marshall.

In association football Bart.'s succumbed to Guy's 1-0. It seems that nothing could go right, for after attending the joint football clubs' dinner the *Journal's* correspondent wrote: "Not only was the food bad and meagre, and the speeches little better, but music was conspicuous by its absence. Truly, indeed, there were bucolic voices, but their clang would have risen on any occasion."

In cricket we seem to have done better. Unfortunately, June is the only month in which the Club's matches are recorded, but by then it had won six of the eight it had played, and defeated London Hospital in the first round of the Cup. The Tennis and Swimming secretaries were more energetic in reporting their clubs' activities, but their tales are doleful ones. The Boat Club announced its wakening from a three years' slumber and its decision to enter the Inter-Hospitals Challenge Cup race.

The Editor, though not apparently a great sportsman himself (he figures in none of the teams), was a keen critic throughout the year, and firmly approved of sport and exercise. In January, 1894, in an Editorial entitled "Football as a Moral Agent," he quoted with approval from an article in the *Nineteenth Century*: "Whatsoever tends to quicken the circulation, to raise the spirits and to purify the blood is, *ipso facto*, a moral agent." Shades of Dr. Arnold!

Other Clubs and Activities

The Abernethian Society flourished throughout the year, and its meetings, which were weekly in term-time, were fully reported in the *Journal*, not a few of the addresses being reprinted in full. They were given by many who were already well-known in medicine and surgery, among them Sir Dyce Duckworth, Dr. (later Sir) Archibald Garrod, Dr. (later Sir) Wilmot Herringham, Mr. (later Sir) Anthony Bowlby, Mr. McAdam Eccles, Dr. Ormerod, Dr. Shore and Dr. Kanthack. Plans were being made for the centenary of the Society in 1895.

Probably the most interesting paper read was that by Mr. Alfred Willett on Edward Stanley, F.R.S. Born in 1792, he was made Assistant Surgeon to Bart.'s at 24, became P.R.C.S. twice, and was appointed Surgeon to Queen Victoria. Mr. Willett had been his house-surgeon and his account of the man and his career is a model of lucidity and interest, describing with candour and insight "a man of no transcendent genius, nay, of hardly more than average ability, who, almost without fortune or friends, by his own unaided energy, having a good start in his professional life, so availed himself of his opportunities that he reached the topmost rung of the ladder."

In marked contrast to the grave deliberations of the Abernethian Society were the gay noisy concerts of the Smoking Concert Club. Meeting at St. James' Restaurant about six times during the winter, its talented members sang, played and recited to each other in the traditional Victorian mode, all, it is to be assumed, in an atmosphere heavy with smoke and redolent with the aroma of Havanas. The artistic standards were not particularly high —"Mr. Dick Welch came on again and sang 'Now he's found out where 'e are' and 'Liza's Tootsies,' which brought forth great applause" — but the concerts were very popular with both students and staff.

The Musical Society boasted a Conductor, and Orchestral and Choral Librarians, as well as the usual officers, and during the year entertained at a Conversazione of the British Nurses' Association, joined the Dramatic Society in the Annual Christmas Entertainment and in mid-summer blossomed forth in strength at the Annual Summer Concert in the Great Hall.

The Dramatic Club was the subject of a short historical review in February, 1894. It had been formally inaugurated in 1884, though the first dramatic performance was the production of "Little Toddlekins" and "A Regular Fix" on January 3, 1883. The Christmas Entertainment was not the Pot-Pourri we enjoy today, for there were then no ward shows. It was a concert, jointly put on with the Musical Society, for the benefit of nurses, students and staff. One of the disadvantages under which the Club laboured was the persistent refusal of the College authorities to allow any women to take the female parts in its productions. In 1890 it had been very ambitious with "The Merchant of Venice" and "The Critic," but these must have been too much for their audience, and by 1894 the Club was back to "Little Toddlekins" standard with "Freezing a Mother-in-Law" and "Not such a Fool as he Looks." The Club also used to undertake something called "Inquest Room Entertainments," which may not have been so bad as they sound. No wonder that "a short time since one of the very few who were opposed to the Club, expressed his opinion that members . . . were only saved from the mischief that Satan finds for idle hands to do by rehearsing for the Christmas Entertainment. We are happily in a position to refute this charge, for we have gone carefully through the careers of past members, and find that many of them now hold high positions, that gold medals, scholarships and honours have by no means infrequently been gained by our members and that 95 per cent. of past members have qualified." And the odd 5 per cent. presumably, did very well on the stage.

Other clubs which still flourish actively participated in the life of the Hospital 60 years ago. The Photographic Society had an exhibition early in November, 1893, and one part of it was set aside for the technical work of the Society—the photographing of cases from the wards for the Museum. This is a task which has now been taken over by the Department of Medical Photography.

The Cambridge-Bart.'s Club held its eighteenth dinner at the Café Monico, also in November. Dr. (later Sir) Norman Moore was in the Chair and the diners, as usual, provided their own entertainment. "Drs. Glover and Stack sang several songs, and Mr. Maitland gave the song which commemorated the foundation of a college by Dr. Caius. Dr. Moore entertained the company with a piece of Irish folk-lore, which was received with great interest and applause."

The Decennial Clubs were a flourishing feature of old Bart.'s social life. The First Club was inaugurated in 1816 and the July 1894 *Journal* announces the demise of the Fourth (whose members joined the Fifth). The Fifth, Sixth and Seventh all announced and held dinners, and steps were being made to start the Eighth.

We can also read of what may well have been the first Hospital Ball. In December, 1893, a student wrote: "A dance, I think, would be hailed by many of us with great satisfaction. Would it not be possible to get up something of the sort?" But he hastened to dissociate himself from all responsibility, for he ended: "Trusting that this suggestion will be taken up by someone more capable than myself . . ." It appears from subsequent issues that the idea was encouraged by the wives of two members of the visiting staff and in May it was announced that "a dance will be held under the patronage of Lady Lawrence at 77, Harley Street, by the kind permission of Mr. and Mrs. Walsham, in aid of the Samaritan Fund of St. Bartholomew's Hospital." Dancing was to be from 9 p.m. to 2 a.m., and the price of tickets was to be: Ladies, 7/6d.; Gentlemen, 10/6d.; *two* Ladies and *one* Gentleman, £1 1s. 0d. It duly took place, was adjudged a great success and £15 6s. 0d. was given to the Fund.

Our predecessors seem to have been more convivial than we are today, for the *Journal* contains the records of various social functions which we no longer enjoy. Prominent

among them was the Stewards' Feast, held every two years in the Great Hall, to which the Stewards seem to have invited everyone connected with the Hospital and Medical College down to and including Junior Registrars. It was also known as the "Buck Feast," venison always being one of the chief items on the menu. The Old Students' Dinner —a casualty of the recent war which still has to be revived—was also held in the Great Hall. View Day was another occasion for a dinner, given by the Treasurer to the Governors, Visiting and Resident Staff, and Prize Students; while the retiring resident members of the Junior Staff gave a farewell dinner for fifty people on March 29, 1894. It was followed by a concert until 11.30 p.m. "The concert over, the company divided itself—a few went home, some untoothed the sorrow of parting with the aid of cards, while others solaced themselves with a keenly contested game of football, played in Smithfield, and followed by a concert at Mackenzie's."

The Nurses

There are not many references to the nurses in the first volume. At the View Day Dinner in 1894 Sir Trevor Lawrence said that though the number of in-patients was the same in 1884 as then, the number of nurses had increased from 117 to 303. (It is now over 600.) It would seem that they attended the Abernethian Society in greater strength then than now, for the introductory address by Mr. Henry Power, F.R.C.S., on "Observation" was attended by Matron, several Sisters and rather more than 100 of the nurses.

In April, 1894, the Editor records with approval that the Matron, Miss Stewart, "upholds the cardinal principle of *mens sana in corpore sano*, and recommends golf and other outdoor exercises for nurses," while in June she is recorded as having started a Debating Society for the nurses. Miss Stewart was obviously a lady of some eminence among those of equal rank, for in July she was elected the first "chairman" of a new nation-wide Council of Matrons, in the formation of which she had been the foremost advocate.

Famous Bart.'s Men

The first issue of the *Journal* records the presentation to the Governors by his colleagues and pupils of an oil-painting of Sir William Savory, consulting surgeon to the Hospital. He had been elected P.R.C.S. four times and was surgeon-extraordinary to Queen Victoria. The record of the presentation ends with the somewhat ambiguous remark: "He was the great opponent to Listerism (not antiseptics) when it was introduced by that great surgeon."

The retirement of Dr. Andrew, the senior physician, is also regretfully recorded, and at a ceremony in July he, too, was presented with his portrait which he then entrusted to the Hospital. The record leaves one in no doubt of the affection and esteem felt for him by both students and staff.

Among the students' achievements the most notable was that of T. J. Horder, who was just starting his clinical course. During the year he won the Hichens, Harvey and Wix Prizes, and the Senior Scholarship in Anatomy, Physiology and Chemistry, took first place in Honours Physiology in the B.Sc. examination, and passed the First F.R.C.S. examination. The late G. E. Gask, who was Professor of Surgery here, Director of the Surgical Unit, and one of the originators of the medical and surgical unit system, also distinguished himself in the prize and examination lists. P. Horton-Smith (later Sir Percival Horton-Smith Hartley) was appointed house-physician to Dr. Gee, and M. G. H. (now Sir Matthew) Fell and the late-lamented Josiah Oldfield figure in the examination lists, among others whose names have a familiar ring.

Such, then, was Bart.'s sixty years ago, as recorded in the first volume. The very first article, by Sir Dyce Duckworth, was entitled, appropriately enough for a hospital journal, "On Clinical Aptitude." The last was "A Reminiscence of Forty Years Ago," by Dr. Elizabeth Blackwell, of whom you will read elsewhere in this issue and who begins thus: "Among the most honourable records of the ancient foundation of St. Bartholomew's is the admission of the first woman-physician to the full educational advantages of the Hospital."

For sixty years the *Journal* has noted these "most honourable records" as they have occurred, and with the passing of the Hospital *Reports* it is the sole official publication emanating from Bart.'s. Its bound volumes are the richest mine of recent Hospital history—a never-ending source of information, interest and — as *Round the Fountain* will witness—delight. That they should continue to be so is the responsibility of all Bart.'s men.

I.H.B.

COMPETITION

By kind permission, we reproduce in the form of a Readers' Competition the paper for the Stephen Potter Medal and Prize. Only one entry was received this year, that of a gentleman of quality who refused to take the examination on his own because, as he said, it seemed unsporting. Readers will be spared the ordeal of the usual time limit in this paper (ten minutes) but are warned that an unusually high standard is expected in entries. The final decision will rest in the hands of the gentleman of quality to whom we refer above and who informs us that he is looking forward to some amusing attempts. The usual prizes will be awarded.

STEPHEN POTTER MEDAL AND PRIZE
1953

February 29 — 10 to 10.10 a.m.

Q.1.	(Preclinical)	What led **you** to take up Medicine ?
Q.2.	(First Year)	The new Registrar fagged for you at school. Exploit the situation.
Q.3.	(Second Year)	A Visiting Physician mistakes you for his new houseman and invites you to dinner. Discuss.
Q.4.	(Final Year)	By accident and unknown to yourself you are elected unopposed as President of the Abernethian Society. Greet the announcement.
Q.5.	(Failed M.B.)	Why ?
Q.6.	(Compulsory)	You win the Stephen Potter Medal and Prize but you are not offered the usual house-appointment. Explain.

Candidates are requested to write their names and schools distinctly on the top of each page and also on the outside of the folded paper; to begin each question on a fresh page; to place the answers in the order they consider most important and to number the pages. Marks will not be lost for careful handwriting but the use of typewriters is recommended to all but Final Year candidates. A continuous photographic record will be made of the movements of all candidates during the written examination. Successful candidates must be prepared to present themselves for vivas at short notice.

Though readers may not believe it, this is a proper Competition, for which the usual prizes of book tokens will be awarded. Two questions only to be attempted. Entries to A Gentleman of Quality, c/o The Journal, by May 15th.—ED.

POPULAR FALLACIES IN MEDICINE

By P. F. LUCAS, M.D., M.R.C.P.

continued

Causes of blood-stained pleural effusion: Lord Horder (1921) said: "The commonest cause of blood-stained pleural effusion is not malignant disease of the lung or pleura, but the commonest cause of pleural effusion in general—tuberculosis." Gee (1908) had also noted that ". . . it occurs in some cases which rapidly recover . . ."; these are mostly the result of infarction of the lung.

Significance of bronchophony and pectoriloquy: These valuable physical signs seem to be a blind spot for many students. All appreciate the importance of bronchial breathing and all have difficulty in distinguishing it, yet few make use of nature's kindness in providing two confirmatory signs.

Treatment of Dicoumarol Overdosage: James, Bennett, Schienberg and Butler (1949) demonstrated that water-soluble preparations of vitamin K (the only ones in general use in this country) have little action in this condition; they did show that pure vitamin K1 oxide in large dosage is effective. Until this drug recently became available in this country fresh blood transfusion was the only means of relieving this dangerous hypoprothrombinaemia. Now that vitamin K1 oxide is more freely available it is good to find Toohey (1952) confirming James *et al.* in their opinion of its great superiority, even when given by mouth, over water-soluble preparations.

The Meaning of Malignant Hypertension : This term may mean primary malignant essential hypertension, a disease which usually occurs over the age of 40 and which may prove fatal within a few weeks ; or it may mean a syndrome of hypertension associated with papilloedema and renal failure arising on hypertension of any other cause —benign essential hypertension, perhaps of some years' duration, chronic nephritis, or pyelonephritis, Cushing's syndrome or even coarctation of the aorta or suprarenal tumour. The diagnosis of malignant hypertension of any type is made by the demonstration of its specific pathology — acute arteriolar necrosis ; the presence of this lesion may be deduced from the presence, with hypertension, of papilloedema and renal failure (Pickering *et al.*, 1952). That secondary to so-called symptomatic hypertension is probably commonest, especially under the age of 35 years (see Platt, 1948, and Platt and Davson, 1950).

Treatment of Pulmonary Congestion : The oedema of the lungs when the left ventricle fails is comparable to the peripheral oedema of right ventricular failure. Its relief requires almost identical measures and is usually more urgent. Restriction of salt in the diet and administration of digitalis and diuretics will generally provide relief in either case. A student who will not fail to prescribe them for peripheral oedema often boggles at pulmonary oedema.

Distinction Between Cardiac Impulse and Apex Beat : These terms are not synonymous. The first is the movement caused by the contraction of the heart, the second is a point—that point furthest downwards and outwards at which the cardiac impulse can be clearly felt. Valuable information will be lost if the attention is not focused on each separately (see Horder and Gow, 1928).

The Occurrence of Pulmonary Infarction : The misconception that thrombosis in leg veins, and consequent pulmonary infarction, is primarily a surgical and obstetrical problem is dying hard. Short (1952) found that of 120 consecutive cases of pulmonary infarction 70 occurred in medical wards (2.5 per cent. of all admissions), 30 in surgical and 20 in obstetrical. The classical pleuritic pain and haemoptysis were present in only a minority. 80 per cent. of the medical cases had heart disease. Discomfort in the chest, dyspnoea and tachycardia were common. Pleural effusion was present in 20 per cent. Physical and radiological signs were often transient or absent; the classical wedge-shaped shadow was seen in only four cases (Short, 1951). Diagnosis must depend on awareness of the conditions in which it is common (British Medical Journal, 1952). Stasis is the main factor. Who fails to anticipate the dangers of bed rest (Asher, 1947) allows potential emboli to form in his patients' legs.

(To be continued)

STAFF APPOINTMENTS

The following appointments to the Junior Medical staff have been made with effect from the dates indicated :

Diagnostic X-ray Department	
Registrar	Dr. B. Green, from 1.2.53 (vice S. J. Hinds)
Ophthalmic Department	
Refraction Officer	Mr. H. J. R. Thorne (vice H. B. Jecobs)
Junior Surgical Registrars	
Mr. Corbett's firm	Major Grant, as locum from March to July. (vice D. A. Watson)
Mr. Naunton Morgan's firm ...	W. M. Keynes, for one year from date to be arranged. (vice J. H. Roberts)
Junior Medical Registrars	
Dr. Cullinan's firm	Miss E. S. Tomlinson, for one year from 1.3.53, (vice R. C. King)

ELIZABETH BLACKWELL

(concluded)

The news excited much attention throughout America. Her scoffers were compelled to admit that this small, pale figure, in her black brocade gown, black silk stockings and gloves made an imposing and dignified sight as she bowed before the President. He rose, doffed his mortar board and substituting "Domina" for "Domine," presented her with the diploma. Even in England the event was reported in the papers, and Punch hailed the fair M.D. in a poem of seven verses, even suggesting that the ladies of England might follow her example:

Young ladies all, of every clime,
Especially of Britain,
Who wholly occupy your time
In novels or in knitting,
Whose highest skill is but to play,
Sing, dance, or French to clack well,
Reflect on the example, pray,
Of excellent Miss Blackwell!
Ye bachelors about to wed
In youth's unthinking hey-day,
Who look upon a furnish'd head
As horrid for a lady,
Who'd call a female doctor "blue";
You'd spare your sneers, I rather
Think, my young fellow, if you knew
What physic costs a father!

Doctor Elizabeth Blackwell, one might suppose, would want a rest—but she was immediately anxious to set off for Europe. Her brother, Samuel, records in his diary: "Sanguine, and full of confidence, obstacles overcome this far only make her more resolute in her course ; she told me I could not conceive how intensely she desired to be at work. Even the two weeks at home seemed like lost time."

It was still early spring in 1849 when Elizabeth embarked on her journey for Europe. Her American passport stated that she was 28 years old, 5 feet 1½ inches tall that her forehead was high and full, her eyes light grey, her mouth large and her hair sandy.

In England she was received by the Staffordshire Blackwells, a wealthy and influential family, owners of the Russell Hill Ironworks in Dudley. She was escorted to London and for the first time since she began her unique career she was accepted into Society. She was fêted and flattered. The ladies of fashion were intrigued. She was the daring little doctress from America and there she was to their great surprise, a tiny blonde creature in pale blue taffeta, dancing with flowers in her hair and a modest crinoline.

Elizabeth was enjoying every moment of living. She visited several hospitals, met the leading London doctors of the day, drank her first glass of wine and loved it, and was invited to dances in the elegant West End drawing rooms. "Indeed, engagement treads upon engagement, so that I've hardly a moment to think . . . I've never had such an experience ; I must have walked ten miles a day. I come home sometimes hardly able to move a foot : I wash and dress, and in an hour I'm up again and fresh for as much more."

Next month, on May 21st, she arrived in Paris with few possessions, a slender purse and some letters of introduction to the leading men of medicine in Paris — but they hardly benefited her. None of them would recognise her status as a doctor and after failing to gain admittance into the Hôtel Dieu and L'Ecole de Medicine she was finally received at the end of June in La Maternité, the greatest lying-in hospital of its day. She was not, however, admitted as a registered doctor, but as a lowly aide. Here she was cloistered for five long months. She shared a dormitory with sixteen rowdy peasant girls who chattered and romped day and night. Swallowing her pride she undertook the most menial tasks, and for the first few weeks she was permitted to do no more than carry basins of water and towels for the senior students.

But all the time she was training her powers of observation—years later, in a letter of advice to her sister Emily, she says, "the most important thing in the Maternité is the drilling in the more ordinary labours, for only where the finger is thoroughly trained can you detect varieties."

But misfortune again befell her. On November 4th of that year, 1849, we read this in her journal. "I felt all the afternoon a little grain of sand, as it were, in my eye. I was afraid to think what it might be, for in the dark, early morning, whilst syringing the eye of one of my tiny patients for purulent ophthalmia, some of the water had spurted into my own eye. It was much swollen at night, and in the morning the lids were closely adherent from suppuration." Within three days the sight of her left eye was lost. Even this disaster was met by her characteristic refusal to accept defeat and, hoping to regain full vision in time, she wrote to an uncle, "I still mean to be at no very distant day *The first lady surgeon in the world*."

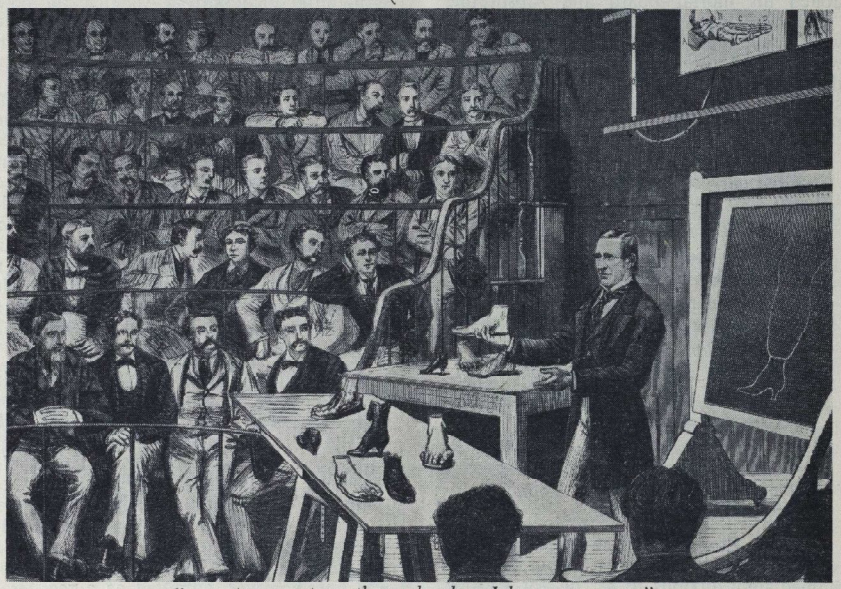
But she never recovered sight in her left eye and after a brief inner struggle she reconciled herself to becoming a physician.

Early in May, 1850, Elizabeth Blackwell returned to London. Mr. Kenyon Blackwell, her cousin from Staffordshire, had by then applied to "the able and highly esteemed Dean" of St. Bartholomew's Hospital, Mr., later Sir James, Paget, for permission for her to study in this Hospital.

To her great joy this was granted and she received a letter of most cordial welcome from James Paget himself.

She hastily obtained lodgings in 28 Thavies Inn; one of a set of houses leading off from Holborn Circus (the house was demolished in the last war). Hence she could walk to Bart.'s in five minutes; down Holborn Hill, up Cock Lane and to a gate of the hospital "that enables me to enter with only a side glance at Smithfield Cattle Market."

"My first introduction to St. Bartholomew's was at a breakfast at Mr. Paget's. He has a house within the hospital boundaries, and a special oversight of the students. At the commencement of each session he invites the students to breakfast in parties of about a dozen, and to one of those breakfasts I, on my arrival, was invited. The students seemed to be gentlemanly fellows, and looked with some curiosity at their new companion; the conversation was general and pleasant, the table well covered; Mrs. Paget very sensible and agreeable; so that it was quite a satisfactory time."



". . . the most gentlemanly class I have ever seen."

(*A lecture at Bart.'s on a pressing subject.*)

She was accorded entry into every department except that of female diseases. Charles West, the Professor of Midwifery, wrote to her saying that he intended no disrespect to her personally, but he heartily condemned her object and could not approve a lady's studying medicine. Mr. Paget, however, was most kind. When she expressed her great interest and desire to attend his Pathology lectures he spoke first to the students and explained her situation. "When I entered and bowed I received a round of applause. My seat is always reserved for me and I have no trouble. There are, I think, about sixty students, the most gentlemanly class I have ever seen." To her sister, Emily, later to be her partner in medicine, she wrote of the experience she gained at Bart.'s. "I spend now about three or four hours each day in the wards, chiefly medical, diagnosing disease, watching the progress of cases, and accustoming my ear to the stethoscope. Already, in this short time, I feel that I have made progress, and detect sounds that I could not distinguish on my entrance. I advise you, Emily, to familiarise yourself with the healthy sounds of the chest. When you go home, auscultate all the family; you will find quite a variety in the sounds, though all may be healthy persons. Lay a cloth over the chest and listen with the ear simply; it is as good as a stethoscope with clean people."

Elizabeth was not entirely uncritical of medicine as practised at Bart.'s. She missed in London the active spirit of investigation that was so alive in the French amongst students and Professors alike. She recalled the ardent discussions which she used to enjoy while sitting in the Luxembourg gardens and the enthusiasm which was occasioned by every new topic or discovery, and she compared this with the conservative plodding of the British physicians, who would accept no new theory unless proved several times over. She respected their good sense and clear, substantial thought, but reserved her greatest admiration for the eloquent French.

At the end of a year she left Bart.'s, esteemed by all. Mrs. Paget described her as a benefactor of the race and Mr. Paget told her how sorry they were to lose her.

In July, 1851, she sailed for America, only two years since her departure, but with "another most important page in life fairly closed."

Most of her work had not even begun, but she had achieved her most desired ambition, to open the Medical World to Women—and what better, more noble pioneer could we have chosen to represent us.

How thoroughly she had fulfilled her task is realised when we consider that less than sixty years after she had qualified there were more than 7,000 women practising medicine in America alone. But St. Bartholomew's, having once said farewell to Miss Blackwell, stood firm against all subsequent invasions, and not until 1947 did the University Grants Committee compel the Hospital to surrender. We all hope, however, that the further passing of time will never give cause for us to be like Kitty, Elizabeth's adopted daughter. This child, after the visit of a friendly physician, came to her foster mother with a most puzzled face, and exclaimed "Doctor, how very odd it is to hear a *man* called Doctor!"

JANET NYE.

CORRESPONDENCE

The Editor,
St. Bartholomew's Hospital Journal.

Dear Sir,

Frequently many of us find much difficulty in accurately assessing the asymmetry of chest movement in doubtful cases, which may be often helpful to the arrival at the correct diagnosis. The following simple, accurate method of measurement, like that of "the laying on of hands," is based on the assumption that in respiration the vertebral column behaves as a fulcrum and that the sternum moves to and fro in a sagittal plane.

The tape is placed around the thorax as for the measurement of chest expansion, but with the difference that the ends cross in front. A vertical ink mark is made at the level of the tape, at approximately the middle of the sternum. The patient is arranged flat on his back so as to fix the tape posteriorly. After a full expiration the excursion of the ink mark on each side during a full inspiration is noted. The total chest expansion without moving the position of the tape or patient is measured, using some prearranged mark on the tape instead of the end as is customary. Then the excursion for the expansion of the right side plus that on the left will equal the total, if all measurements have been made correctly. This serves as a check against error and also that the tape has not slipped.

Because the two lesser values are of necessity fairly small, better results will be obtained by measuring in millimetres. After practice and with the aid of an assistant to do the recording, measurements can be made simultaneously on the one inspiration only, at all events a maximum of three respiratory excursions should be sufficient for the most uninitiated. The estimation of respiratory lag on either side must still be made by direct observation.

If it is found that satisfactory measurement cannot be obtained due to the slipping of the tape, the determinations may be made with the patient sitting or standing and the tape fixed against a vertebral spine either by means of an assistant's finger or a piece of adhesive plaster.

Using this method it has been found that there is an apparent physiological difference between the two sides of the chest, the right side having a slightly greater expansion. It would be interesting to have a series of normals to test if this difference is real and if so for reference (expressing the difference as a percentage of the total chest expansion), statistically analysed by age group and sex.

Yours truly,

Abernethian Room. G. C. L Goss.

CONSULTATIONS

Sir,

The story of Dr. Geoffrey Evans and the E.C.G. upside down had a better setting than that given on page 13 of the January number. It was at Medical Consultations, in front of all his colleagues on the Staff, and a multitude of students (of which the writer was one). And it was Lord (then Sir Thomas) Horder who tapped him on the shoulder and drew forth the incredibly rapid reply, "Yes, I know Sir Thomas, but . . ."

The beauty of the occasion was vastly enhanced by the rapidity of the reply which was instantaneous.

Yours faithfully,

G. HADFIELD.

Sheerwater Lodge,
West Byfleet.

The Cambridge Graduates' Club of St. Bartholomew's Hospital.

The Editor,
St. Bartholomew's Hospital Journal.

Sir,

The Sixty-third Dinner of this Club will be held at Frascati's Restaurant on Friday, 17th April, at 7 for 7.30 p.m.—dress, dinner jacket. This particular function of the Club continues, by common consent, to be a purely masculine affair, and Members may introduce male guests. Dr. G. F. Abercrombie will be in the Chair. The Honorary Secretaries would be glad to hear from any Bart.'s man who is a Cambridge graduate but has not received a notice.

Yours, etc.
H. JACKSON BURROWS,
R. A. SHOOTER,
Honorary Secretaries.

EXAMINATION RESULTS

CONJOINT BOARD

Final Examination

December, 1952

Pathology			
Austin, S.	Cowper-Johnson, H. F.	Gibbs, J. T.	Stephenson, J. W.
Blow, R. J.	Eminson, B. I. F.	Lacey, S. M.	Williams, W. D. W.
Keil, A. McL.	France, G.	Smeed, I. M. P.	
Medicine			
Bartley, R. H.	Geldart, R. E. M.	Marker, H. R.	Warburton, T. H. M.
Caldwell, A. M.	Gretton, A. H.	Thomas, P. I.	Wynne-Jones, A. P. J.
Dunger, G. T.			
Surgery			
Caiger, V. G.	Chia, A. K.	Lacey, S. M.	Scott, H. G.
Midwifery			
Brown, I. P.	Gompertz, R. M. H.	Lacey, S. M.	Pearsons, D. E.
Castell, E. O.	Green, A. N.	Luke, M. F.	Stephenson, J. W.
Eminson, B. I. F.	Hill, A. N.	McAdam, B. N.	Thomas, P. I.

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

Bartley, R. H.	Gompertz, R. M. H.	Gretton, A. H.	Wynne Jones, A. P. J.

UNIVERSITY OF LONDON

M.D. Examination

December, 1952

Branch I (Medicine)			
Banks, P. J.	Felix-Davies, D. D.	Jaslowitz, B. W.	Newcombe, C. P.
Branch II (Pathology)		*Branch III* (Psychological Medicine)	
Pugh, J.I.		Folkson, A.	
Branch IV (Midwifery & Diseases of Women)		*Branch V* (Hygiene)	
Burke, S.		Andrewes, J. D. B.	Mayers, J. R.
Branch VI (Tropical Medicine)			
Adams, J. C. L.			

SOCIETY OF APOTHECARIES

Final Examination

January, 1953

Pathology	*Medicine*	*Surgery*	*Midwifery*
Keil, A. McL.	Keil, A. McL.	Keil, A. McL.	Keil, A. McL.

The following candidate, having completed the Final Examination, is granted the Diploma of the Society: Keil, A. McL.

SPORT

Rugger The Hospitals' Cup.

Bart.'s v. St. Mary's. Lost 3—21.

The second round of the Hospitals' Cup, played at Richmond on February 17, resulted in a win for the holders—St. Mary's. They did not have the easy victory the score might denote and had to work hard throughout the game before winning by three goals and two tries. With Cannell included, St. Mary's had a strong back division, and though well supplied with the ball they had a hard time to find a way through, being opposed by some good marking and tackling. Hackett, marking Cannell at the start was unfortunately soon injured and thereafter could use but one arm. However, Taylor and Lammiman, sharing his duties were no less effective.

From the kick off, St. Mary's put on the pressure; most of the play being in the Bart.'s half of the field. However, a line out close to the Bart.'s goal line resulted in a try for Bart.'s. A long ball was caught by Taylor who made a fine run up the field towards the left wing. Phillips gathered a short punt ahead and ran clear to score. Though returning the attack, it was not until half an hour later that St. Mary's drew level with a try by Sullivan in the corner, and a few minutes later Scott scored, the try being converted by Sullivan.

Throughout the second half, St. Mary's pressed hard. Time and again good passing was broken down by good tackling. Sullivan and Speed on the left wing were made use of by cross kicking by Fleming and in the end an attack got home resulting in a touch down between the posts for Stevenson. Sullivan scored again in the corner from a well placed cross kick. All this while the Bart.'s forwards fought hard and on several occasions, with clever footwork managed to ease the pressure. But once again St. Mary's scored when Rusk picked up a loose ball, close to the line. In the back division well placed kicking and good tackling by Burrows did much to ease the defence, whilst behind the scrum Charlton was noticeably quick.

Team: P. J. Burrows, M. Phillips, M. Taylor, M. N. Hackett, D. A. Lammiman, G. Scott-Brown, C. A. Charlton, F. I. Macadam, P. Knipe, M. V. I. Fitzgerald, B. Reiss, D. A. Roche, L. Cohen, E. F. D. Gawne (Capt.), C H. W. Havard.

Other Results:

Bart.'s v. Old Ruthshians. Won 8—3.
Bart.'s v. O.M.T.'s. Drawn 3—3.
Bart.'s v. Loughborough College. Lost 5—6
Bart.'s v. Saracens. Draw 3—3
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Bart's v. Catford Bridge. Won 20—0.

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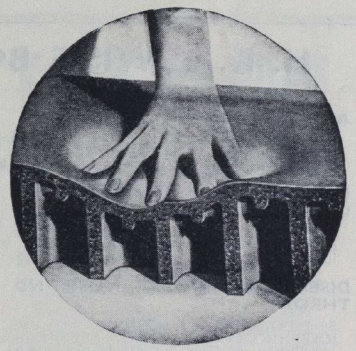

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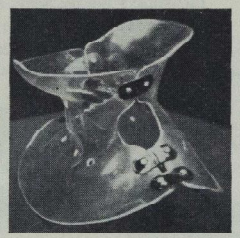

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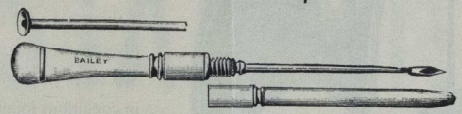

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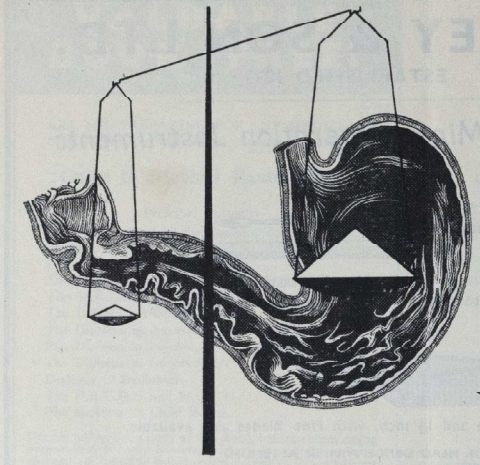

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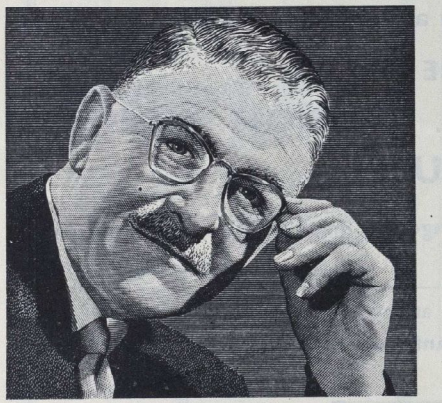

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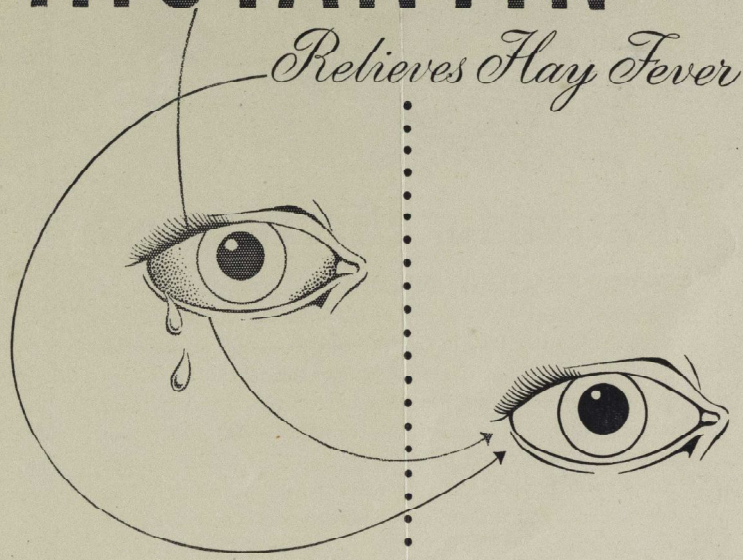

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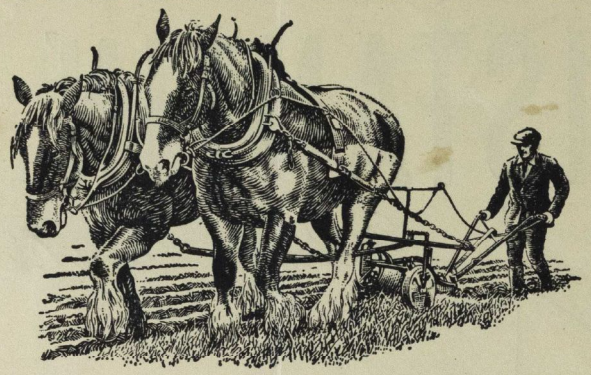

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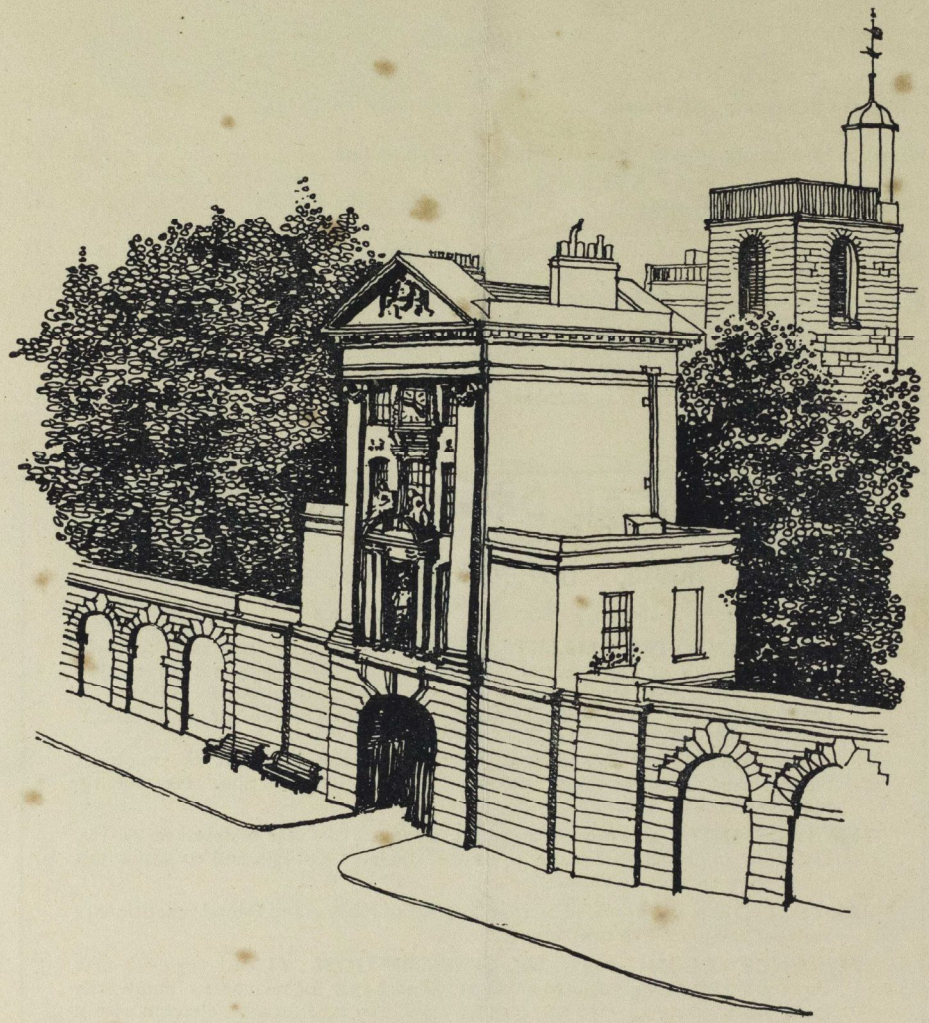

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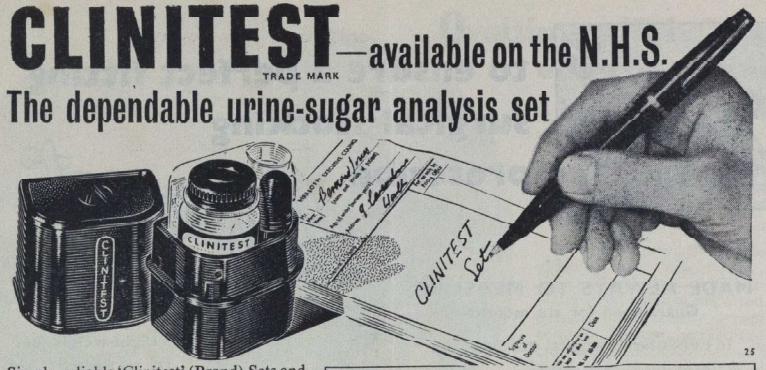

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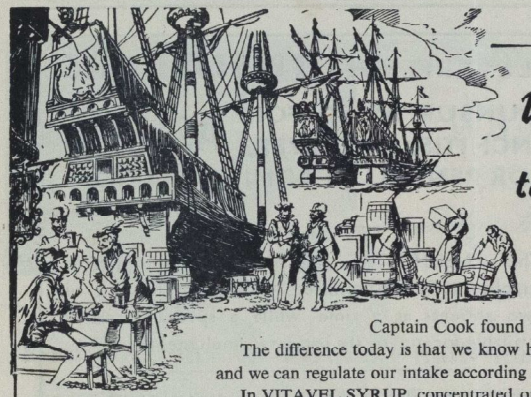

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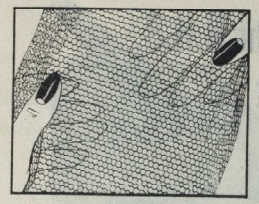

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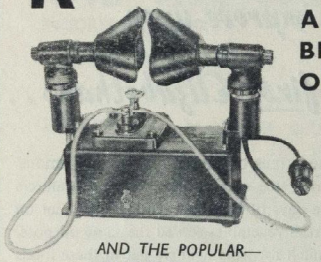

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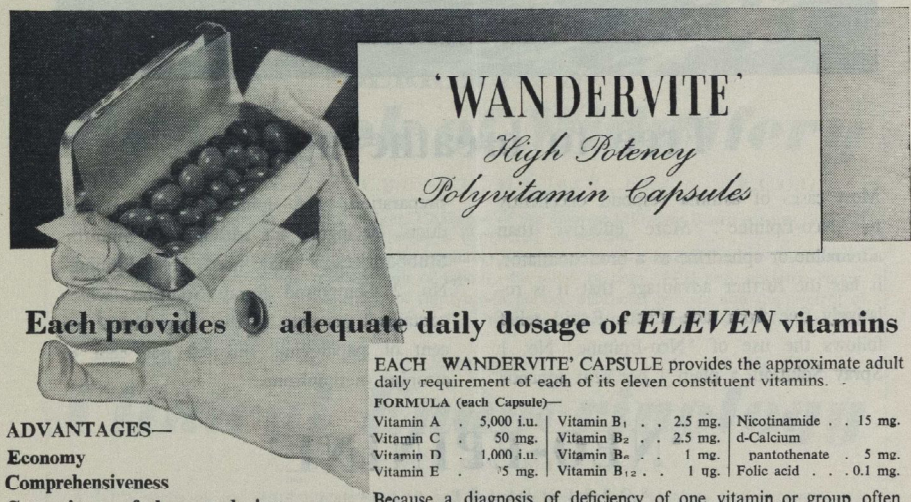

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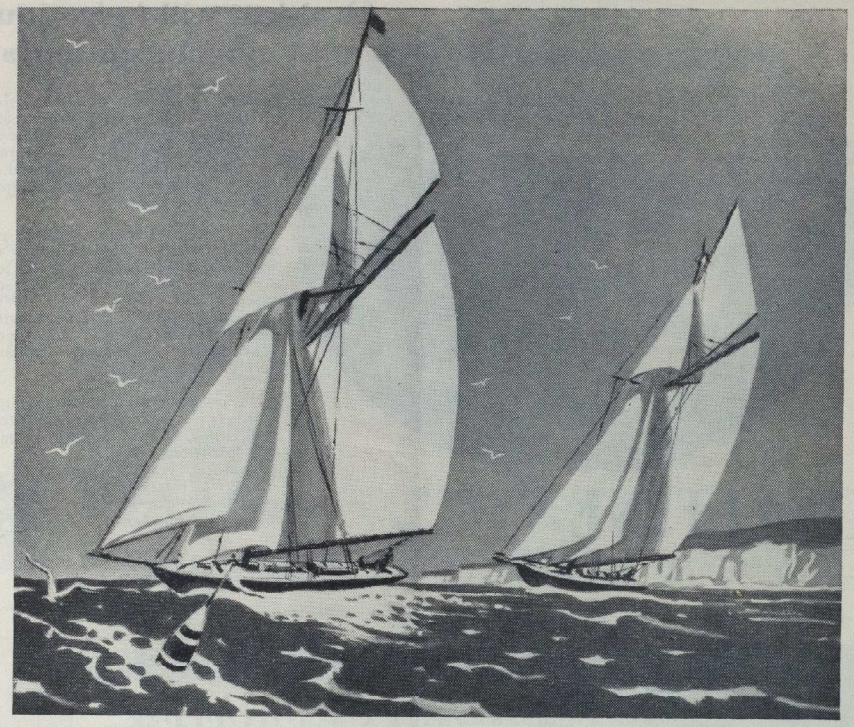

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ST. BARTHOLOMEW'S

HOSPITAL JOURNAL

Vol LVII MAY, 1953 No. 5

BRIMSTONE AND TREACLE

We recently conducted a private pilot-survey among the students of this hospital. Of ten we asked the question: "Who is the most famous cricketer of all time?", and having steered about half of them away from Bradman, they all arrived at the same answer —"W. G. Grace." When asked what they knew about Grace three knew the county he played for, two knew funny stories about him, five knew that he was a doctor. But when asked, as casually as might be, what hospital he trained at, one volunteered "St. Thomas's," one "the London," six did not know, and two only knew what all should have known—that he was a Bart.'s man. This is appalling ignorance, for W. G. Grace is the *best known* of all Bart.'s men, not even William Harvey excluded. We cannot think of any English sportsman who is so well known, and challenge any reader to name one. The acid test is to ask women-students —they have all heard of Grace.

This ignorance about our greatest sporting hero seems to go hand in hand with a disastrous lethargy in Bart.'s sport, which is saddening to all who realise that the eminence of any teaching hospital is a many-sided quality, depending not just alone on its brilliance in research, or the high standard of its medical and nursing care, or the excellence of its students' examination results, or their prowess in sport, but *on all these together*. The medical profession may judge us on the first three, but the public will judge us largely on the fourth, and even in these protected days a hospital like Bart.'s needs all the public goodwill it can foster.

On another page in this issue a correspondent quotes chapter and verse for his contention that the students here have little interest in the sporting reputation of their hospital, and if we judge by results—and how else can we?—we can not but agree with him. Considering that this is the largest medical school in London, and has well-nigh 700 students, our record in sport is deplorable.

It seems to be an inborn metabolic defect of some large colleges that they should be unable to win anything. Their large resources in numbers, which should give them an overwhelming advantage, prove a source of weakness, and they seem unable to call upon any reserves of loyalty. To this phenomenon Bart.'s proves no exception, but we may hope for some amelioration with the expected reduction in the annual entry.

But we are not so willing as our correspondent to place *all* the blame on the students, and *none* on the captains of the various sports clubs. *Noblesse oblige*—and the greatest responsibility, especially in our predicament, is to find players, and then to

make them play. It is notorious that most students anywhere have to be asked at least three times in summer and six times in winter before they will play in any game. We need, not captains who are good players only, but captains whose enthusiasm is infectious and whose determination to build a good team is patent for all to see.

The lead must come from the rugger club —for rugby is the hospitals' sport, *par excellence*—and there are encouraging signs that our record in this is an improving one. At the end of the season we can look back on a winter which, while not spectacular in its successes, has seen a long-overdue revival which, we hope, is but a foretaste for further successes to come. It was, after all, 1931 when Bart.'s last won the Inter-Hospitals' Cup, so no one can accuse us of impatience if we deplore its failure to reappear.

There are no quick results in sport. A bad team does not become a good one in a season, and we must be content to see foundations laid in one year and the building not completed for a few more. Meanwhile, if those who play no sport and can, did, and those who play some sport occasionally did so regularly, then we might soon fill the glass showcase in the Library with cups which are there, not because they belong to us, but because we have won them.

We might even cover the insurance from the profits of the *Journal*!

William Harvey stays put

Many readers will remember the discussion in the leading article, *Where is William Harvey to go?* (*June*, 1952), of the fate of the remains of our most distinguished physician. Many, and the Harveian Society of London especially, were shocked at the dilapidated condition of the Harvey chapel in Hempstead Parish Church, and wished to remove the tomb to more suitable and dignified surroundings. We suggested that, if this were to happen, St. Bartholomew's-the-Great had the best claim.

We recently sent a special reporter to Hempstead who tells us of the great improvement he found. The church itself is having a thorough overhaul and the roof is being re-tiled. The chapel, whose ceiling was falling down and whose walls had the plaster peeling off them, is now spick and span once more, and gleaming with distemper. It has become again a fitting resting-place for Harvey.

Our reporter was interested to see the memorials to other members of the Harvey family, military and naval men for the most part. The most recent memorial is dated 1830. The bust of William Harvey is an admirable piece of sculpture, and the sarcophagus surprisingly plain and inoffensive, considering its date of construction (1882). We recommend all readers who find themselves near Saffron Walden in Essex to make the détour to see for themselves. Hempstead lies seven miles to the east.

Errata

"Fate is a jealous old bitch," as one of the school of "tough" novelists says. We, too, felt that Nemesis had at last caught up with us for the March *Journal*, which contained a note on Sir Humphrey Rolleston's insistence on accuracy of the printed word—an idea which, incidentally, we commended to our contributors—contained more errors of fact and printing errors than we like to detail here. Some important corrections for the issue will be found under the heading of Obituary: the rest may be left in silence. We must apologise for all these mistakes and, after the manner of all modern recantations, will endeavour to mend our ways and to redevote our energies to the common cause. We thank all those who wrote or told us about the mistakes, and will welcome any future similar observations.

View Day

As already announced View Day this year will be held on Wednesday, May 13. We are hoping that the quantity and quality of the various exhibitions and demonstrations this year will be even greater and better than in 1952. Especially are we looking forward to thrilling our lay guests again in the Pathology Museum and to Mr. Thornton's treasures in the library. To set a good example the *Journal* also hopes to celebrate the year of its diamond jubilee with a fuller display than is usually seen. We hope to include a section on the production of the *Journal* from manuscript to the bound copy and a selection of the more interesting of our past issues, as well as the cover designs over sixty years.

Mrs. Dale's Diary

As sure as night follows day, so does Mrs. Dale's Diary follow Music While You Work, morning and afternoon, five days a week, month after month, for the last two or three years. It may well be that many readers have never heard one of these programmes, for they are broadcast at times when most doctors and students are, fortunately, out of range of a wireless. You should know, therefore, that Mrs. Dale is a doctor's wife. Mrs. Dale's Diary should be listened to once, and once only—like going to greyhound racing and watching all-in wrestling—so that you know to avoid it in future.

We recently heard it one morning—on the Editorial holiday, we hasten to add—and noted that the cast had grown to 19, all of them trying very hard to give some dignity, meaning and common-sense to the piffle they are obliged to recite.

We wouldn't wish Mrs. Dale on to anyone as a doctor's wife. If we thought for one moment that doctors ran any risk of marrying Mrs. Dales and begetting little Dales we would demand that the Medical College set up a properly-run marriage bureau, and would agitate unceasingly in Editorials till this was done.

We all know of the fall in prestige that the family-doctor has suffered in the past few years. Could Mrs. Dale's Diary be a symptom, or a cause, or both? It may well be so. Anyway, it's about time that this nonsense came to an end. Could not the new College of General Practitioners do something about it?

Congratulations

to Dr. Geoffrey Bourne, Senior Physician and Chairman of the *Journal* publication committee, on his marriage at Midhurst on April 8th to Miss Patricia Mary McCready. Their honeymoon is being spent in Greece.

to T. C. Bradford on his engagement to Miss Ann Thomas.

Bart.'s Fair

What has happened to the idea of a Bart.'s Fair? This, which apparently was a regular feature in pre-war days, was mooted again in these columns in April, 1949. It was to have been held at Charterhouse Square in September and its object was to raise funds for the students' union; attractions promised were an art exhibition, club features and music provided by the Metropolitan Police Band. Later it was announced that the fair had been postponed until the opening of the College Hall, but over the last year even our ears have failed to catch even a whispered suggestion of it. Is it already too late to suggest that the idea should be considered to celebrate the Coronation, or must we wait until the need for funds is more pressing than at the present time?

Dousing the Dowser

Bart's students must be the blue-eyed boys of the television service, for the Medical College was chosen a second time within two months for a programme in the series "Is there anything in it?"—this time on radiesthesis ("divining" to you and I). Mr. L. J. Latham strengthened his hand before the demonstration by making no exaggerated claims for his skill. Sometimes it works, he said, sometimes it doesn't; but it works too often for it to be dismissed as bunk. He was then tested with hidden water, copper, lead, gold and silver, and was correct twice, with a third near-miss.

Photo: Masheker

Dr. Rushton, a visiting physiologist from Cambridge, was the scientific critic, and as such wanted to get everything weighed and measured. He suggested experiments that could be done to set dowsing on a quantitative footing, to shew if there *was* anything in it.

The Senior Secretary of the Students' Union, L. N. Dowie, was once again the competent, word-perfect, unhesitant commentator. Unconfirmed reports reach us that his new-found and unsuspected talent is giving him second thoughts about medicine, and that he is only waiting for a sufficiently attractive offer from Hollywood to go and find out if there is anything in *that*.

Prizewinners

Kirkes Scholarship and Gold Medal
Awarded to G. SCOTT-BROWN.
Brackenbury Scholarship in Medicine
Awarded to P. SLEIGHT.
Brackenbury Scholarship in Surgery
Awarded to J. G. ROSS.
Prox. Acces., R. M. REWCASTLE.
Matthew's Duncan Gold Medal and Prize
Awarded to J. M. HALL.
Burrows Prize
Awarded to R. W. AINSWORTH.
Prox. Access., A CLARKE.
Skynner Prize
Awarded to A. K. THOULD.
Prox. Access., P. I. THOMAS.
Willett Medal
Awarded to J. G. ROSS.
Prox. Access., P. SLEIGHT.
Walsham Prize
Awarded to J. G. ROSS.
Prox. Access., P. SLEIGHT.
Roxburgh Prize
Awarded to S. P. LOCK, P. SLEIGHT, *aeq.*
Senior Scholarship in Anatomy, and Physiology Biochemistry
Awarded to R. A. GOULD.
Prox. Access.: M. A. BEDFORD, E. R. NYE
Awarded to R. A. GOULD.
Foster Prize
Awarded to: M. A. BEDFORD, D. H. ELLIOTT, *aeq.*
Certificates: G. B. Gillett, R. A. Gould, E. R. Nye, D. Rosborough, H. T. Shacklock.

The Cambridge-Barts Dinner

was held at Frascati's on April 17th. Dr. G. F. Abercrombie was in the chair and the principal guests were Sir Lionel Whitby, Sir Alexander Ingleby Mackenzie, Dr. John Hunt, Mr. Basil Hume, Mr. E. G. Tuckwell, and Dr. E. F. Scowen.

Dr. Abercrombie, almost but not quite the first G.P. to fill the chairman's throne, made a most fluent and witty speech, throwing *en passant* a most sweet-perfumed bouquet at the *Journal*. Sir Alan Moore told once again the story of Hairy Rouchy, with Mr. Reginald Vick leading the chorus.

The Radiogram

With the aid of some of the money earned by our television appearances and a small extra "amenities" charge on the monthly bill, the Students' Union has now been able to purchase a radiogram for the use of College Hall residents. This is a handsome piece of furniture which would grace any music room. It also reproduces gramophone records so well that it is at times difficult on closing one's eyes, to realise one is not inside an actual concert room or opera house. Unfortunately at the moment electrical interference of fantastic proportions makes listening to the wireless portion more of a torture than a pleasure. Presumably similar distortion to individuals' wireless sets has prompted the recent appearance of aerials on long iron poles projecting from upper floor windows. When the summer comes, no doubt the temptation to hang washing on these bars will be irresistible and quite a colourful scene should result; though perhaps more appropriate to a Naples slum than to a fine modern building.

We would suggest to those responsible that if and when they think of purchasing a television set for the Hall, they should take steps to ensure that these unexplained disturbances in the ether will not be manifested on the screen as well.

Ski-ing

To bring together all those interested in winter sports, a Bart.'s Ski Club was formed recently. The objects of the Club are to advise and encourage all those interested in ski-ing, particularly those who have not ski-ed before; and to arrange films, talks and occasional meetings. It is hoped to organise a ski-ing party abroad early next year. All those interested in joining the club should contact Peter Rycroft or Geoffrey Dawrant.

New homes for old departments

The old Casualty Department, where Robert Bridges wrestled with the problem of giving separate audience to the troubles of 150 women in three hours and a quarter, has been remarkably transformed by the Physiotherapists into their new quarters. Here, at last, behind gaily-patterned curtains and under an impressive display of strip lighting they have permanent and sufficient room. Physiotherapy at Bart.'s has only in recent years come into its own, but it has had a long history and many wanderings since, shortly after Bridges' time, Lieutenant Tham of the Swedish Army first taught his drill in the wards.

Also recently opened is the new Surgery Ward, another example of tasteful and economical hospital design. One cubicle is, however, exceptional as the subject of a rather chilling experiment in interior decoration; but perhaps no "query fractured base" will very much care.

The Physician

(*Symbolised by a glass urinal*)

I study to uphold the slippery state of man
Who dies when we have done the best and all we can
From practice and from books I draw my learned skill
Not from the known receipts of pothecaries' bill
The earth my faults doth hide, the world my cares do see
What youth and time effects is oft ascribed to me.

The twelve wonders of the world.
(John Davis: 1569-1626)

These verses were written to adorn one of a set of twelve trenchers used at a dinner given by Thomas Sackville, first Earl of Dorset in 1600. They were set to music by John Maynard in 1611. The complete set of trenchers featuring the different professions may be seen in the Victoria and Albert Museum.

Eponymous Streets

Oxford and Cambridge men have their own special ways of being rude to each other, and they are ingenious in exploring all possibilities. Thus, Cambridge Street, Oxford, could be set down in the middle of any London slum and not be out of place. Cambridge has no slums like Oxford's, but were not to be outdone, and riposted with an Oxford Road which is the archetype of Acacia Avenues the country over—snug, secure, middle-class dwellings, all revelling in such names as *Chez Nous, Whispering Pines,* and *Shangri La.*

Bart.'s men have no particular feud with anyone, so it is impossible to apply the same line of thought to the three streets up the Goswell Road which have a familiar ring—Gee Shreet, Rahere Street and Paget Street. In Gee Street a colossal new block of flats dwarfs everything else, but until recently it must have been very like Rahere Street, which is as dull, dirty and dreary as Cambridge Street, Oxford. Paget Street, on the other side of the Goswell Road, is no better.

These three streets lie in an area which was (perhaps still is) Hospital property, and as ground landlords, it was presumably the Governors who chose the street names. But if this is so, how does Wakley Street (a mere two turnings further up) come to be so named?

For Thomas Wakley, founder and first editor of *The Lancet*, was the avowed enemy of John Abernethy, who obtained an injunction against Wakley in the Court of Chancery when *The Lancet* published his course of surgical lectures without permission. For the rest of his life Abernethy came under occasional cross-fire from Wakley's periodical. Surely the Governors would not have named a street after *him*!

Perhaps one of our readers can explain.

Consultations

In our last issue we surmised that Consultations began in the 1860's. But the following Order, made by the Governors on February 17, 1729, would seem to have instituted something very like them 130 years earlier.

"Resolved that the Physicians, Surgeons, Assistant Surgeons and Apothecary of this Hospital do in a Body, once every Week, on Saturday from Lady Day to Michaelmas between seven and Eleven o'Clock in the morning; and from Michaelmas to Lady Day between Eight and eleven of the clock in the morning, Go through and view all the patients within the Hospital, and Enquire into and Counsel together upon their several Maladies, and the most proper Means to be used for their Recovery."

Coronation Journal

The June issue will be a special one, in celebration both of the Coronation and of the 60th anniversary of the *Journal*. It is being sent out to *all* old Bart.'s men whose names and addresses appear in the Medical Directory, and should be distributed by the end of May. It will contain contributions by, among others, Lord Horder, Philip Gosse, R. B. Price, C. H. Andrewes, and Kenneth Walker, contemporary members of the Staff, and students.

Exhibition of historical documents

The archives, early charters and other historical treasures of the hospital will be on view to everyone in the Great Hall on Thursday, Friday and Saturday, May 14, 15 and 16, from 10.30 a.m. to 6.30 p.m.

A date to make a note of

The Coronation Ball will be on Friday, June 12, at the Royal Festival Hall. Tickets —£2 10s. each (double)—have been going fast recently and you will only be courting disappointment if you delay much longer.

Sister Kenton has asked us to express the grateful appreciation of all in the Children's Ward and Department for the work of all those, and especially the organisers, which has led to these gifts. They will be used in the new Children's Ward, shortly to be opened.

Engagement

The engagement is announced between Napier Arnold, only son of Mr. and Mrs. Thorne, of Prospect Hill, London, E.17, and Pamela Joan, younger daughter of Mr. and Mrs. Houchin, of Turves, Ruckinge, Kent.

Correction

We regret that in our April issue we congratulated Mr. Hume on his election to the Council of the University ot London Senate. This should have read *to the Senate of the University of London.*

We should like to make it clear that he, Dr. Harris and Professor Christie (not Mr. Tuckwell as stated) are the members of the College on the Senate, We apologise to all concerned for these errors.

THE MACHINE AGE

When a joint's got arthritis,
The Surgeon's delight is
To take the whole structure to pieces.
With joy he'll explore it,
And substitute for it
A brand-new acrylic prosthesis.
But he feels much frustration
About lubrication,
And deplores this regrettable fact :—
These unfortunate cripples
Have only two nipples,
So he can't get a grease-gun to act.

A.B.

THE EYE SIGNS IN THYROTICOXIS

By Seymour Philps *

" About three months after lying-in, while she was suckling her child, a lump of about the size of a walnut was perceived in the right side of her neck. This continued to enlarge till the period of my attendance, when it occupied both sides of her neck, so as to have reached an enormous size, projecting forwards before the margin of the lower jaw. The part swelled was the thyroid gland. The carotid arteries on each side were greatly distended : the eyes were protruded from their sockets, and the countenance exhibited an appearance of agitation and distress, especially on muscular exertion, which I have rarely seen equalled (1786)."
—Caleb Hillier Parry, Collected Works, 1825.

A hundred and twenty-five years ago, Dr. Parry of Bath described eight cases of what is now known as exophthalmic goitre, drawing particular attention to the prominence of the eyes. His papers were only published posthumously and created little interest and it was left to Dr. Graves to rediscover and write up the condition now known as Graves' Disease. The ultimate, or even the immediate, cause of that exophthalmos was unknown then and is little better understood today, but certain facts have come to light, which justify a restatement of modern views. Tracing the history of the disease for the past century and a quarter, we find that, at first, there was no useful treatment and the patients usually drifted into cardiac failure without any remission in their disease, but later, with the discovery that iodine was beneficial, some relief could be given, though usually not to the eye condition. Then, forty years ago, the operation of partial thyroidectomy immediately produced dramatic results and we may note with pride that it was partly owing to the work of one of our consulting surgeons, Sir Thomas Dunhill, that this operation was male a comparatively safe procedure.

After partial thyroidectomy, the patient's general state improved remarkably. The nervous excitability, moist skin and the tremor disappeared, the B.M.R. returned to normal and the " exophthalmos " was often but not always, improved and it came to be taught that one must not expect complete relief from the staring eyes, which were one of the most distressing features of Graves' disease. Much argument about the cause of the exophthalmos failed to give any good explanation, the possibilities seeming to lie between venous engorgement of the orbit, the action of an orbital muscle, such as was present in the dog, but could not be found in man, or simply an increase in orbital fat, which, indeed, it seemed could be demonstrated surgically, though it was difficult to know why there should be an increase of fat in the orbit and a decrease everywhere else in the body. In any case, as Foster Moore pointed out, it was difficult to know what was an excess of fat in a cavity normally full of it.

Between the two world wars, the experience of thyroid surgeons brought out one more startling fact. Not only did thyroidectomy not much improve the eye condition, but it might actually make it worse, and a patient who had no more than a mild exophthalmos before operation might shortly after operation develop an exophthalmos of such degree that the lids would not meet in front of the eye and the sight was endangered through drying and perforation of the cornea. This apparent paradox of the eye that might be made worse or better by the same operation made it necessary to postulate two different kinds of exophthalmos—the one which was relieved when the toxic symptoms were relieved was called thyrotoxic exophthalmos, and the other which was made worse was called thyrotrophic.

It also became known that exophthalmos was not directly related to the thyroid gland at all, but was more a function of the anterior lobe of the pituitary gland, which produced a thyrotrophic hormone, excess of which caused exophthalmos.

Perhaps that brief statement sums up the present teaching on the exophthalmos of Graves' disease and, indeed, it is the teaching

* *A clinical lecture given on Jan. 16, 1953.*

of two new articles published in 1952, the one in a major text-book and the other in a medical journal, that there are two types of what we may now call endocrine exophthalmos, the one thyrotoxic, minimal in amount and disappearing after the relief of the thyrotoxicity, and the other more marked, unrelated to the thyroid and made worse by thyroidectomy. One wonders how the poor thyroid surgeon is to know whether he is likely to make a patient better or worse, and a cautious enquiry certainly seems justified to try to unravel this very difficult problem.

The Anatomy of Exophthalmos

Exophthalmos denotes an abnormal protrusion of the eyes, so that the first point to establish is the normal position of the eyes in the socket. Whitnall (Anatomy of the Human Orbit, 1932—p. 258), working on post-mortem material, found that a ruler held vertically against the superior and inferior bony margins of the orbit just touched the cornea and he laid this down as a "base line," but he also found wide variations, the position of the eye varying from 12 mm. in front to 10 mm. behind the plane. Ambialet (1905) found that in living persons the protrusion was positive, i.e., in front of this base line in 85 per cent., while Heymes (1929) gives average figures as follows: infants + 5.8, at puberty + 15.0 and in adults a variation of +11.0 to +17.0.

From this, there emerges the fact that there is no one normal position. Even for a given individual the reading will vary according to age and state of health and, though a series of readings may show that the eyes have become more or less prominent, the statement on first examination that both eyes are, say, 2.5 mm. proptosed is one that it is impossible to justify scientifically.

At the present time, the external orbital margin is taken as the base point from which to measure exophthalmos, being more accessible than the superior or inferior margins, and this is done either by an ingenious, but rather expensive, arrangement of mirrors (Hurtel's exophthalmometer), or a much simpler plastic ruler (Fig. 1). From many such measurements, it is clear that any figure from +12.0 to +22.0 is normal for an adult, though for a given eye the variation in normal health is very small—not more than 1—2 mm.

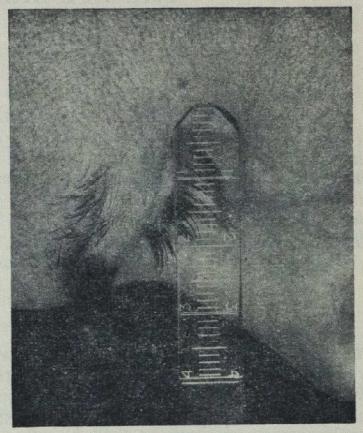

Fig. 1. By courtesy of Sir Stewart Duke-Elder, "Textbook of Ophthalmology," Vol. V. Kimpton; London.

The Diagnosis of Exophthalmos

It has been realised for many years that the first change occurring in the ocular appearance in Graves' disease was a retraction of the upper lid, which exposed the upper cornea instead of hiding it and might even leave a narrow strip of sclera exposed at the upper corneo-scleral margin. This certainly gave an appearance of exophthalmos, which deceived the earlier investigators and still deceives many today. Just how remarkable this deception may be can be seen from Fig. 2, where the amount of exophthalmos is equal in the two eyes. Indeed, pictures regularly appear in the press to illustrate an exophthalmos which is nothing of the kind, but an illusion due to lid retraction, and one of the latest contributions in a major text-book illustrates thyrotoxic exophthalmos with a picture of lid retraction and nothing more.

While much on this subject is difficult to explain, at least lid retraction has a sound anatomical and physiological basis, for there is an easily defined plane of muscle tissue in close association with the levator palpebral superioris, which is innervated by the sympathetic nervous system. This muscle (Muller's muscle) (Fig. 3) is responsible for lid retraction and it is made to react by any stimulant to the sympathetico-adrenal system, whether this be fright (the wide staring eyes of fear), or a

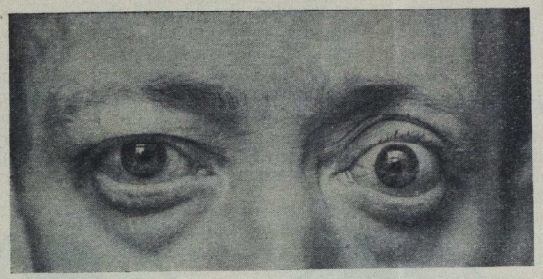

Fig. 2. By courtesy of Mr. Kenneth Wybar, "Medicine Illustrated," July, 1952.

drop of cocaine or adrenaline in the conjunctival sac. Some confusion has arisen about this muscle because the name of Muller's muscle has also been given to the vestigial orbital muscle, which has been said by some to surround the eye and produce exophthalmos. No one has ever been able to demonstrate this muscle to me, and belief in it has died.

Appearances are deceptive and one must beware of judging exophthalmos by the relation of the globe to the lids, but not everyone has an exophthalmometer and so certain rules must be laid down. In normal health, the upper lid cuts across the cornea just above the half-way mark between the centre of the pupil and the superior corneal margin, while the lower lid either touches the inferior corneal margin or is just below it.

If the position of the upper lid alone is altered, there is lid retraction but no proptosis. If both upper and lower lids are equally withdrawn from the cornea, the upper lid touching the corneo-scleral margin and the lower leaving a ring of exposed sclera, there is proptosis but no retraction, while, if sclera is exposed above and below the cornea, there is probably retraction and proptosis. (Fig. 4.)

For some years now, it has been the custom to add confusion to the already confused state of the medical student by attaching names to various eye signs which accompany exophthalmic goitre. The first of these, Dalrymple's sign, is fair enough, for that is lid retraction due to spasm of Muller's muscle, but what of von Graefe's sign? He notes that, when the eye looks downwards, the upper lid follows imperfectly. Not such a very remarkable observation, one would think, and one which automatically follows on lid retraction and spasm of Muller's muscle. There are many reasons why we shall never forget von Graefe, but may we now forget his sign?

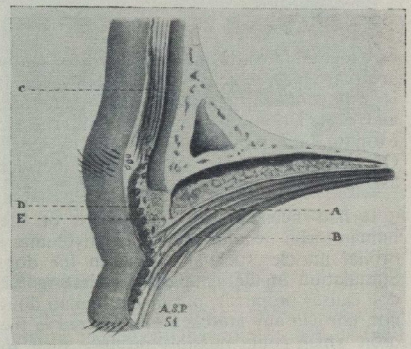

Fig. 3.
(a) Levator Palpebrae Superioris
(b) Muller's muscle.
(c) Frontalis.
(d) Orbicularis.
(e) Orbital Septum

What of Stellwag's sign—infrequency and incompleteness of the blinking reflex—surely understandable, if the upper lid, which is the only one concerned in blinking, is held in spasm. I should like to propose we forget Stellwag's sign, though I am more sorry for him, as I do not know of any other claims he may have on our memory.

Rosenbach's sign—tremor of the upper lid on closing the eyes—the orbicularis is acting against Muller's muscle, and Joffroy's sign—failure of the frontalis to contract on looking up—are equally explained by spasm of Muller's muscle, and I should like to think

that the day may come, when this simple explanation may replace a list of eponymous signs, which, even those who teach ophthalmology, have to look up regularly to make sure they have them right.

Thyrotoxic and Thyrotrophic Exophthalmos

Having tried to clear the air a little, we can now consider the nature of these two types of exophthalmos, if one believes there really are two types, which I do not. However, it is still confidently asserted that there are, and explanations of the cause of thyrotoxic exophthalmos are given. What are they? Quoting from most recent literature, they are as follows:

Fig. 4.

Lid retractional without proptosis. Proptosis without lid retraction. Proptosis and lid retraction.

It had been hoped that search of the human orbit would reveal an involuntary orbital muscle, such as occurs in the dog. Stimulation of the sympathetic nerve in the dog causes proptosis, but in the human does not, nor can any muscle be discovered in the orbit which could possibly produce such an action. This is a disappointment, but do not let us give up. In man, the sole remaining part of the dog's orbital muscle is a vestigial muscle lying in the inferior orbital fissure. This cannot affect the position of the eye in any way, but it is stated that contraction of this muscle may constrict the orbital veins and so produce proptosis. Added to this, it is known that in Graves' disease muscle tone is poor and it is claimed that, rectus muscle tone being poor, the eye is allowed to prolapse forwards out of the socket, being aided in this by the mechanism in the inferior orbital fissure above mentioned. It does not seem a very likely explanation. Venous engorgement in the orbit would cause a suffusion of the eye, which in thyrotoxic cases is not apparent, while deposition of fat can hardly be reckoned a cause when immediate relief by operation is claimed.

It seems, therefore, that the time has come to abandon the idea of thyrotoxic exophthalmos as a clinical entity and to say outright that exophthalmos, so far as we know it, is a function of the anterior pituitary. Any improvement in exophthalmos after thyroidectomy is due to relief of lid retraction and nothing more. The surgeon seeking to know whether or not he is likely to make the eye condition of the patient worse or better by operation can know that, if true exophthalmos exists before operation, he is likely to make it worse, but, if only lid retraction exists, this will be improved.

Thyrotrophic Exophthalmos

If the arguments so far put forward are accepted, this is the only form of endocrine exophthalmos. This exophthalmos is due to a hormone produced by the anterior lobe of the pituitary, which is normally in a state of physiological balance with the thyroid. Reduction in the amount of thyroid secretion, as by thyroidectomy, will give a physiological advantage to the pituitary and an exophthalmos may result. This is quite certainly an over-simplification of the matter and other endocrines play a part. Whereas toxic goitre is commoner in women, thyrotrophic exophthalmos is commoner in men (9:1) and, for this reason, it has been stated that the gonads also have some influence on this condition.

Regarding the actual cause of the exophthalmos, all observers until recent times agreed that exploration of the orbit revealed, firstly, an excess of rather pale fatty tissue and, secondly, a great increase in bulk of the intra-ocular muscles. There was no sign of venous engorgement and none of an orbital muscle, such as is found in the dog. More recent investigations have shown that what was thought to be an excess of fat was, in fact, a lymphocytic infiltration and oedema of the fat lobules. The same infiltration is true of the extra-ocular muscles, which are swollen to about six times their normal bulk. It has been said that, in addition to this oedema, there is actual new deposition of fat globules, but proof of this is, at present, lacking.

Course of Thyrotrophic Exophthalmos

Mild cases remain unchanged over many years without developing any complications. In these, no treatment is necessary. When more severe and the patient develops some dryness of the eyes, a small lateral tarsorrhaphy will relieve this symptom. Occasionally, the exophthalmos takes on an acute course, developing rapidly to the point, where the lids cannot be closed—so-called malignant exophthalmos. (Fig. 5.) It is noted that in these patients the conjunctiva becomes very oedematous and congested and it has been suggested that the enlargement of the orbital contents produces some interference with the venous return and so a marked increase in exophthalmos.

Whatever the cause of this acute phase, immediate treatment is necessary. The practised observer usually has some warning of its onset by the increase in exophthalmos and conjunctival oedema. Such a patient should be warded at once and a central tarsorrhaphy performed, before the eyes reach the position where the lids cannot be made to meet over the globe. Once the lids are joined, the cornea is no longer in immediate danger and other measures can be taken to reduce the exophthalmos. These measures are:

(*a*) To do nothing more, except to keep the patient under observation. Malignant thyrotrophic exophthalmos is a self-limiting condition and runs a course of six to ten weeks, after which it subsides to a point where the tarsorrhaphy can be undone without danger to the cornea. This fact must be remembered in studying all claims for relief of the condition.

(*b*) To irradiate the orbit and reduce the round celled infiltration.

(*c*) To irradiate the anterior pituitary and reduce the output of thyrotrophic hormone.

Which of these treatments will prove the better, is not yet known. At Bart.'s, Dr. Arthur Jones employs X-rays to the orbit, while, at the Middlesex, treatment is given to the pituitary. Results are claimed for both methods and, indeed, they may be the same method, for we think some of their rays fall on the orbit and they think some of ours fall on the anterior pituitary.

If the patient is allowed to reach a state where the lids cannot be drawn over the cornea extreme measures are necessary, if any sight is to be saved. A transfrontal approach to the cranium with removal of the bony orbital roof will allow the orbital contents to herniate upwards into the cranium and the eyes to sink back, after which the lids can be sewn together. This extreme, but sight saving, measure is known as Naffziger's operation.

Fig. 5. By courtesy of Mr. Frank Juler, Proc. R. Soc. Med. 1952, XLV, 243.

Exophthalmic Ophthalmoplegia

This terrible mouthful relates to the paralysis of movement that attacks one or both eyes in thyrotrophic exophthalmos. The patient complains of double vision and, indeed, finds it the most distressing symptom of the disease. From what has been said before, it will be accepted that the cause of the paralysis lies in the muscles themselves and is due in part to their greatly swollen condition and in part to the oedema and subsequent fibrosis which affects their fibres, advanced cases showing that the muscle fibres have largely been replaced by fibrous tissue. The muscle most usually affected is the superior rectus, perhaps because it is naturally one of the weaker rectus muscles and also because in the roof of the orbit it has less room in which to work than have the other rectus muscles. Once the general condition of the patient is stabilised, some relief can be given to these patients by suitable surgical adjustment of the affected muscle's natural antagonist.

THE LOCUM

By PERCY HAYES CARPENTER

Arriving with great suddenness or postponing his advent is that isolated but exclusive member of the profession known as the locum. And like the scamp, safe-breaker or rogue he may have other names of which relief, substitute, link or stopper of gaps are but few. In any case he is temporary, coming when he pleases or leaving at his own or express wish of another. He may be young and alert, full of form and comeliness, or one imbued with the dignity and protuberances of middle age or appear as a knee-flexed, bowler-hatted totterer upon the brink. Or with red neckcloth above and gaiters below, paunch acting as link he may appear as one big surprise like the oyster found in the offertory or the camel that appeared suddenly in little pants. In any case he is there.

And being there he works when he pleases in spasms or starts like a sail caught in the breeze or speedboat bereft suddenly of petrol. One as a seasonal adjunct or rising as an executioner to an emergency, or as a bowl-dropping, gate-crashing trampler to alleviate or exterminate the human race. Or as a well-equipped physician plying his instrument of two strings which with hammer or toe-tickling device he sits, stands or kneels to elucidate the diagnosis. And there is the question of his transport. Shall he be mounted upon a horse, mule or stout cob, in car, cab or polished gig, or just upon a bike? Will he bring topper, tails or hunting coat or starch, alpacas or llamas? And what of his treatment? Will he want a large beer before lunch, a small morphia before sleep or a large hot water bottle, nail-brush and comb? It is, as they say, all according.

Those in rich houses in full possession of attics, surgeries and cellars, in institutions desirable yet deplorable, on ships static or full of steam, or by train, car or ambulance he will propogate his art as one tasteful and pear-shaped retracting or expanding in all directions, but taking his own time and in all weathers but pleasing to himself. Or he may be fly-ridden upon the desert breathing dust with the sun a flaming sword, or tossed upon the high seas or in an asylum just. Or in a ward having removed dust, pills or confetti from his instrument he listens at the chest that creaks. He may go further and do more; relieve on a tea farm or cable boat there to stand, or stare or to spit. Or upon a luxury boat, not to eat, make love or to dance with she of the cream skin or raspberry lips, but to sit, walk or to traipse not with she of the dainty touch or nylon silk, but with a lunatic who pays.

Or a brief sojourn in the Services, in them yet not of them, a wanderer without benefit of pageantry. Not a crowner, two-striper or one-pipper, but a stop-gapper, shutter-upperer and pro-temmer. A link between fetter and freedom, one authoritative and temporary but shorn of glory or uniform. Shorn also of the incumbency of discipline, or the giving or taking of salutes. A decorative vista of pageantry, in it yet not of it, novel in its unusualness or fantasy. Yet of interest, he thinks. Interesting in that it is short-lived, free from swords or cannon yet rich in qualms or snobbishness. In it yet not of it; he is temporary just. Immune from order, regulation or command, the crash of instrumentry or rattle of pans, anaesthesia or steam. He leaves it all without tears, warning or farewell. He goes to relieve one who, bag in hand, is about to leave for Margate.

A word and he has left for that city, left he who is temporary with a maid slow and oystery without nod or recognition or intimation that food is imminent. Left him with bed, chair and pew, all rights and emoluments, key of the cupboard. Map also. He surveys this thoughtful wonder with pubs in red and calls in black. In this Elysium of gentle chairs and candelabra he unpacks his novel, rests comfortably and cosily praying for peace and tranquillity; yet the telephone rings. Fumbling with key, door and garage he is without, groping for crank handle, the orifice in which to thrust it, torch to see the way; he cranks. He should now be off, but he is not. He has forgotten the map. He recovers it and drives into the night.

Drives, yet he must know where. True there is a moon, possibly police or a kiosk although his coins are all half-crowns. There is a light in the odd house, as there are gates that open and shut and those that stay as they are. Farm gates may be hingeless and must be moved in their entirety and replaced, for there are cows. Yet he persists o'er moor and fen, crag or tor as he would with alleyways, knobless doors and broken stairs or the inevitability of the dog. Nothing, he thinks, is as bad as a dog. Love me love my dog, yet one cannot love all dogs, neither can dogs love all locums. Yet he likes the country locum, likes its cider at farm houses, ale at its wayside inns in spite of wind or weather. True streets are without names, houses also. In towns houses are numbered, not always consecutively. Some are inside the door-posts requiring a walk for diagnosis and some are painted the colour of the door, hence invisible. Front doors fail to respond and the other is where the dog is. Finding one's way is a problem. Of course there are landmarks, the doctor told him in that split second that allows for such tellings. There is the church, the pub or the nurse's bike, as there are cross-roads, Red Cross signs and exceptionally cross women. A bit stiff, he thinks.

But he yearns to be off, for his feet bother him. On to fresh scenes, people or pay at that point where the doctor returns and the cheque is signed. A minute for greeting, another for the cheque, another to store it away and he is off. Off to the great world be this a house, ship, factory or hospital. Or for a quiet browse at the sea to play golf, write his memoirs, work for an exam or exercise the dog.

He is just temporary.

POPULAR FALLACIES IN CLINICAL MEDICINE

by P. F. LUCAS, M.D., M.R.C.P.

Indications for iron therapy: "Iron deficiency anaemia" is almost always consequent upon blood loss. The features of this anaemia are lack of saturation of red blood cells with haemoglobin (hypochromia—low MCHC), and the small size of the cells (microcytosis—low MCV). The more hypochromic and microcytic the anaemia, the more likely is blood loss to be the cause. If the anaemia does not have these features iron will do no good, its administration is wasteful and it often upsets the patient. Thus the normochromic, normocytic anaemias of uraemia, hydraemia or marrow damage will not improve on iron. It should not be forgotten that the hypochromic anaemia consequent upon bleeding carcinoma of the colon may respond to iron as well as that resulting from bleeding piles.

Distinction of macrocytic from megaloblastic anaemia: These terms are often thought synonymous. Macrocytic anaemia is anaemia in which the average volume of the red cells is above normal (high MCV); formation of cells in the marrow may be normal (normoblastic) or abnormal (megaloblastic). In megaloblastic anaemia, by definition, the bone marrow contains megaloblasts; the average size of the cells is usually large. These distinctions have important therapeutic consequences.

Diagnosis and occurrence of Addisonian pernicious anaemia: This condition is often mentioned early in the clinical differential diagnosis of anaemia in youth. It is, in fact, uncommon under the age of 45 years, and it is likely that a patient with macrocytic anaemia under this age is not suffering from pernicious anaemia. Israels and Sharp (1950) pointed out that some of these patients have latent steatorrhoea. Diagnosis must be certain in a disease which requires maintenance therapy for life. Premature treatment may preclude subsequent assessment. Macrocytic anaemia, megaloblastic bone marrow and histamine-fast achlorhydria must all be present; response to specific treatment is the final arbiter. In the absence of any of these pernicious anaemia is unlikely to be present.

Erythrocyte sedimentation rate (ESR) in anaemia: A simple and valuable indication of the cause of hypochromic anaemia is lost as a result of the teaching that anaemia is necessarily associated with a high ESR, and that anaemia per se is adequate explanation

for high ESR. The fallacies were well demonstrated by Terry (1950). He showed that anaemia is often present with normal ESR. and then demonstrated that in those cases in which the ESR is raised there is always some serious underlying disease present. It is important to stress that in the latter group the ESR is often only moderately raised (9-19 mm. in 1 hour).

Terminology of differential white blood cell count : The old term, "relative lymphocytosis," continues in common use in spite of its condemnation by many authorities. If there are too few polymorphonuclear leucocytes in the blood there is polymorph leucopaenia ; if there are too many lymphocytes there is lymphocytosis. Comparison of numbers of lymphocytes with numbers of polymorphs is not important and serves only to distract attention from what is. The term " relative lymphocytosis " will only become extinct when students are taught how many blood cells are normally present per cmm. of blood, instead of their percentage relation, and when pathologists record their counts in the same way.

The association of purpura with splenomegaly : It is the almost universal opinion that the spleen is palpable in most cases of idiopathic thrombocytopaenic purpura. A more correct statement is that if in a case of purpura the spleen is palpable, the patient is not suffering from idiopathic thrombocytopaenic purpura. Whitby and Britton (1950) and Wintrobe (1951) say that there is some splenomegaly in one-third of all cases, but this is never great. The spleens in Pemberton's (1934) 22 cases weighed 30-700 G. (average 201 G.), in Nickerson's and Sunderland's (1937) five cases 95-311 G., and in Hertzog's (1947) 20 cases 103-365 G. (average 232 G.). The normal spleen weighs about 150 G. so, as it is generally agreed that the spleen must be two to three times the normal size before it can be felt, few of these spleens could have been palpable. Most significantly, Ehrlich and Schwartz (1951) felt the spleen in only 13 of 110 patients with purpura and thrombocytopaenia ; 12 of these 13 patients had diseases other than idiopathic thrombocytopaenic purpura.

The occurrence of ketosis : The question, " What is the commonest cause of ketosis ? " has plumbed the depths of ignorance of many students. The "plough" answer is "Diabetes." A child may become ketotic after only a few hours' starvation : vomiting is a common symptom and may rapidly result in ketosis. This ketosis may be associated with alkalosis —ketosis and acidosis are by no means synonymous (see Harrison, 1944).

Types of Diabetes : Most practitioners tend to accept without question diabetes as of unknown cause. Diseases of the pancreas and certain endocrine disorders will be missed if this is not also put amongst the " scrap-heap " diseases, to be diagnosed only by exclusion. On the lines of Lord Horder's (1921) aphorism, "All myasthenia is not myasthenia gravis," we might say "All hypertension is not essential hypertension and all diabetes is not diabetes mellitus." The great importance of separating those diabetics liable to ketosis from those, usually obese ones, who are not (Lawrence, 1951) is still not sufficiently widely known. The treatment of the former is weight reduction ; insulin will do them more harm than good.

Simmonds' disease, myxoedema and physique : These two misconceptions are dying hard—that all patients with Simmonds' disease are thin and those with myxoedema fat. Both are perpetuated by the pictures in standard textbooks, and the former by Simmonds' term " pituitary cachexia." In fact, Simmonds made little mention of loss of flesh in his original report. Sheehan (1948) showed that of 155 cases of this disease (100 personal cases) only 22 were classed as thin or emaciated. Burnstein (1934) analysed 151 cases of hypothyroidism and myxoedema ; he found weight loss in 31 per cent., weight gain in 30 per cent., 51 per cent. were classed as obese. Rose (1942) stressed the uncommonness of obesity and Kohlhas (1944) found it in only 10 per cent of 50 cases of hypothyroidism. Both these conditions have proved to be commoner than used to be taught and, now that effective therapy is available, their early recognition is of great importance.

Bowel disturbance in enteric fever : In the early stages of enteric fever constipation is commoner than diarrhoea. In an outbreak of 85 cases of which I was able to keep a record, 50 per cent. had constipation, 13 per cent. diarrhoea in the first week.

Testing for serum sensitivity : The fallacies of the commonly-used intradermal tests for serum sensitivity were discussed by Laurent and Parish (1952). Not only may they indicate trouble when none is likely, but they may fail to do so when there is danger. The method of trial dosage which they recommend is the only safeguard.

Relief of salicylism : Smull, Wegria and Leland (1944), and Smith, Gleason, Stoll and Ogerzalek (1946), showed that sodium bicarbonate will reduce the blood level of salicylate. Graham and Parker (1948) showed that toxic symptoms of salicylates depend on the blood level of the drug. Thus, the relief of these toxic symptoms by giving sodium bicarbonate is a direct consequence of lowering the blood level of the drug, an effect more easily achieved by reducing the dose of salicylate.

The value of demonstrating urobilinogen in the urine : The test for this substance is simple and much-neglected. Normally, some stercobilinogen is absorbed from the bowel and re-excreted by the liver into the bile ; only a small amount, insufficient to give a positive Schlessinger's test, is excreted into the urine where it is called urobilinogen, which is then oxidised to urobilin. Urobilinogen is present to excess in the urine if there is excess bile pigment in the stools, i.e., in any condition in which there is increased haemolysis ; or if there is liver disease, e.g., hepatitis or cirrhosis, which prevents re-excretion of that absorbed from the bowel. If there is biliary obstruction, quantitative tests may be used to demonstrate the complete absence of urobilinogen from the urine. Thus the main value of these tests is in anaemia, as evidence of haemolysis, and in liver disease, either to demonstrate impaired liver function or as a means of distinguishing different types of jaundice.

The occurrence of hypochromic anaemia : In 1930 Witts drew attention to a type of anaemia which has masqueraded under a variety of synonyms such as simple achlorhydric, iron deficiency or idiopathic hypochromic anaemia. This was a very valuable paper, but unfortunately it has become a facile explanation for any hypochromic anaemia in the group of patients which he described — women at middle age. This attitude is fraught with danger, because it is well known that hypochromic anaemia is commonly the presenting feature of serious underlying disease. Deficiency of iron in the diet and impairment of its absorption to the extent of producing anaemia in the absence of blood loss, are rare in this country. The blood loss may be the legacy of years of menstruation or child-bearing, bleeding piles or more serious disease; but whatever it may be, freely to administer iron without attempting to find the cause, and if possible to stop it, is to court the disaster which so often follows. It is, in fact, questionable whether " idiopathic hypochromic anaemia " exists at all, except as a result of our inability to demonstrate bleeding (see Heath and Patek, 1937).

Use and abuse of colour index : The colour index has the respectable stamp of tradition upon it. It was introduced when the importance of the size of the red cells was not understood. Reliance upon it may be misleading. It may be altered either by alteration in cell size, the amount of haemoglobin remaining constant, or by alteration in haemoglobin content, cell size remaining constant. Combination of these cannot be detected by the colour index, although most errors can be avoided by the examination of a stained blood film. In order to avoid these pitfalls a system of absolute indices is used which give the mean corpuscular volume in cubic microns and the mean corpuscular haemoglobin concentration as a percentage saturation of the cell. Calculation of these indices requires the additional information of the packed cell volume. Unfortunately, these indices have become surrounded by an aura of esoteric obscurity but, now that anaemia can be treated on a rational basis, ignorance of them will lead to therapeutic disaster.

Diagnosis of tuberculous meningitis: When early diagnosis was less urgent than it is today attention centred on the level of the chloride in the cerebrospinal fluid (CSF). A simple means of early diagnosis, of anticipating relapse and of assessing response to treatment is needed now that potent therapy is available : the sugar content of the CSF has proved an excellent indicator (Robertson and Gardner, 1952). Somner (1952) found it reduced in all cases presenting as meningitis, and Harvey (1952) in 144 of 150 cases at the first examination. Harvey found all cases of meningitis with clear CSF and low sugar content to be tuberculous. This is especially

valuable in making diagnosis from other types of meningitis with mononuclear exudates, mostly viral, because the virus does not metabolise sugar. Diagnostic fall in the chloride occurs late. Demonstration of tubercle bacilli remains the only certain proof of the diagnosis, proof which is so important in a condition requiring such heroic therapy. Harvey found them in 69 per cent. of his cases at the first examination.

The occurrence of lymphocytic meningitis : Meningitis with mononuclear exudate other than tuberculous is not rare in this country. Other causes are virus diseases which may be manifest by meningitis alone, e.g., benign lymphocytic meningitis, or may be associated with other specific conditions, e.g., mumps, vaccinia or almost any specific virus infection, encephalitis and polioencephalitis ; glandular fever, syphilis, leptospiral infections ; cerebral abscess usually results in a CSF lymphocytosis in the absence of diffuse meningitis.

Signs of portal hypertension : Ascites is commonly placed under this heading. The highest portal pressures are found in children with congenital abnormality of the portal vein ; these children rarely have ascites. Lowering of the portal pressure by operation on patients who do have ascites rarely cures the ascites. Ascites in chronic fibrosis of the liver is a result mainly of the hypoproteinaemia and salt retention ; high portal pressure and other factors play a relatively small part. Portal hypertension is also only one factor responsible for the splenomegaly in cirrhosis of the liver. The demonstration of collateral venous circulation is the only sure clinical sign of raised portal pressure (see Himsworth, 1950).

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I wish to thank Professor Christie for his advice and encouragement and for reading the manuscript of this article. P.F.I.

HOW LITTLE BRITAIN GOT ITS NAME

In the good old days of yore, O Best-Beloved, about the time of the year DOT[1] when people were not, as now, born equal, there was quite a sizeable town where the great City of London now stands. Like the City we know today it had many Venerable Institutions, and not the least among them was a large hospital, ministering to the sick poor, which nestled up against the walls of the City. In fact, it occupied the exact site of our own Hospital. It wasn't called St. Bartholomew's then ; it was, to be frank, known by the somewhat less dignified title of Smithfield Infirmary, but there can be no doubt that this was the forerunner of Bart.'s.[2]

Apart from asepsis and antibiotics and X-rays and barium and anaesthetics and statisticians and archivists and ECT and ACTH and BCG and NATO and one or two other things, the Hospital, its inmates and its practise of medicine and surgery were much as we know it today. Then, as now, there were three doctors, four students, five nurses and six lay staff to every patient.[3] There were several professors and also many distinguished physicians and surgeons. (It was not till much later that the heavy tips earned by hairdressers attracted the latter into barbery, so that they became barber-surgeons.) As now, the professors came to the Hospital on foot or by humble conveyance, whereas the physicians and surgeons all bowled up in splendid chariots. And the students, as always, were as poor as church-mice and were the only ones who paid for the privilege of working there. There were just two differences. There wasn't a Hospital Journal *then* (or Rahere would never have got away with it). And there isn't a Local Ogre *now*.[4]

We are really very lucky in not having a Local Ogre. He was a monstrous thing, cast in the shape of a man, but colossal in size, being 300 ft. high, weighing 700 stone, and taking size 56 boots. He was 420 years old (quite young for an ogre), used to comb his hair with an oak tree (a new one every morning), had the abominable (and, for poor human beings, dangerous) habit of spitting, and worst of all, was a bad fellow, being a cannibal. For the most part he was, fortunately, no worse than the best of us and enjoyed mutton, beef and pork like everyone else. But occasionally he yearned for human, and then woe betide those of Bart.'s ! There was nothing he liked better in all the City than a succulent young nurse—except perhaps a plump, middle-aged physician. The students and professors he would never touch, the former being too thin and scrawny and the latter too old and leathery. He also harboured the spirochaete, in her tertiary form, so that whenever he walked abroad the ground cracked underneath him. All the Thames Estuary was his home, but he was far too fond of the wooded slopes of Clerkenwell and Islington for the peace of mind of most Bart.'s men.

Well, My Children, this went on for many years, and though there were many schemes for doing away with the Local Ogre none of them came to anything. The physicians and surgeons were very jealous of the Acquired Immunity of the students to being eaten, and were always trying to organise them into battalions to go and kill the Local Ogre, holding out the promise of Brackenbury's and house jobs. But as the Council of the Students' Union politely pointed out, if only the physicians and surgeons were to *slim*, they wouldn't be in such danger. No : there just didn't seem to be anything for it but to wait until his Unmentionable Disease killed the Local Ogre, and as he was already in the tertiary stage there was reason to hope, so the Professor of Pathology (a wily Pict) asserted, that he would die in about 150 years. Unfortunately, he didn't know (really through no fault of his own) that in Local Ogres there are quartiary and quintiary stages as well, so that he couldn't be expected to die from his Unmentionable Disease for about 300 years.

Now at this time, O Best-Beloved, there were living in a little lane running along the east side of the Hospital a young boy (an adolescent male, in fact) named Cedric, who was apprenticed to the instrument-maker of the Hospital. Cedric (who took good care to keep himself thin and scrawny for fear of being eaten) brooded long over the problem of the Local Ogre, and would fain have solved it. In fact he brooded so long that he was nearly sacked. And then one day (a day most memorable in the history of this Hospital) an idea struck him ; it practically laid him out. He had, of course, frequent occasion to pass in and out of the Hospital and

it had appeared to him somewhat paradoxical that though a large number of *ill* patients entered the Hospital, only a very small number of *well* patients left it. In short, the mortality rate was something shocking. And when he asked the students why this was so, they all made the same reply—" Infection."

In the course of time he had learned a little about infections, how some were acute and some chronic, and some gave rise to rigors and some to high fevers and some to vomiting and so on.[5] He also deduced something else, which seemed quite self-evident to him but has only recently been re-discovered. It really made him much cleverer than all the professors and physicians and surgeons put together. He saw that where there were dirt and an open injury, then there was infection, and not being very well versed in Logic and Metaphysics he made the reasonable deduction that the dirt caused the infection.

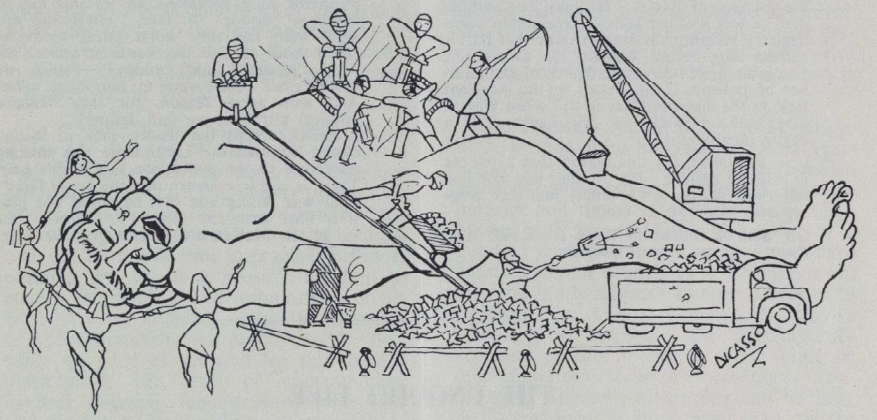
And so he had a Bright Idea. Inflict a small wound on the Local Ogre, he thought, make it infected with dirt, and leave the rest to Nature. As he quite rightly mused : " We haven't got penicillin yet, and even if we had the Hospital wouldn't treat him.[6]" And so he went about collecting some dirt. Though London wasn't really so clean then as now, O My Well-Scrubbed Children, Cedric knew that no ordinary dirt was likely to infect a Local Ogre. It would have to be special, and specially collected. So he made a Horrible Concoction. He took a dustbin and into it he put all his nail-clippings for three months, and all his hair-cuttings, and all his dirty hankies, and all his dirty collars, and spent matches and cigarette ends and the dust from under his bed and lots else besides, till the dustbin was full. And then he dragged it out into the wash-house, set a good fire going, and boiled the dustbin and its contents steadily for three days and three nights till he was sure that the Horrible Concoction was fit for use.[7]

And then one morning he took his master's sword, and a needle and some thread, and the dustbin on his back, and strode off out of the City towards the wooded slopes of Clerkenwell and Islington where the Local Ogre lay sleeping. When Cedric had reached him, he made a 3 ft. long incision with the sword (which, fortunately for this story and the future of this country, was *very* rusty and dirty) in the side of the Local Ogre's left foot. This made him stir a bit and Cedric had to nip out of the way a bit sharpish. Then, when all was quiet again, Cedric took the dustbin, emptied its completely sterile contents into the wound, spread them about nicely, and sewed the wound up again. He returned home quickly, saying nothing of his venture and getting a good thrashing for being absent when needed.

Every day he went to see his patient until the Local Ogre got quite used to having him around. (He didn't want to eat him because he was too thin and scrawny.) One day he asked him—in a whisper because he knew he only made humans deaf if he spoke to them normally—why he was so regular in coming to look at his feet and Cedric said quite openly : " Because I've given you an infection." And with this the Local Ogre had to be content, not having the faintest idea what an infection was, though he was very soon to learn.

Now, O Best-Beloved, the incubation period for Local Ogres is a long time,[8] so it was not till eight weeks had elapsed that our Local Ogre began to experience symptoms and display signs. His symptomatology was bizarre, to say the least, and his signs were the most elicitable, palpable, obvious signs that the most ignorant dresser in S.O.P.s ever prayed for. Suffice it to say that he suffered very badly indeed, and nearly flattened Bart.'s (he *did* flatten the meat market) with his rigors.

The people of the City and of Bart.'s sensed that there was something wrong and for several weeks came to watch the agony at a respectful distance. Thus it was that they learned what a hero they had in their midst. For Cedric always went up close and had a particularly good look, and the Local Ogre, now nearing his end and too weak to move, spotted him one day, and shouted out (and his shout was no more than a whisper) : " It's you, you wicked human. It's your infection that's killing me, you Bloody Ruddy Irritating Troublesome Aggravating Interfering Nitwit !" And so the people of the City knew that it was Cedric who was their saviour.



One week later the Local Ogre expired, and the City and Bart.'s were *en fête*—everyone, that is, except the students. For they, poor things, were made to work harder than ever. As the Professor of Pathology (that wily Pict) looked out of the dirty windows of his laboratory he could see the inert mountain of the Local Ogre, and it suddenly struck him what a heaven-sent opportunity this was to do a P.M. on a Local Ogre. And so he rounded up all the students, all 700 of them, marched them out and made them all help in this Gargantuan Autopsy. They were at it for weeks, during which time everyone else had a wonderful time. At the end of it all the spate of papers emanating from the Pathology Department—especially the monograph on "Unmentionable Diseases in Local Ogres" — won great fame for Bart.'s, but the students were Fed Up to the Back Teeth. Cedric, a hero with everyone else, was extremely unpopular with his one-time friends, who could think of no words in common use in their own vocabularies which would adequately describe their dislike for him. So they used the Local Ogre's, and Cedric's ears rang to the shouts of " You little Bloody Ruddy Irritating Troublesome Aggravating Interfering Nitwit." This was rather a lot to howl at him as he disappeared round corners and up and down stairs, so they took the initial letters of the Local Ogre's swear-words and called him " Little BRITAIN," placing great emphasis on the last word.

The rest, My Children, will be briefly told, for it is long past your bedtime. It goes without saying that the citizens of London called the lane Cedric lived in " Cedric Street," but the students would have none of it, and called both him and his lane " Little Britain."

In the course of time all the witnesses of the events in those High and Far-Off Times passed away. The fame of Cedric lived on, but by one of those curious distortions of history which occasionally occur, it was his other name, " Little Britain," which lingered on. On the 1,000th anniversary of his death the old greybeards running Wessex decided to change the name of the country, and what

more natural than that they should choose "Britain" as the new name, calling it "Great" in addition because it was so obviously Little?

And, My Best-Beloved, if you can think of a better reason why Little Britain got its name, you'd better write and tell us.

I. H. B.

REFERENCES

[1] DOT=Days of the Old Testament.

[2] One of the greatest hoaxes in history was played when Rahere so fixed things that he managed to convince posterity that *he* was the founder of Bart.'s. It is not for nothing that he was a Court Jester. Irrefutable documentary evidence survives to show that Bart.'s existed long before William the Conqueror. For instance, we have the figures of the number of patients (215) treated in the Accident Box on the disastrous day in 817 when Wessex played the Danelaw at Twickenham in a rugby international.

[3] It is, of course, for this reason that a patient is called a patient. He (or she) was not just suffering (patior, *L*=I suffer) but was *long-suffering*—patient, in fact).

[4] Oh, and of course, in those *good* old days, there were no women students.

[5] The interested reader is referred to his text-books. It's about time he had a look at them anyway.

[6] Hippocrates had not yet been born, so there was no Hippocratic Oath to worry about.

[7] You might think from this that Cedric was an ESNAM (educationally sub-normal adolescent male) but he was really quite bright. No one knew in those days that heat kills bacteria.

[8] We *do* know that local staphylococcal infections don't have incubation periods, so don't go writing clever letters to the Editor. We'll only tear them up.

[9] You may think that "interfering nitwit" is very mild language to use of one who is killing you, but just as the Local Ogre's moral standards were perverted, so was his use of language curious. In fact, "interfering nitwit" were the very worst swear-words he could think of, and the words he started off with, "bloody" and "ruddy"—which we think rather rude—were to him quite tame. And with some reason, for they describe physical attributes we find desirable.
I cannot accept the theory that in calling Cedric a nitwit the Local Ogre was making references to the population in Cedric's hair. There is ample evidence that the Local Ogre's sight was failing and that he could not possibly have seen any nits. For "nitwit," see R. M. B. McKenna's *Diseases of the Skin*, p. 250.

THE UNQUIET LIFE

"No biography can portray fully the force of a man's character and personality but it can provide the material for us to create for ourselves a fairly accurate impression (of him)."
Prof. Ross, reviewing John Fultons's biography of Cushing, The Journal, December, 1947.

Just as the literature of the nineteenth century was characterised by the double decker novel, so one might typify that of the twentieth as the biography. Famous and infamous men of the present day are constantly inspired to commit this; so much so that one might paraphrase the Bard and say that some are born to biography, some achieve biography, and some have biography thrust upon them. This phenomenon, which must reflect a definite demand on the part of the reading public, may be explained in several ways. Firstly, this century has seen the final abandonment of any pretence at privacy in the lives of the great; in the popular press one reads of their personal preferences in breakfast cereals and bath mats, and the radio and television take us into their very homes. The development, too, of psychology has led to extensive analysis of one's own and other's motives. For the lazy man sitting in his library by a comfortable fire, an adventurous life story offers all the excitement and unusual possibilities so lacking from his own, without any of the concomitant risk.

This century has already seen several works of the first order cast in the biographical mould. Perhaps the tradition

Hamey the Stranger, by John Keevil, pp. xvi, 192; 6 illust. Geoffrey Bles, price 21*s*. net.
John Abernethy, by John L. Thornton, A.L.A., pp. 184; 8 plates, 5 figs. Printed for the author and distributed by Simpkin Marshall, Ltd. Price 25*s*. net.

started with George Moore's rambling works, of which "Confessions of a Young Man" is probably the best known. In the 'twenties there was an unfortunate *mésalliance* with fiction: thinly disguised autobiographies told of fathers who hated their sons, mothers who could never understand, and beefy sadistic schoolmasters. Perhaps the best work in the *genre* at that time was done by Lytton Strachey, whose portraits of Queen Elizabeth and of some eminent Victorians will long be treasured by connoisseurs of the incisive phrase and flowing sentence. A "purer" form of biography was seen in H. G. Wells's "Experiment in Autobiography," which appeared in the middle 'thirties and which paved the way for the two masterpieces of self-observation, namely Sir Osbert Sitwell's memoirs and Stephen Spender's recent "World Within World."

So far with a few notable exceptions, of which Mr. Kenneth Walker's self-portrait is one, there have been few medical biographies produced which have any literary pretensions or which have achieved a wide public. This is not altogether surprising, for the medical man can have little time to practise this most exacting art, nor is it possible for him to convey the conflicts and technicalities of his work to a lay audience, unless he descends to a sensationalistic and popular level. But, while we must as yet wait for this unborn masterpiece, the level of contemporary medical biography remains remarkably high and the two books under review do nothing to confound this statement. Though dealing with widely differing times and personalities, they are nevertheless worthily considered under one heading.

Baldwin Hamey was a sixteenth century physician who early in life sought refuge from the religious persecution of his native Bruges in Leiden, in which university he afterwards studied and obtained his doctorate in 1592. From 1594-97 he held the unusual appointment of Physician to the Kremlin under Czar Fedor—a court characterised by "... excessive drinking, strange wedding and funeral customs with their suggestion of witchcraft, the curious music of the bagpipes and the balalaika." Many of Hamey's letters to his friends at that time have survived and, translated here by Dr. Keevil, have a contemporary sound about them in the description of an "iron-curtain" capital. Understandably, Hamey soon tired of the claustrophobic atmosphere and petitioned the Czar for permission to return. From 1698 to his death Hamey made his home in London and the greater part of the book is concerned with his marriage and his struggle to obtain recognition of his professional status. The book is well written. Dr. Keevil possesses a civilised prose style and whether writing of the Essex rebellion or the Plague, or Hamey's early days in Leiden or Moscow, can always be relied upon for a clear and fascinating treatment of his subject. The illustrations, also, have been well chosen—especially noteworthy is a superb map of old Moscow. A novel feature of the binding is the incorporation of the family arms in gold on the cover. We look forward to the sequel to this fascinating biography: this will deal with Hamey the younger, Baldwin's son, and is promised for this spring.

Mr. Thornton started with a disadvantage in the writing of his biography of John Abernethy, in the shape of the highly detailed documentation of the surgeon's contemporaries and times. One shudders to think of the predicament of the biographer of a hundred years hence, who no doubt will have a fierce internal struggle as to whether or not to mention his subject's income tax forms in the biography. This is, of course, Dr. Keevil's book's great strength; the contemporary accounts of life in Hamey's day must be much fewer than those of Abernethy's. Consequently Hamey's biographer can be freer in his treatment of his subject than can the biographer of a surgeon living at the beginning of the nineteenth century. It seems to us that Mr. Thornton has surmounted these problems in no uncertain way and has evolved for himself a highly successful synthesis of historical scholarship and human interest. It must be confessed, however, that to our minds the high esteem with which some still regard Abernethy is a little disproportionate to his actual achievement. Many of his quips and quarrels now seem merely boorish, he founded no school of surgery and his writings possess only historical interest. His claim to fame, of course, rests in the founding of the medical school at Bart.'s, and it is a pity that this important aspect of his work is not more fully discussed in the present work. But the book will be of great value to all those interested in the history of medical education, and to all Bart.'s men Mr. Thornton's labour of love is indispensable.

OBITUARY

We very much regret the occurrence of a number of errors in the Obituary of March, 1953. The corrected details are as follows:—

B. L. Jeaffreson, aged 56 (*qualified* 1921).
James Cole Marshall (*qualified* 1900).
F. E. Saxby Willis (*qualified* 1913).
A. M. Ware (*qualified* 1899).

Dr. Josiah Oldfield

died on February 2, aged 89.

The death of Dr. Josiah Oldfield, within a fortnight of his ninetieth birthday, has deprived the world of one of its most stimulating and sometimes turbulent campaigners for minority causes.

Josiah Oldfield studied at the Newport (Salop) Grammar School and then proceeded to Oxford, where he obtained Honours in Theology and Civil Law. In 1892 he was called to the Bar by Lincoln's Inn; he then practised for some time on the Oxford Circuit. Deciding that a knowledge of medicine was an indispensable qualification for anyone who wished to understand either the religious or the social nature of mankind, he took to the study of medicine and, in 1897, qualified from Bart.'s. His interest in moral and legal problems led him to write a thesis on Capital Punishment, for which, in 1901, the University of Oxford awarded him a Doctorate in Civil Law. In the same year, he founded the Society for the Abolition of Capital Punishment. During World War I, he served as a Lieut.-Colonel in the R.A.M.C. After he was demobilised, he reopened the Lady Margaret Fruitarian Hospital, of which he had been founder, warden and senior physician.

In his undergraduate days he had become an advocate of Fruitarianism and, until the end of his life, he conducted a vigorous campaign against the eating of slaughtered animals. His tremendous energies expressed themselves in a bewildering diversity of activities—books, lecture tours, visits, to most of the countries of Europe, to Jamaica (where he became a member of the Jamaican Bar) and to India. Even this continual activity left him time to devote critical attention to everyday events in England. Yet he did not forget the past. In his last years, he would frequently refer to the period he had spent as a student at Bart.'s, remembering particularly the work of Dr. Gee, under whom he had trained. Dr. Gee, he used to say, had been a "first-class teacher and technician." Then he would add: "There are very few who even remember Dr. Gee now—but, in his day, he was a Great Man." J.M.O.

Sir Holburt Waring, Bt., *C.B.E.*, *M.S.*, *F.R.C.S.*,

died on February 10th, aged 86.

J.B.H. writes:

Holburt Waring entered Bart.'s in 1886 as a scholar in Natural Science, and qualified with Honours in 1890. His appointment that year as a House Surgeon commenced an almost unique record of continuous service to the hospital which continued until his retirement in 1932. He was elected assistant surgeon in 1902, and full surgeon in 1909. Between these dates two temporary operation theatres were built, where the Sasoon D X R department now stands, and here Waring and Lockwood developed a sound and practical aseptic ritual which became the pattern of the new aseptic surgery throughout the country.

Not only did Waring work hard for Bart.'s, but he served the University of London and the Royal College of Surgeons as faithfully. He was Dean of the Faculty of Medicine, and later Vice-Chancellor (1922-1924), while at the Royal College he held many lectureships, served ten years on the Court of Examiners, and twenty-four years on the Council. He became President in 1932.

Further details of his full and interesting career can be found elsewhere, but to very many now at the hospital and to those who have qualified in the last twenty years, Waring represents only the name of a ward in the surgical block. This is perhaps a fitting memorial, for he had more than anyone else to do with the building of the surgical block and the planning of the medical block. The new buildings alone represent a fine achievement, but in addition he worked hard in making our school an efficient institution, and was the moving force in obtaining a Charter of Incorporation in 1921, thereby establishing the Medical College. It is interesting to reflect that prior to World War I any profits (and there were profits) made from students' fees were shared between the Medical Officers and the Lecturers.

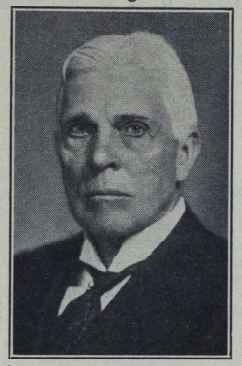


Photo by courtesy of the B.M.J.

Waring exerted a profound influence on the training of Bart.'s men for more than three decades. He was a most successful, if unorthodox, teacher. The teaching was all done in the wards or the operating theatre. His speech and manner were abrupt and forceful, so that some found him frightening. He was a strict disciplinarian, and woe betide the dresser who transgressed one of the rules of asepsis while in the theatre, but the result was that a correct technique became second nature. He taught, too, observation, exactness of expression, an ordered manner of thought, firmness of decision, and punctuality. These were worth while and lasting acquisitions, and those who were trained by him realise now how purposeful his methods were and are grateful.

Waring was made C.B.E. in 1919, and was knighted in 1925. In 1935 he was created a baronet "of St Bartholomew's in the City of London," showing clearly his great affection for our ancient and Royal foundation.

COMPETITION

Set by Chimp Eagle.

The writer was beset by an appalling dream the other night. Through some agency unknown the "chiefs" had been separated from their own departments and assigned to others: without mentioning names, though not restricting themselves in any other way competitors are invited to give the first hundred words of *one* of these ward-rounds (no special knowledge by the chief of the new subject should be assumed).

Psychiatric ward round by an Orthopaedic Surgeon.
Gynaecological ward round by a Physician.
Surgical ward round by a Psychiatrist.

Entries by June 15. The usual prizes will be awarded.

COMPETITION RESULTS

How Little Britain Got Its Name

The entries received for this were of a low standard and no prize was awarded. An "official" version will be found on page 111.

Limerick Competition

Report by Burbank and Bleistein

The response to this competition was gratifying. Several queries were raised as to the accuracy of our spelling, but did not seriously disturb our competitors. We confess to having cheated over Hackenbusch, which was the name adopted by Groucho Marx in one of his immortal films, and was later used in a highly successful leg-pull on one of this hospital's recent prizewinners. Several competitors discovered a near relative in a doctor Hackenbruch, who made a discovery about local anaesthesia. One competitor complained

> Higomenaki and Hackenbusch, have caused me some frustration,
> I never learned about those boys in my conjoint education.

We might have foreseen that to that indefatigable manufacturer of verses who provided our text, this competition would prove an irresistible challenge. It was overwhelmingly met, and by every post came pages of foolscap bearing alternative answers.

So to R. B. Price goes the first prize. The other entrants were lengths behind but

T. Arwyn Evans and Dr. Spafford sent worthy attempts. They receive book tokens for 10/6. D. Carrick's entries were marred by poor scansion and R. Hutchinson did not describe the symptoms of the conditions very adequately.

Space forbids us to print many of the winning verses. Here is R. B. Price's "Loa-loa."

LOA-LOA

Quickly, quickly, doctor I've a
Tickling in my conjunctiva—
Take your needle, get your goad,
Nab this nimble nematode!
Ow! My eyeball feels on fire—
Not there, doctor, higher, higher!
No, you've missed him! Take it slower—
Ah! That's better, lower, lower!
Got you, Mister Loa loa!
Late inhabitant of Goa,*
Ex internal organ blower,
Little puffy tumour grower,
Fierce volcanic larva thrower,
Chrysops flight-excursion goer,
Conjunctival to-and-fro-er,
Periodic come-and-goer,
Pre-diluvian, and so a
Fellow passenger of Noah,
Trickiest of protozoa†
Hiya! Hiya! *Loa-loa*!

* My geography was always weak—never could distinguish between Malabar and Calabar.
† What's in a name? That which we call a worm
By any other name would crawl and squirm!
And the concluding lines of Ayerza.

AYERZA'S DISEASE

But having my disease named after you
Is the last straw! That genuinely hurts, Sir,
To be described as "typical AYERZA"!
How it's pronounced I neither know nor care, Sir,
But don't give *me* your b——y name AYERZA!
If that's still wrong, then tell me how on earth a
Confounded dago *does* pronounce AYERZA!

The other winners did best on onychogryphosis

I've got horns on all my toesis, what can be the diagnosis?
Eeny-meeny-miney-mosis—Ah! Yes, onychogryphosis.
T. Arwyn Evans.

My first wife tore our marriage up with moans and halitosis
My second tore the sheets, with onychogryphosis.
J. A. Spafford.

EXAMINATION RESULTS

CONJOINT BOARD

First Examination

March, 1953

Anatomy
Millard, F. J. C.
Physiology
Arthur, J. K. Millard, F. J. C.
Pharmacology
Goss, G. C. L. Hill, E. J. Kellett, P. Perkins, M. V.
Whitting, H. W.

ROYAL COLLEGE OF SURGEONS

At the Primary Examination held in February, 1953, the following were successful:—
Braimbridge, M. Green, N. A. Rothnie, N. G.

UNIVERSITY OF CAMBRIDGE

Examination in Pharmacology for Medical & Surgical Degrees.

Lent Term, 1953

Bourne, W. R. P. Nottidge, R. E. Williams, W. D. W.

M.Chir. Examination

Stephens, J. P.

SOCIETY OF APOTHECARIES

Final Examination

February, 1953

Medicine
Smith, G. C. Taylor, G. I.
Surgery
Kaan, N. Halabi, N. S. Taylor, G. I.
Midwifery
Stevens, J. L. Chapman, L. Taylor, G. I.

The following candidates have completed the Final Examination and are granted the Diploma of Senior Scholarship in Anatomy, Physiology and Biochemistry.
Kaan, N. Chapman, L.

UNIVERSITY OF OXFORD

2nd B.M Examination

Hilary Term, 1953

Forensic Medicine & Public Health
Bateman, J. G. Jones, J. M. Tilleard-Cole, R. R. Bush, G. H.
Mellish-Oxley, K. G. Ford, F. D. C. Radford, B. L.
Special & Clinical Pathology
Bush, G. H. Ford, F. D. C. Jones, J. M.

CORRESPONDENCE

BART.'S SPORT

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

Dear Sir,

Those who take an interest in the various sports clubs of the Hospital cannot fail to have noticed that most have declined sadly in the past few seasons. The cricket club last season was hard put to it to raise even one eleven on occasions, the soccer and hockey clubs are having similar trouble now and even the rugby club which once fielded five fifteens has had great difficulty in running three since Christmas. The climax was reached in February when in the United Hospitals cross-country championships only two members (out of 700 students) were willing to run.

A general apathy is spreading through the Hospital, and unless we do something to check it our results will be even worse. The chief offenders seem to be the younger students, especially Charterhouse members. I suppose the reasons are partly financial—though playing for a club is one of the cheapest ways of spending a Saturday in London but chiefly because the wrong approach is being made by many students to the problems of studying for examinations. It is just as easy to get mentally as physically stale, and the ideal way to prevent this is to indulge in some healthy, vigorous exercise once a week. Second M.B. results in the past have shown that those who have played all the way through have done equally well and in many cases better than those who gave up sport to study.

This Hospital is judged by the public just as much by its sporting as by its medical achievements. We have great traditions in both spheres but unless we do something to combat this apathy our reputation in the former will be lost.

W.B. CASTLE.

Abernethian Room.

POST-GRADUATE REFRESHER COURSES FOR GENERAL PRACTITIONERS

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

Sir,

I put forward the following suggestion for the post-graduate tuition of general practitioners.

That as an alternative to the usual post-graduate course at a teaching hospital, the general practitioner could apply to his old teaching hospital or other central body for a senior registrar (or what was called in my day a chief assistant) to come and spend a week in his own house.

The advantages to both, in my opinion, are great. I feel that more medicine and more tips are learnt over a cup of coffee or glass of port in the evening than by attending any number of post-graduate lectures. The registrar would also have the advantage of seeing how a general practitioner works and possibly make useful contacts and would undoubtedly see a number of interesting and rare cases. The general practitioner would, no doubt, be able to obtain another opinion on many of his undiagnosed cases! A registrar could surely be spared by his chief at hospital for one

week or possibly two in a year. A general practitioner could apply for this visit say once in every three or five years. The only disadvantage that I can see is that one's wife would have to put up with a week of "shop talk," but I am sure she would realise the immense benefit to one's patients, the general practitioner and registrar to such a scheme.

I will be interested to hear what other general practitioners and registrars think of this suggestion and how to put it into operation.

I am, etc.,
J. B. BAMFORD,
Ely, Cambs.

We shall welcome the opinion of our readers on this suggestion.—Ed.

ON THE TILES

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

With reference to "Tiles" on page 53 of your current issue, it may interest you to know why "the camels that Rebecca rode have a very supercilious expression." An Arab in the Sudan told me: "There are one hundred names for Allah. Every good Mohammedan knows ninety-nine of them but only the camel knows the hundredth."

But that was thirty years ago. Perhaps the higher education has altered all that. Who knows? If we knew, we might adopt the supercilious expression of the aforesaid camels!

Yours faithfully,
NORMAN F. SMITH.

P.S.—I am aware of the anachromism as between Rebecca and Mohammed. But what of it? It makes the camels all the more wonderful!

THE NEW COVER

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

You asked for the views of your readers regarding the latest cover of the *Journal*. Personally, I like it and hope most of your other readers will approve of it.

I don't know what year the Bart.'s *Journal* started, but I suppose I have been a subscriber for over fifty years, as I date back to '98 and was H.S. to Cripps and Waring—Yellow firm—and am very sorry to see in today's *Times* the notice of the death of Sir Holburt Waring. He was Head of the "rooms" when I was dissecting and was ten years older than me.

With all good wishes to the *Journal*.

Yours truly,
F. P. CONNOR.

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

A number of years ago you kindly published a letter of mine deploring the newly designed cover for the Bart.'s *Journal*, representing the Monk, Rahere, in a somewhat compromising position!

I should now like to be one of the first to offer my congratulations on a really excellent design which should appeal to all Bart.'s men, on account of its dignity and simplicity. This change is a great improvement and I should like to offer you my sincere congratulations on it.

Yours faithfully,
C. MARTIN-DOYLE.

Worcester.

DOWSING

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

I was most interested to see your most instructive and entertaining programme on water divining, which was televised last night.

The subject was investigated by the late Dr. G. A. M. Lintott of the Physiology Department, Guy's Hospital, in 1933.

Dr. Lintott's account of his investigation was reprinted in the "Guy's Hospital Gazette," Vol. LXVI, No. 1681, published on December 27, 1952.

He found by experiment that running water gave a far greater stimulus than did still water, and that the actual physical phenomenon of "dowsing" depended upon small changes in muscle tone of the dowser, and were independent of any form of divining rod.

Like yourselves, Dr. Lintott was unable to deduce the source of the stimuli, but considered that " . . . the production of the response is a subconscious affair concerned with the more primitive centres rather than the cerebral cortex.

The late Professor Plumbey was concerned with the experiments which took place in the Guy's Physiology Department and also out in the country, and it was concluded by these workers that water divining is in fact a genuine phenomenon.

It is to be hoped that the suggestions made by Professor Rushton indicating lines on which future research might run will be carried out and the results obtained made known at a future date.

I am, Sir,
Yours, etc.
B. H. BASS,
Lieut. R.A.M.C.

EMIGRATION

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

I was perturbed to read in your Editorial article of February that nowadays only a very few countries, e.g., Gold Coast, Ethiopia, etc., do not suffer from a shortage of doctors. This statement must be disappointing to any new graduates who are thinking of joining the Colonial Medical Service and I can assure you that it is not the case in the Service in Kenya, where there are at the present time a number of vacancies.

I have practised in this country since World War I, and, in spite of the present state of emergency which I cannot believe will be of long duration, would still prefer to live and work here rather than anywhere else in the world. I know of no other place where business and pleasure can be so adequately combined. Should the mention of the Gold Coast provide an analogy to thinking minds, I can only say that successive British Governments have emphasised the fact that European settlement has come to stay.

I would with all due seriousness invite any Bart.'s man nearing the end of his time seriously to consider the Colonial Service in Kenya, even if only to complete his compulsory year as a house-man.

I am, Sir,
Yours faithfully,
C. VINEY BRAIMBRIDGE,

Nairobi.

SPORT

Fencing Club

Few formal matches have been fenced so far this year because of the absence of most of the team on other courses. The ladies' team have acquitted themselves well, however, winning all their three matches.

Results.

v. Royal Free (home)	**Won 6—3**
v. L. S. E. (home)	**Won 5—4**
v. Royal Free (away)	**Won 6—3**

Rugger Results

v. Stroud (away)	**Lost 19—6**
v. Taunton (away)	**Lost 19—0**
v. Kennworth (home)	**Drawn 3—3**

Matter for this column is always welcome. It should be handed to the Sports Editor by the 1st of the month preceding month of issue.

BOOK REVIEWS

MANAGEMENT OF BRONCHIAL ASTHMA, by H. G. J. Herxheimer. Butterworth & Co., pp. 107. Price 22/6.

Dr. Herxheimer has given a considerable amount of thought to this enigmatic disorder in the past few years. He has tried out various standard remedies and has come down largely in favour of very big doses of anti-spasmodics. The book is a creditable effort in a difficult field and is well produced. It is unfortunate that a book of some hundred pages should have to cost as much as 22s. 6d.

NEVILLE OSWALD.

ORGANIC CHEMISTRY FOR MEDICAL, INTERMEDIATE SCIENCE AND PHARMACEUTICAL STUDENTS, by A. Killen Macbeth. Third Edition, 1952. Longmans, Green and Co., pp. xvi + 324. Price 12/6.

For the medical student commencing the study of Organic Chemistry the choice of a suitable textbook is always a difficult one. There are comparatively few textbooks of reasonable size which give an adequate treatment of the general principles of the subject, and at the same time introduce the reader to the wide range of naturally occurring and synthetic organic compounds which are of particular interest to the biochemist and the medical scientist. This third edition of a well-known book is to be particularly commended in this respect. Attention is paid to the general properties of the different types of organic compound rather than to a detailed study of complete families, and the amount of space devoted to aspects of the subject of relatively little interest to the medical student is commendably small.

The general layout of the book has not been greatly altered, but the bias towards the particular needs of the medical student has been increased by the addition of sections dealing with synthetic drugs and chemotherapeutic agents. The author is also to be congratulated on having introduced descriptions of modern methods of preparation and procedure, such as the utilisation of petroleum cracking products in the synthesis of alcohols, microanalytical techniques and chromatographic analysis.

There are a few respects in which the book might have been further improved. A section on keto-acids would have been welcome; the reference to four stereoisomeric forms of tartaric acid is definitely misleading, and greater emphasis might have been laid on the relationship between the chemical properties of organic compounds and the nature of the substituent groups within the molecule. These are, however, small criticisms of an otherwise admirable little book.

G. E. FRANCIS.

SURGICAL APPLIED ANATOMY. By Sir Frederick Treves, Bt. 12th Edition. Cassell. 21s.

Anatomy, although no longer chief mistress of our studies, still lends to them a charm and respectability which her fickle daughters, the new sciences, fail to emulate. Even if she is sometimes dull she is never old fashioned, and once wooed she is never unfaithful. Assured of the honesty of our intentions, she introduces us to her family, of whom the eldest, Surgery, turns out to be, unlike her mother, a woman of the world with all the brittle attraction of success. Hard to please and changeable, she is even critical of our manners and the cut of our clothes. If we are to gain her favours, then, we must win the confidence of her chaperone once more and court mother and daughter together.

Such a situation is fraught with dangers for the student. In his ardour for the young lady he must not forget his duty to her mother, nor must be linger so long in his respects as to stir the daughter's jealousy. If he is wise he will consult the long experience of other suitors, and it is to such a book as the one under review that he might turn.

The work is now in its twelfth edition and seventieth year. Written originally by Sir Frederick Treves, whom we remember best for initiating a fashionable operation at the expense of his Royal patient's convenience, it has passed through the able hands of Sir Arthur Keith and the late Professor Choyce. The last three and the present editions have been the responsibility

of Professor Lambert Rogers. The revisions which it has undergone are largely a reflection of the changing needs and methods of surgery. The anatomical teaching is still set down with a clarity of description which refuses to sacrifice either accuracy or elegance of phrase to the needs of brevity. Illustrations are not confused by a plethora of detail nor are they made a substitute for precise textual exposition.

Throughout the work, Anatomy and Surgery are introduced always together and without occasion for family jealousies. It is interesting to note that in the preface to the first edition the original author acknowledges his debt to "Mr. Hilton's familiar lectures on Rest and Pain." To say that the present edition still owes much to those remarkable lectures is recommendation enough. With this volume in his pocket the student may sally forth as confidently as the suitor with a manual of eitquette in his coat tails.

TEXTBOOK OF MEDICAL TREATMENT. edited by D. M. Dunlop, M.D., F.R.C.P., L. S. P. Davidson, M.D., F.R.C.P., and Sir John McNee, D.S.O., M.D., D.Sc., F.R.C.P. E. & S. Livingstone Ltd. Sixth Edition, pp. xvi + 1,023. Price 50/-.

This book has been produced primarily for the newly qualified and for the general practitioner. Its writers show a rare understanding of their needs. Both these groups will find it an invaluable tool about their daily tasks. Treatment is described in its widest and best sense, the whole management of the patient, and this in a delightful spirit of true charity and kindliness. Throughout there is a refreshing impression that one is helping a patient, and not dealing with a case.

Details of drug treatment (indications, contra-indications, doses and dangers), practical procedures, diets and nursing are full and explicit. Doses, Lord be praised, of both modern and Galenicals are in the metric system. Doses of the older Galenicals are also given in the apothecaries system. It would be pleasing if the authors, in the next edition, would be so bold as to commit the grains, minims and drachms to an overdue grave.

The general practitioner lacks his more fortunate hospital brother's army of almoners, dieticians and therapists. In this book he will find many of the answers which these worthy ladies supply. Where to buy salt-free bread and butter, the make of a good jock strap to keep the venereal patient's underclothes clean, trades suitable for the young cardiac patient, where leprosy sufferers may turn for help, etc., etc. The book abounds with evidence of that thrift and common sense we have come to expect from north of the border. There is a useful table of current (1953) price of foodstuffs, that the poor may be rationally advised on diet. With drugs of equal efficacy, the cheaper is always prescribed. Further evidence of the book's origin is found in the indignant statement that "Epidemic Dropsy is caused by Agemone Mexicana, erroneously and libellously called Scotch thistle."

However desirable, it is unlikely that many students will have time to read this book. For examination purposes they would do well to read at least the lucid chapters on "Principles of Cardiac Therapeutics," "Chemotherapy of Malignant Disease," "Chemotherapy," and "Dehydration and Electrolyte Deficiences." As essays in physicianly wisdom "The Care of the Aged" and "Psychotherapy in General Practice" should not be missed.

The Index is excellent.

RECENT ADVANCES IN ANAESTHESIA AND ANALGESIA. By C. Langton Hewer, M.B., B.S., M.R.C.P., F.F.A.R.C.S. 7th Edition, 1953, pp. viii and 440, 169 Illustrations. J. and A. Churchill, Ltd. Price 30s. 0d.

Most of us do our month's anaesthetics with Ostlere as our main reading, with an occasional visit to Minnitt and Gillies, or Mackintosh and Bannister. Mr. Hewer's new edition should be added to our list for it covers the well-established, the discarded, and the latest agents and techniques, which latter we see used in the theatres. The presentation is clear and interesting and it is easy to hold when reading, which will commend it to the lazy man. For those specially interested in anaesthetics there are hundreds of references showing where more information can be obtained from original papers. There are excellent chapters on the actions and pharmacology of the various drugs, and a very useful list of the barbiturates, with all their trade names, in the first half of the book. The second half is devoted to anaesthesia and analgesia for various types of operation, (some of the techniques can be seen at Hill End), and the final chapter explains the purpose and use of the yellow cards for charting the blood pressure and pulse during operations.

MEDICINE. Vol. I. "The Patient and His Disease," by A. E. Clark-Kennedy, M.D., F.R.C.P. Second Edition, 1953. E. & S. Livingstone Ltd., pp. xiv and 410. Price 25/-

In this second edition Dr. Clark-Kennedy has made some changes to bring it into line with Volume II, but the book still remains medium sized. This is not a textbook but a demand for a philosophical approach to medicine, and an attempt to show medicine as an integration of art and science. There is nothing that is new to those taught at Bart.'s, except perhaps the emphasis on the body-mind relationship.

The book consists of six chapters, which are really self-contained essays, each with a summary. The first, "Body and Mind," is an introduction for those beginning the curriculum, wrich can be read with benefit by all. The next two are designed for those who are starting clinical work, and cover symptoms and their commoner causes, and the examination and the commoner pathological states that may be found; this pair of chapters is written in a chatty style, and are not so useful for those who have done their first appointments. The next three are designed for the senior student and qualified man, and would be more acceptable still if they were not so verbose. "Heredity and Environment" spends 70 pages emphasising the uses of the classification "Congenital and Acquired, etc.," that we meet so early in our career at Bart.'s. "Reactions of Body and Mind" is a good account of the various responses to genetic and environmental troubles. "The Nature of Disease" emphasises our old friends "Congenital and Acquired" as well as the interaction of body and mind, and reminds us that health and disease merge into each other and no one can say exactly where one ends and the other begins, but there are also certain stations on the line that can be recognised as diseases. The book ends with a seven-line definition of disease.

The book is designed to make the reader think, and in this it succeeds. However, at Bart.'s we are taught to think along, perhaps not so far along, the lines advocated in this book. It should be borrowed and read as a useful corrective to the massive doses of textbooks that tend to upset our mental digestion.

PRINCIPLES OF HUMAN PHYSIOLOGY. By Professor Sir Charles Lovatt Evans, D.Sc., F.R.C.P., F.R.S., LL.D. 11th Edition.

Professor Lovatt Evans retired in 1949 from the Starling Chair of Physiology at University College, where for many years he had been teaching the principles of the subject and carrying out research in both the biochemical and biophysical branches of physiology. He is therefore eminently qualified to present this well-known book, as the cultured and wide scope of it shows.

The historical and biochemical introduction, always an excellent facet of the presentation, is retained, although the treatment of biochemistry is inadequate for the present 2nd M.B. syllabus. The cheapness of this reliable, comprehensive and up-to-date book will make it deservedly popular amongst students studying the pure subject. The academic approach may not appeal to those studying clinical medicine.

The rapid strides being made at the present in the use of electronics and isotopes make the treatment in the book seem meagre. A criticism of the many excellent histological drawings in the book is that hardly one has a scale attached, and much of the value of the erythropoiesis photomicrographs, Figs. 337 and 338, is missed because of the absence of colour.

The format of the book is good, but unfortunately the irritating alteration of size and character type is continued in this edition.

Generally the book is excellent value and is to be recommended.

PROGRESS IN CLINICAL MEDICINE. Edited By Raymond Daley and Henry G. Miller. Price 30s.

The second edition of this symposium is almost entirely rewritten. It contains much information that the student will have heard of in his rounds and lectures but does not find in standard text books.

There is a useful chapter on gastro-intestinal disorders, including liver diseases and the peptic ulcer problem. The sections on disturbances of water and electrolytes and potassium unbalance are excellent. The basic principles of electrocardiography are explained in fourteen pages and could be read with advantage by every student. These are a few examples of the excellent material. Other chapters deal with aspects of medicine that have become more prominent recently and include industrial medicine, psychomatic medicine and physical methods of treatment in psychiatry.

This is a first-rate book and well worth possessing even at a cost of 30s.

CANCER IN GENERAL PRACTICE. By R. W. Raven, O.B.E., F.R.C.S., and P. E. T. Hancock, F.R.C.P. Butterworth and Co. (Publishers) Ltd. First Edition, 1952. Price 30/-, postage 10d. extra. Pages ix + 265.

The authors state that their aim is to encourage the early diagnosis of cancer. This book does not quite achieve what it sets out to do. Perhaps this

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Case of R.R. Photograph taken 17th March, 1948, before treatment with "F99". Diagnosis, very severe Infantile Eczema.

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is due to the purely cancer approach, which ignores the more usual causes of such things as haematuria, postmenopausal bleeding, and discharging ears. The symptoms and signs of the later growth are well done, but there is a suggestion that this is the more important stage of the disease, as the early signs and symptoms are covered in many cases in one or two lines. The diagnosis is usually dealt with in a way that is only possible in a hospital, but this is designed for the general practitioner, who does not usually have access to such methods. The warning signs of a growth are not hammered home in any of the chapters, except that on uterine cancer.

For those who do not mind the occasional inaccuracy, this is a book to widen one's acquaintance with cancer. It is well printed, not profusely illustrated, and has an engaging cover.

ELEMENTARY PHYSICS, by G. Stead. Churchill. Eighth Edition, pp. xv + 578. Price 18/–.

The ever-increasing popularity of this book has by now established it as the standard textbook on "Elementary Physics" for medical students both here and in the Dominions.

The author succeeds admirably in producing a book which is both clearly and concisely written and covers the necessary ground for medical students fully.

The material on "Nuclear Physics" has been brought to to date and gives the student a clear picture of the rapid advances being made in this field.

"Stead" will surely maintain its well-deserved popularity for a long time to come.

"BAILLIERE'S NURSES' MEDICAL DICTIONARY," by Margaret Hitch. Thirteenth Edition. Baillière, Tindall, & Cox (thin paper edition). Price 5/–.

It is a pleasure to find that Miss Hitch's dictionary can once more be carried in the pocket. There is a misleading description of the action of pheniodol on page 492, which suggests that the dye finds its way to the gall bladder up the common bile duct, and that this can be helped by keeping the patient on his right side.

AIDS TO THEATRE TECHNIQUE, by Marjorie Houghton, M.B.E. Second Edition, pp. xvi + 260, 125 illus. Price 6/–.

AIDS TO TUBERCULOSIS NURSING, by L. E. Houghton, M.A., M.D., pp. xii + 308, 18 plates, 63 illustrations. Baillière, Tindall, & Cox. Price 6/–.

These are new editions of popular small textbooks. That on tuberculosis nursing is up to date enough to include the hydrazides. Theatre practices differ widely among hospitals, but Miss Marjorie Houghton's book contains sound information on all operative procedures.

AIDS TO MATERIA MEDICA FOR NURSES, by Amy Squibbs. Fourth Edition, pp. xvi + 248, 3 figures. Baillière, Tindall, & Cox. Price 5/6.

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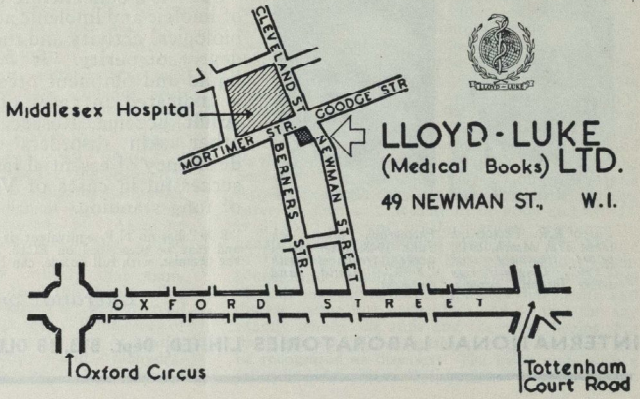

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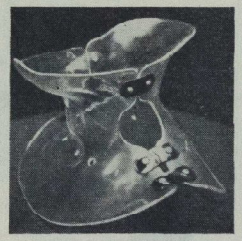

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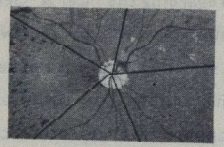

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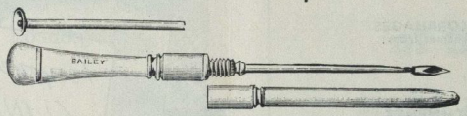

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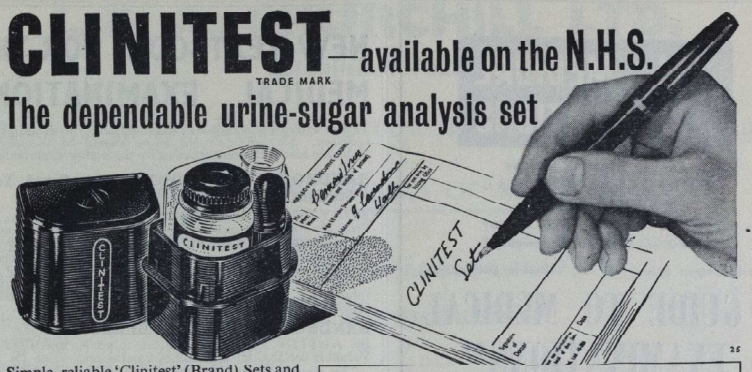

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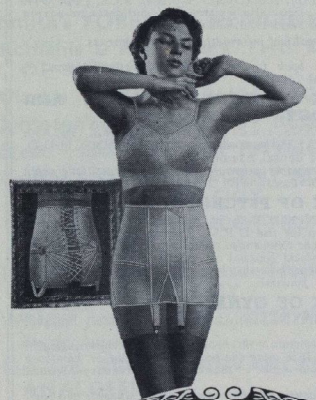

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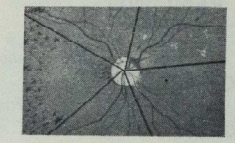

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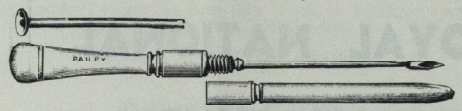

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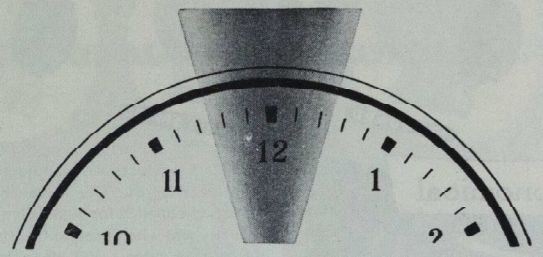

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ST. BARTHOLOMEW'S

HOSPITAL JOURNAL

Vol LVII JUNE, 1953 No. 6

In the coming fortnight the thoughts of all will be with the Royal Family, especially our beloved Queen. In a country which has always been inspired to greatness in thought and deed by the presence of a Lady on the throne, it affords us great joy that in these troubled times one should be there again.

We beg leave humbly to offer our own good wishes to Her Majesty for a long and prosperous reign.

* * * * * * * *

At such times there arises an opportunity for reconsidering the past and making plans for the future. Times of festival always provide a fixed point, both for the historian and the common man, for subsequently it often seems to both that the pattern of life changed perceptibly at that moment. What then are our hopes for the future at this new turning point? Foremost in everyone's mind is the ultimate solution of the larger world problems, the maintenance of peace and the improvement of living standards. Here at this hospital we look forward to further recovery from the scars of war and the gradual expansion of all the individual departments. At Charterhouse Square the distinguished façade of the College Hall will soon have a fellow in a new preclinical block. We predict that it will not be long before the preclinical site becomes a mecca for all those interested in seeing the solution of architectural problems in a truly contemporary style.

We look forward, also, to the breaking down of the barrier between specialist and layman. Too many today are concerned in extreme specialization, whether in science or the arts; neither their colleagues nor the intelligent layman can appraise or understand their work. We believe the time has come to call a halt to this cult of the esoteric, and for a new perspective to be found. It will not be easy. The public must always be prepared to meet the individual halfway, for otherwise mental sloth is pandered to, with results painfully obvious in present-day totalitarian countries. Not to attempt this *rapprochement* is to court disaster; ultimately society depends not on the technicians, but on those who—by virtue of a broad grounding in the humanities—are able to appreciate the far-reaching effects of the technical advances.

* * * * * * * *

This issue celebrates both the Coronation and the Sixtieth anniversary of the *Journal*, which falls later in the year. It is being sent out to all Bart.'s men whose addresses can be traced, and we take this opportunity of sending our greetings and cordial good wishes to them on behalf of all at the Hospital and Medical College.

Photograph of a contemporary drawing on wood of Queen Elizabeth I. in Ashburnham House, Westminster School.

RETROSPECT

A Review by an unknown author, which seems to have been read to a meeting held at St. Bartholomew's Hospital, in 1700.

In addressing a meeting of so learned a group as this it should hardly be necessary to concern myself with the current argument as to whether this year of 1700 in which we live is the first of the eighteenth century, or the last of the seventeenth. Suffice it that the "sixteen hundreds" have passed away. With the approaching centenary of the death of our great Queen Elizabeth we may look back upon the many achievements—and especially those in medicine—which have taken place since her accession to the throne in 1558.

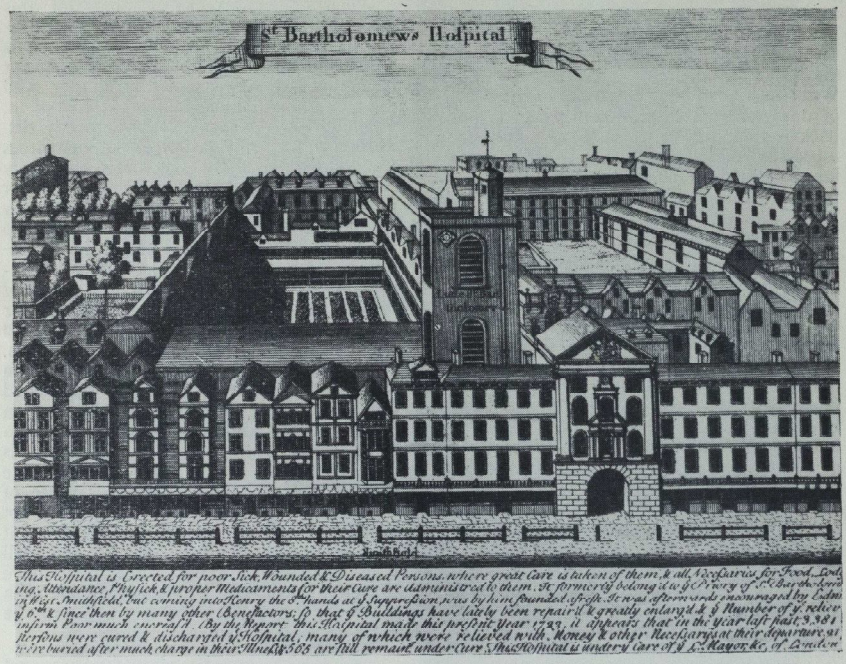
It is difficult to survey this period of nearly a century and a half without some misgivings. The life of the people has altered but little or better or worse despite. on the one hand, the glories of Elizabeth the art of Shakespeare. the great medical and scientific discoveries—and on the other, the intolerant religious disturbances which culminated in the Protectorship of Cromwell. Even the Great Fire, which destroyed so much of our City, and was finally put out a mere stone's throw from where we meet, brought evil with its good. The excellent modern dwellings which have now been put up all around us, and the better water supplied to the district from the springs of the village of Islington, have already shewn how health may be derived from pure air and water even in a city. But those of our fathers who remember the terror of the Fire itself, and the beauty of old London dominated by the glorious Norman work of the Cathedral of St. Paul and our own Priory Church will find it sad indeed to see the ugly new buildings, the overwide streets, and the hideous modern work of Sir Christopher Wren on the City Halls. and his nearly completed "Cathedral."

Turning to medicine, it is difficult to know what to say that will not offend one or another of you—and since that is far from my desire, I must ask you to bear with me, to regard me if you like as a visitor from the twentieth or some other century—and forgive me my opinions.

When one reads the accounts of this Hospital written in the time of Queen Elizabeth, and compares them with today, it is difficult indeed to say that much is done for the patients that was not then done. And lest you should think that it is only of St. Bartholomew's I speak, let me quickly disillusion you. Only last week I went across London Bridge to St. Thomas's—the only other great Hospital in this town—and after consulting their records and seeing their wards as they stand today, I could not help concluding that a patient might have preferred the kindliness of the fifteenth century to the ill manners and carelessness of today. Queen Elizabeth is dead, and our warlike King William provides an unkind contrast. but one in keeping with the times. In the past there was but one authority on most medical subjects, and if one approached the patient with the classical treatment on one hand, and kindliness on the other, then no more could be expected. Now all is changed. The famous physicians—if one may except such noble names as those of Sydenham and Sir Thomas Browne—are not any longer interested in cures, in treatment or in kindliness, but rather in what they call "discovery"; and that some may have caused suffering to already ill patients with their "experiments" is scarcely to be believed, but nevertheless true.

The great name of Harvey is revered among us, and indeed I find that it is so also at St. Thomas's, as that of no other. That he was a gentle and good physician, as well as an "experimenter," should be his chief cause to fame. But it is not so—and it is for his discovery that the blood moves through the veins and arteries by the action of the heart that he is chiefly remembered. That it is interesting one cannot doubt, but I have yet to see such knowledge used to cure or alleviate the pain or sickness of any disease. One found it hard to agree with Monsieur Guy Patin that Harvey's discovery was "paradoxical, false, impossible, absurd and harmful," but when he added that it was also "useless," there was a grain of truth in what he said.

The stories that we are privileged to hear from the older physicians, who were here with Harvey and knew him, leave no doubt that a great man and a much loved one has passed away. But when the last of these has gone to join him, the name of William Harvey will be soon forgotten. A useless discovery will hardly survive the memory of the man who made it.



Of the many other discoveries it is easy to choose those that are of use today from the others of a purely academic nature. I know there are those amongst you who hold that all discovery is progress—but this is an opinion with which I cannot agree, and I will mention only those discoveries which have proved to be of use.

For myself, I prefer Peter Chamberlen's invention of the forceps for delivering babies, Santorio's discovery of the temperature of the body which alters in disease, and the stolid hard work of Sir Thomas Browne, Sydenham, and some of our own physicians, to all the many other "wonderful discoveries" of which we hear. And the work of Monsieur Vincent de Paul in Paris is to be preferred above all, and shows that true faith and honest work are what help the sick. We should do well to emulate his methods here. Our patients would be more grateful for one de Paul among us, than for a hundred inventions and new discoveries.

The classical teaching of Hippocrates can show us a middle path where our discoveries are useful and the cure of disease is our aim. The life of Thomas Sydenham can show us the benefits of such teaching to the cause of true medicine. He felt that all theories and systems of philosophy should be forgotten, and diseases described with the same accuracy observed by a painter when he paints a portrait. How much this was Sydenham's own idea we do not know, for Viscount St. Albans—better known perhaps as Francis Bacon and Lord Chancellor of England—had, in 1620, strongly urged the approach which Sydenham followed so closely, and demanded a return to—

> "the ancient and serious diligence of Hippocrates, which used to set down a narrative of the special cases of his patients and how they proceeded, and how they were judged by recovery or death."

For the remainder of this discourse I would follow such teaching myself, and try to show you the advantages to the patient which have followed the use of so excellent a method in recent years. There is indeed little to tell, except of Sydenham himself, and in time to come it will be to him and to Monsieur de Paul that physicians will point as the leaders of true medicine in an age of "experimenters."

I will mention, then, the physicians', apothecaries', surgeons' and nurses' work in that accepted order of their importance.

Sydenham has made much use in fevers of the Peruvian Bark or Cinchona, which he described as a specific in all fevers; and in the terrible spread of malarial fever over the country for nearly 10 years from 1657 the drug saved many lives. It could have been used even more widely, if it had not become known as Jesuit's Powder, which name caused much opposition from those who would not take a "Popish Medicine."

Before the plague came on in London, it is of interest that Sir Christopher Wren—then Mr. Wren—was concerning himself with medical matters. Since then he has been so busy rebuilding our burned City that he has not again had time for such "frivolities." But in 1665, he and Richard Lower were interested in the subject of passing blood from one body to another. As you know, it is essential in many diseases to let out the evil spirit or humour which resides in the blood of the patient—and so we bleed the sick as we judge necessary. Richard Lower and others have often suggested that evil blood removed should be replaced by fresh and pure blood from another, and they quote the cure of Pope Innocent the Eighth by this method nearly three hundred years ago. Mr. Lower and Sir Christopher succeeded in passing blood from one dog to another; then the plague arrived and no further work was done, although Mr. Robert Boyle has since been interested in similar work, and also in the giving of drugs into the veins of the patient, which seems very dangerous and unnecessary.

Only 35 years ago, the terrible Plague descended on London and the following year the Great Fire burned its way almost to our doors. And following the Fire, the plague ended, then pestilence of the smallpox spread all over England for nearly 10 years.

One feels that the cause of so much disease spreading rapidly among the people cannot be far to seek, and it is difficult not to condemn the habit of smoaking. With the eye of imagination, one can almost see the contagion spreading in the smoak from the mouths of those who indulge in the habit.

Before passing from the physicians to the apothecaries, it must be noted, as Sydenham has said, that without the help of opium few would be sufficiently hard hearted to practise medicine. An opinion he may have formed after so treating his own attacks of gout.

During the last century, as you know, the apothecaries have been combined with the grocers and separated from them; they have been forbidden to prescribe; forbidden to charge for prescribing, and allowed to do both. Until by now they are, as has been said, "the physicians of the poor in all cases, and of the rich when the distress or danger is not very great." But though the apothecaries may charge too high prices for their drugs, while we *give* our services to the poor at least their drugs are now more standard and reliable, as a result of the London Pharmacopoea of 1618, and the current edition published as recently as 23 years ago.

In surgery it is strange that in an age of experimenters not much new has been achieved. And indeed some of the ideals and practice of Paré and of William Clowes have fallen by the wayside. But in the relieving of pain in surgery, the new work of Severino is of interest. To the old and tried methods of relief with opium, strong wine, the pressure over nerves, the tying of tourniquets, cupping and heat, he has added ice and snow which applied sometime before make the part quite painless for the operation, and the bleeding less.

When one hears of the work of Monsieur de Paul in Paris, it is impossible to be satisfied with the nursing in England, even in so great a hospital as this. The rise of our English Church ended the old monastery nursing, and in the years of which I speak there has been no good attention paid to the patients either in their care, housing or feeding. Indeed one feels that had we had nurses such as they now have in Paris, the physician would have been forced to pay more attention to his patients, and less to his experiments. Monsieur de Paul's system has much to commend it, and his rather surprising edict that nursing sisters

should not be fully admitted to the Holy Order has provided probably the finest nursing service anywhere in the world—and certainly better than that which existed here even under the monastery law ; for sisters who were also members of a Holy Order had, of necessity, to divide their time between the patients, and regular and frequent prayers.

If any conclusion may be drawn from so brief and incomplete a survey—I would have it that we make a return to the true principles of Hippocrates, that we find an end of extravagant "experiments," and do pray for an English Vincent de Paul. And of these I prefer the last, for I believe that good nursing must come before good medicine and not after it.

THE MAYOR OF BURBERRY

by LORD HORDER, G.C.V.O.

At various club dinners where Bart's men congregate I am often asked to tell the tale of the Mayor of Burberry. My natural shyness, and a desire not to injure a practice from which I am not yet retired, generally result in someone else telling the story, and with rather less than more verisimilitude. Elaborations have occurred ; accretions not altogether creditable to myself have been made ; so I think it not amiss to put on record the authentic happenings upon which the story is based.

And where more appropriately than in the columns of the *Journal*?

The story, as told by others, begins with the question: "Do you know why Horder never goes to Burberry for a consultation?"

Well, the reason would seem to be as follows.

The Mayor of Burberry fell ill of a somewhat obscure complaint and was sent to me for an opinion. A deputation from the Council had seen His Worship off at the station. His appointment, unfortunately as it transpired, was my last on a particular morning of a "Bart.'s day." In those days we were punctilious in our attendance at hospital. The members of the staff turned up in the Square not before, but certainly not after, the stroke of one-thirty. If one of us was late the students (other than the clerks, who, of course, had no option) shewed their indignation by "going round" with one of our colleagues. That this sometimes resulted in cutting off their nose to spite their face did not lessen, but increased, their resentment.

With all this in the back of my mind I had my eye on the clock when the Mayor entered my room. He was a pompous person and, like most pompous people, he was prolix. It seemed desirable to supplement his doctor's letter by a few questions and answers ; especially did this seem indicated by his obvious disappointment at being asked to go behind the screen and undress whilst he was still in the middle of his own story. I therefore continued with a few more questions. But the Mayor was one of those persons who could not do two things at the same time: he could not answer questions and undress whilst doing so. At each question he appeared from behind the screen, his waistcoat or some other garment half off, but was quite unable to say "yes" or "no."

Clearly my technique, designed to save time, was losing it. So I adopted another. "I've got the information I wanted," I said ; "take off *all* your things, lie on the couch and I will come and examine you." As it was obvious this would take several minutes I "nipped" down the corridor to my secretary's room and ate the frugal lunch awaiting me there, intending, of course, to return to my patient.

I was caught by the Nemesis of Pavlov, as we are all liable to be caught. Lunch suggested Bart's, with the anxiety as to being late in the background of my mind. And so conditioned reflex led to that quick walk to Great Portland Street Station, that detraining at Farringdon Street, that half walk and half run through Smithfield to the Square—arriving, yes, on the stroke of 1.30.

Rahere. (No. P.M.s that day, I remember.) Several new cases. Beds 1, 2 and 3 were dealt with *secund. art.* At Bed No. 4 there was some stir in the group. A porter whispered to the "Pro," who whispered to the Staff-nurse, who whispered to the Sister, who whispered to the H.P., who whispered to me: "The Mayor of Burberry is on the couch and is waiting to be examined."

"Gentlemen ; I am sorry that I must leave you for half an hour or so ; Mr. X will take you over the old cases and I will return as soon as possible," which, as events showed, was sooner than I expected. The journey in reverse but rather more run and less walk. I arrived at 141 Harley Street to be told that his Worship, cold and tired of waiting, had dressed himself and had departed in high dudgeon.

* * *

"And what was the opinion of the specialist?" asked the delegation from the Council, as the train was met at Burberry Station . . .

But that is adventitious: an impish corollary to this unfortunate story for the accuracy of which I cannot vouch.

But I do know why I never go to Burberry for a consultation.

Lord Horder, G.C.V.O.
M.D., F.R.C.P. Extra Physician to H.M. The Queen, Consulting Physician to St. Bartholomew's Hospital, President of Abernethian Society, 1896, Editor of *Journal* 1898-1902 Demonstrator of Biology, Physiology, Pathology and Medicine. Medical Registrar 1904 ; Assistant Physician 1912, Physician 1921.

Probably the best-known doctor in the country and certainly the doyen of the profession. His activities at 80 plus would do credit to one 30 years younger.

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To the Editor,
St. Bartholomew's Hospital Journal

Dear Sir, I congratulate you on the way
Your paper continues to earn all
The well-deserved compliments people all pay
St. Bartholomew's Hospital Journal.
From the old Smithfield fires, where that gloomy recluse
Bloody Mary attempted to burn all
The holders of certain heretical views.
Has sprung, like a phoenix, this Journal,
Which does a free field for discussion provide,
A forum, where one may discern all
The merits of tolerance fairly applied—
St. Bartholomew's Hospital Journal.
May your Diamond Jubilee Number reveal
The interest, almost paternal,
Which its primitive early contributors feel
In our evergreen Hospital Journal!
Some die-hards may jib at its modern disguise,
At the change in its trappings external,
But the tag "Semper aliquid novi" applies
To any live Hospital Journal.
May an ex-teen-age editor, no longer young,
Salute with his greetings fraternal
His flourishing junior, "still going strong,"
Our sexagenarian Journal;
And hope, as it enters its seventh decade,
That freshness and vigour eternal
May continue successfully still to pervade
St. Bartholomew's Hospital Journal;
And that students, who still Round the Fountain resort,
When the weather is suitably vernal,
Will continue whole-heartedly still to support
St. Bartholomew's Hospital Journal.
This doggerel, Sir (if thus far you have read)
Proceeds from an old retired colonel,
Who once had the honour to sign himself "Ed.,
St. Bartholomew's Hospital Journal."

R. B. PRICE.

R. B. Price
Brigadier, R.A.M.C. (retired). Brackenbury Medical prizewinner, 1908; M.B., B.S. (Lond.), M.R.C.S. L.R.C.P., 1908; Editor of the *Jounal* and *Round the Fountain*, 1909. H.P. to Drs. Herringham and Drysdale, and at the Brompton and Royal Northern Hospitals. R.A.M.C., 1912-46; won D.S.O. and three mentions in First World War. Youthful hobbies: tennis, golf and hunting (abroad). Senile hobbies: atheromatous golf and gardening, crosswords and *Journal* rhyming competitions, educating three sons (one for Bart.'s !). Has had life-long (intermittent) craze for composing light verses, usually in the bath, or on long car journeys. Number of baths seems to have been rather excessive recently, under the prodding of the present editor.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

THIS special issue of the *Journal* is being sent out to all doctors listed in the *Medical Directory* as having trained at Bart's. It celebrates both the Coronation and the 60th anniversary of the *Journal*, which falls a little later this year, and it is an appropriate occasion to encourage non-subscribers to take out subscriptions. The *Journal* is the sole official publication of the Hospital and will keep you in touch with it in a way that nothing else can. It is published monthly, and contains three or four articles, the current Hospital and sports news, correspondence and book reviews.

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We would also draw your attention to the application form for the latest (fifth, 1949) edition of *Round the Fountain*, which contains many pieces not found in earlier editions. It has always been and remains one of the cheapest and best anthologies of humorous verse and prose.

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St. Bartholomew's Hospital Journal,
St. Bartholomew's Hospital, London, E.C.1.

CORRESPONDENCE

To the Editor,
St. Bartholomew's Hospital Journal

Dear Sir, I congratulate you on the way
  Your paper continues to earn all
The well-deserved compliments people all pay
  St. Bartholomew's Hospital Journal.
From the old Smithfield fires, where that gloomy recluse
  Bloody Mary attempted to burn all
The holders of certain heretical views,
  Has sprung, like a phoenix, this Journal,
Which does a free field for discussion provide,
  A forum, where one may discern all
The merits of tolerance fairly applied—
  St. Bartholomew's Hospital Journal.
May your Diamond Jubilee Numb
  The interest, almost pater
Which its primitive early co
  In our evergreen Hospita
Some die-hards may jib at it
  At the change in its trapp
But the tag "Semper aliquic
  To any live Hospital Journ
May an ex-teen-age editor, no
  Salute with his greetings frat
His flourishing junior, "still go strong,"
  Our sexagenarian Journal;
And hope, as it enters its seventh decade,
  That freshness and vigour eternal
May continue successfully still to pervade
  St. Bartholomew's Hospital Journal;
And that students, who still Round the Fountain resort,
  When the weather is suitably vernal,
Will continue whole-heartedly still to support
  St. Bartholomew's Hospital Journal.
This doggerel, Sir (if thus far you have read)
  Proceeds from an old retired colonel,
Who once had the honour to sign himself "Ed.,
  St. Bartholomew's Hospital Journal."

R. B. PRICE.

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Brigadier, R.A.M.C. (retired). Brackenbury Medical prizewinner, 1908; M.B., B.S. (Lond.), M.R.C.S. L.R.C.P., 1908; Editor of the *Jounal* and *Round the Fountain*, 1909. H.P. to Drs. Herringham and Drysdale, and at the Brompton and Royal Northern Hospitals. R.A.M.C., 1912-46; won D.S.O. and three mentions in First World War. Youthful hobbies: tennis, golf and hunting (abroad). Senile hobbies: atheromatous golf and gardening, crosswords and *Journal* rhyming competitions, educating three sons (one for Bart.'s !). Has had life-long (intermittent) craze for composing light verses, usually in the bath, or on long car journeys. Number of baths seems to have been rather excessive recently, under the prodding of the present editor.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

THIS special issue of the *Journal* is being sent out to all doctors listed in the *Medical Directory* as having trained at Bart's. It celebrates both the Coronation and the 60th anniversary of the *Journal*, which falls a little later this year, and it is an appropriate occasion to encourage non-subscribers to take out subscriptions. The *Journal* is the sole official publication of the Hospital and will keep you in touch with it in a way that nothing else can. It is published monthly, and contains three or four articles, the current Hospital and sports news, correspondence and book reviews.

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THE GLANDS OF OWEN

by Professor A. J. E. Cave

In the now non-fashionable eponymous anatomical nomenclature the parathyroid glands were the glands of Gley: properly, on the basis of priority of discovery, they are the glands of Owen. For (Sir) Richard Owen (1804-92), successively student, prosector to Abernethy and Lecturer on Comparative Anatomy at Bart.'s, was their true discoverer in 1849-50, as this brief note on parathyroid history demonstrates. Credit for parathyroid discovery customarily goes to Ivar Victor Sandström (1852-89), praelector in anatomy in the University of Uppsala, who, discovering the parathyroids in the dog in 1877, and thereafter verifying their occurrence in the horse, cat and rabbit, and in Man, published[1] in 1880 the first comprehensive account of these "new" glands. Sandström considered these organs to be embryonic portions of the thyroid gland and hence gave them no distinctive name. Indeed the term "parathyroid" was not applied to them until 1896, when it was introduced by Vassale and Generali[2].

In 1881 Cresswell Baber[3] published independent studies of the human and mammalian parathyroids, his findings being confirmed in 1885 by Victor Horsley[4]. In 1891 Eugène Gley[5] re-discovered the rabbit's parathyroids and thereafter worked much upon parathyroid physiology, so that his name came to be applied to these glands: he regarded them, however, as nothing more than so much potential thyroid tissue. In 1892 the intra-thyroid parathyroid gland of the rat was described by Cristiani[6]. In 1893 Chantemesse and Marie[7] confirmed Sandström's original findings in the human subject, noting the generally single nature of the upper gland (=parathyroid IV) and the commonly multiple nature of the lower (=parathyroid III).

The anatomical and physiological distinction of the parathyroid glands was proclaimed first by Kohn[8] in 1895 and thereafter by Welsh[9] in 1898. Yet as late as 1907 Forsyth[10] could regard the parathyroids as but potential sources of thyroid substance.

The small size of the mammalian parathyroid gland, its variable situation (para-, epi- or intra-thyroid) in different species or even in different examples of the same species, and the technical and physiological difficulties attendant upon its experimental investigation may well explain the relatively late recognition of its morphological independence. The greater credit therefore accrues to the real discoverer of the mammalian parathyroid—our own Richard Owen—who, in the Indian Rhinoceros, recognised its distinctive nature as early as 1850, two years before Sandström's birth. And although, on dubious grounds, Sandström himself credited recognition of the putative parathyroid to Remak in 1855 and to Virchow in 1863, it is obvious that, in any case, Owen's priority of discovery stands.

At the time of his parathyroid discovery Owen was Hunterian Professor of Comparative Anatomy and Senior Conservator of the Museum of the Royal College of Surgeons, where he was resident, and at the height of his anatomical prowess. From his indefatigable pen was flowing—in the true Hunterian tradition—that sustained torrent of monographs, papers and catalogues on recent and fossil forms which proclaims the magnitude of his range and industry and constitutes so memorable and permanent a chapter in the history of British biological science. To Owen came the carcases of animals dying in the menagerie of the Zoological Society of London, and amongst them that of the first Great Indian Rhinoceros (*Rhinoceros*

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Publications: On human and comparative anatomy, archaeology, anatomical history, etc.

unicornis Linn.) owned by the Society, purchased on Owen's recommendation for 1,000 guineas on May 24, 1834. This beast, a male, lived in the Society's menagerie from September 20, 1834, until November 19, 1849, whereafter Owen anatomised it.

In a letter[11] to a sister he deplores this animal's death but characteristically remarks, "His anatomy will furnish forth an immortal 'Monograph', and so comfort comes to me in a shape in which it cannot be had by any of my brother Fellows". Owen's jesting prophecy was duly fulfilled and his subsequent paper[12] in the Zoological Society's *Transactions* remains the authoritative and classic account of the anatomy of this species. In this paper is described for the first time the parathyroid gland of any mammal.

The time-devouring dissection was carried out during the winter of 1849-50, chiefly at the Royal College of Surgeons, Owen's wife[13] recording in her diary that "as a natural consequence [of this animal's death] there is a quantity of rhinoceros (defunct) on the premises". Three months later, on February 12, 1850, Owen communicated his findings to a meeting of the Zoological Society. This paper was published as Article III in Vol. IV of the Society's *Transactions*. Here dates may mislead historians. Volume IV of the *Transactions* covers the period January 1851 to September 1862 and bears the terminal date only. Its contained Articles, however, bear their individual dates, that of Owen's rhinoceros paper being March 2, 1852. Owen therefore observed the parathyroid gland during the 1849-50 winter months; this find (*inter alia*) was communicated to the Society on February 12, 1850, and the communication itself was published in the March of 1852.

Nobody else, by 1850, had drawn attention to any mammalian structure which even might have been the parathyroid gland.

In his rhinoceros dissection Owen had particularly observed "a small compact yellow glandular body, attached to the thyroid at the point where the veins emerge"—the parathyroid gland of this species. He neither named this "body" nor suspected its true nature: nevertheless, he was impressed by it, and clearly recognised its anatomical novelty, for he made special reference to it in his later (1868) monograph[14] on comparative vertebrate morphology and meanwhile carefully dissected out and preserved the "body" *in situ* as a spirit specimen in the Royal College of Surgeons Museum (=Physiological Series L.333.1: Old Catalogue No. 772P). (The articulated skeleton of the animal dissected is preserved in the British Museum (Natural History) under reference B.M.722g (51.11.10.2).)

The identification of Owen's "compact yellow glandular body" with the parathyroid gland was confirmed by the writer's dissection of two adult male Indian Rhinoceroses dying in the Zoological Society's menagerie in 1941 and 1945 respectively. In the first animal, a beast of twenty years, a single parathyroid gland existed bilaterally. The left gland was attached to the dorsal aspect of the caudal thyroid pole, completely hidden by fascia and a dense thyroid venous plexus. Its dissection emphasised the difficulty of displaying a structure known to be present within a circumscribed area, the gland being finally disclosed only by a bold section in the neighbourhood of its suspected presence, whereupon its spongy, gamboge-yellow parenchyma proclaimed its true position and nature. The right gland was epithyroid in position and more easily secured amid the emergent thyroid veins.

In the second animal, some fifteen years old, a single parathyroid gland existed bilaterally, in each case embedded in the dorsal aspect of the thyroid and not apparent even after removal of all thyroid vessels and fasciae. Section of the thyroid at the anticipated site of the parathyroid was necessary to establish the presence of the smaller gland. The laborious nature of these dissections engendered enhanced respect for Owen's prosectorial assiduity and accuracy of observation, for the rhinoceros parathyroid has but the diameter and circumference of a sixpenny piece. Not suspecting its presence in his specimen Owen might justifiably have overlooked the gland in the necessarily rapid gross dissection of so unwieldy a subject: had the parathyroids of his animal been intrathyroid in position, it is likely he would have missed them. Owen obviously sectioned the right parathyroid, since he noted its distinctive yellow colour and its glandular nature, but whether accidentally during the dissection, or deliberately after observing the new "body," does not appear.

But that Owen was the first to describe and to preserve the organ now called parathyroid gland, and that he recognised the glandular nature of his discovery, is sufficiently

established. His achievement deserves a wider recognition than it has hitherto received, both as a tribute to his investigatory acumen and as reflecting credit on British anatomical science. It should appeal particularly to Bart.'s men of a generation later than his.

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THE GHOSTS IN THE SQUARE

By KENNETH WALKER

WHATEVER one's philosophy may be we all have to subscribe to the axiom of Heraclitus that "everything flows." Bergson went one better than this when he affirmed that change, and not a thing that changes, is alone real. Instead of postulating an entity which alters its character, but which nevertheless manages somehow to endure through these transformations, Bergson took the view that change itself was fundamental. The whole universe must therefore be looked upon as being a state of flux. Why should I, merely because I have been invited to contribute an article to this special number of the Bart.'s *Journal*, indulge in these philosophical reflections, which seem to have only a remote connection with medicine? This is easily explained. Whenever a man who has reached mature years returns to his old hospital, he is struck by the changes which have occurred there. He recalls his feelings, as I am now recalling them, when he first passed through its portals as a student, and contrasts them with those of the actual moment. He looks at the unknown faces passing him in the Square and remembers the faces with which he used to be so familiar. He listens, as I have just listened, to the talk during luncheon at the Staff Table and is as bewildered by what he hears as a man straining to understand a foreign tongue. He contrasts the professional equipment of the honorary staff of today with that possessed by the staff of forty-odd years ago.

Why, in those far-off days when I was a dresser Roentgen rays had only just been discovered, and look at the splendour of the X-ray department now! It is true that even at that time there were such things as laboratories, but they were poverty-stricken affairs in comparison with the laboratories of today. And as I reflect on all these changes and on my student days, the great Square of Bartholomew's becomes peopled with ghosts. Sitting here on the edge of the fountain, trying to avoid, as I used to do, immersing the edge of my coat in the water, I see again many of the old bygone figures. Sir Norman Moore, "the man with a face like a bird's nest," is over there uttering

Kenneth Walker

Educated at Cambridge and entered St. Bartholomew's Hospital in 1906. M.B., B.Ch., 1907; F.R.C.S., 1908. House Surgeon to Sir Anthony Bowlby, 1909; Junior Demonstrator of Pathology, 1911. Emigrated to Buenos Aires and returned to Europe at the beginning of the First World War. In charge of Special Treatment Clinic 1922. Urologist to the Royal Northern Hospital.

Former hobbies: Fox hunting, mountaineering and ski-ing.

Present hobbies: Philosophy, Psychology and the study of religions. Author of a large number of books on these subjects. Lives partly in London and partly in Sussex.

words of wisdom to his dressers. Sammy West discusses with his clerks the gentle art of percussion, and Sir Anthony Bowlby stops to raise his eyebrows and adjust his glasses. The portly figure of Sir Dyce Duckworth, on the eve of retirement, has just passed the fountain and now makes its way with silent dignity to the wards. And now my attention is diverted towards the Henry VIII Gateway. The go-ahead Mr. Lockwood has got rid of his handsome pair of bays and is causing an immense sensation again by snorting through the archway into the square in a maroon-coloured "horseless carriage." And there are many other ghosts flitting round me, far too many for me to describe. They are all very impressive, these old ghosts, but what did they know in comparison with the consultants of today? It is small wonder that a contributor to Bart.'s *Journal* who has reached mature years, contrasts the present with the past and reflects on the philosophy of change.

Not that change is always synonymous with progress. Fortunately, in the case of medicine it generally is. No one can deny the immensities of the advances made in the art of healing, both in diagnosis and in treatment. The partnership between medicine and science has yielded rich dividends, and we doctors have now become so scientific that we are often tempted to regard ourselves as being no longer artists. Yet when clever Dr. Horder started his medical career by appearing at his patients' bedsides armed with a pipette and microscope slides, his behaviour was considered to be eccentric and irregular. Such instruments as these belonged by right to the pathologist and not to the clinical physician. But those days are over and every modern physician has become something of a pathologist as well.

There is a general over-riding principle which none of us can escape—the principle of payment. Everything we gain, every advance we make, exacts its price. Nothing is given away in this universe for nothing, and the splendid progress made in medicine is no exception to this rule. In the process of becoming scientific, medicine has lost as well as gained. Having made this statement it behoves me to substantiate my point, and in order to do so, I must first draw attention to the methods employed by the scientists.

Science is analytical. For the organisation of his work, the scientist must start by making certain abstractions from the whole. In the words of Whitehead, he "bifurcates the universe," that is to say, he draws an arbitrary line between what he is prepared to take into account as important, and what he proposes to ignore. For example, he divides things up into substances and qualities, causes and effects, entities and their environment, bodies and minds. He forgets the fact that everything in the universe is related to everything else and that it is impossible to separate anything from its environment without altering its nature. And being a docile partner of the scientist, the modern doctor now copies him and subjects his patient to this process of abstraction and analysis. He divides him into a hundred pieces and generally fails to put him together again.

Picture the sick and anxious man who enters some great modern centre of healing, such as the Mayo Clinic at Rochester, U.S.A. After entering the doors of the Clinic he is submitted to a preliminary clinical overhaul, and if his illness happens to be an obscure one he is referred to a large number of special departments. His blood, his various excretions and secretions are all submitted to scrutiny, and his portfolio of notes, as he passes through the countless departments, becomes fuller and fuller of reports. X-rays, cardiograms, encephalograms, biochemical analyses and a vast number of other tests are made, until gradually the patient, as an individual, fades and is replaced by a massive collection of scientific data. He, the human being, is no longer visible to anyone and in all likelihood will never be seen again. He has ceased to be a man suffering from an inner disharmony of function which prevents him from adjusting himself to the stresses and strains of living. He is, at best, a number of organs wrapped up in a waterproof skin, and, at worst, a file of notes.

No adverse reflections are being made on the Mayo Clinic, which is here merely being used as an example of the dangers of a too scientific approach to medicine. In the Mayo Clinic we see the bad as well as the good results of the great increase in specialisation. Now it is not suggested that the growth of specialties could have been avoided, for whenever knowledge advances beyond a certain point, the appearance of the specialist becomes inevitable. Medicine has now reached the stage when no single mind can be master of it all. But specialisation in medicine has become so great that the patient has been completely dismembered and distributed amongst the various experts.

Who is able to see him as a human being again, that is to say, as a human whole, endowed with body, mind and spirit? Formerly it was the general practitioner who possessed this broader vision and who regarded the sick man not only as a patient, but as his friend. Unfortunately, the family doctor is in danger of being eliminated himself, and is engaged in a life and death struggle for personal survival. And if he also disappears, God help the poor patient!

"The greatest and the highest of all qualifications which a physician can possess is *sapientia*, and without this qualification all his learning will amount to little or nothing, so far as any benefit or usefulness to humanity is concerned." So wrote that remarkable old mediaeval physician Theophrastes Bombast, otherwise known as Paracelsus. And if there is anything which is certain it is that wisdom cannot be distilled out of the part, but only out of the whole.

In contrasting therefore the professional equipment of these poor ghosts with that possessed by the scientific members of the staff today, it must not be forgotten that all the advantages do not necessarily lie with the latter. It is true that the old physicians were unaware of the use of Myleran in the treatment of chronic myeloid leukaemia, but to compensate for this they knew a great deal about human nature. It is true also that they failed to recognise Crohn's disease and a host of other syndromes but they were far more likely to recognise their patients. They were consultants and at the same time they were supergeneral practitioners endowed with the good practitioners' fund of common sense. I can visualise my old chief, Sir Anthony Bowlby, recognising a patient returning to Stanley Ward after an absence of ten years. "Yes, you were over there in that corner bed," he says, with his hands tucked under his coat-tails, "and I remember removing your appendix. You had a big abcess that took a long time to heal. How's your husband now? He had trouble with his knees, didn't he, and had to find another occupation. I hope he's got a satisfactory job." Wisdom is not the prerogative of the doctors of any particular epoch, but the ghosts that have crowded into this Square were richly endowed with it. They had a remarkable facility for quickly summing up the total situation and for adopting the action appropriate to it. Even that poor surgeon, Bruce Clark, popularly known as "Bruiser," knew exactly what to do in an unexpected emergency. Having knocked down a Smithfield porter who had insulted him on his way home, he deposited the crumpled-up body in his car, drove back to the hospital and set the porter's broken jaw.

So, great as is my admiration for the skill of the modern staff of my old hospital, I retain a feeling for these ghosts haunting this venerable Square. I welcome the many changes and the prodigious advances made in the healing art—or is it really a "science"? Yes, I appreciate all the changes which have occurred since I first entered that gateway, but I still insist that they have been purchased at a price. All that I ask of Aesculapius, the god of healing, is that the cost should not rise, as the cost of living is now doing, to too high a level.

Everything flows, and change is the sole reality. No, one thing is precisely the same as it was when I sat on the rim of this fountain as a newly-arrived student. Whilst I have been engaged in this soliloquy the tail of my coat has gradually descended into the water and is now wringing wet.

A SERVICE FOR OUR READERS

We are able to tell all Bart.'s men (whether subscribers or not) who live anywhere abroad, in Ireland or Scotland, the names and addresses of other Bart.'s men living in their vicinity. A list is available on application to the Editor at the Hospital. We hope that this may lead to the foundation of Rahere Clubs in many countries.

CORONATION THOUGHTS ON NURSING

by WINIFRED E. HECTOR, D.N. (*Principal Tutor*)

One evening after duty in 1937, a few nurses were collected in a room in the Home doing the crossword puzzle, when someone asked if we had heard of a drug called prontosil which would cure infections. We said no, and returned to the crossword, unaware that a major revolution in our work was taking place. Behind us lay erysipelas, puerperal fever, carbuncles, chronic osteomyelitis and those terrible septic hands slashed open to show the sloughs beneath. Behind lay the days when recovery from lobar pneumonia was a victory for the nursing staff, and then not always won. There can have been very few changes so great in all the Hospital's history: perhaps only the introduction of anaesthetics and of antisepsis are important enough to be named with it.

There have been two great influences on the course of nursing history. The first is the impact of medical and surgical advance: the second is the rise of professional status, and until this began the nurses were not in a position to appreciate the first. It is safe to say that Harvey's work on the circulation of the blood can have roused little interest among seventeenth-century nurses, and that Percivall Pott's description of tuberculosis of the spine was not the topic of conversation then that the first accounts of retrolental fibroplasia were in recent days among the nursing students.

On the wall in St. Bartholomew-the-Less, Sergeant-Surgeon Balthrope's effigy in ruff and doublet has knelt since the days of the first Elizabeth, when already half the history of the Hospital lay behind it. If a sister under the second Elizabeth wants to know what her Tudor colleagues were doing, she can find out from the Hospital Journals. They were wearing blue uniform, they were ensuring a high vitamin C intake in their patients' diet, they were growing old in the service of the Hospital, and retiring on a modest pension.

Over the next two centuries the Journals show a regrettable similarity in the misdemeanours of the nursing staff that come to the notice of the Court of Governors. The sisters have been fighting, or stealing the linen and the patients' beer, or charging them for attention. These, however, are only the bubbles on the stream of daily work. We are too ready to believe that before Florence Nightingale nurses were sunk in ignorance and corruption, and we should feel some pride and pleasure to read these extracts from the Journals on the cholera epidemic of 1849.

". . . . they cannot but allude to the very useful and important services rendered by the Sister of Bentley's Ward, who, when called upon, did not hesitate to take charge of the first patients attacked by this distressing visitation, and continued to attend, with the Sister of Lucas Ward, most carefully and humanely such cases until the Wards were closed."

"Two experienced sisters, with a liberal supply of nurses were appointed. The devotion and fidelity of these two sisters in the care of their patients, their total recklessness of self and disregard of danger in a perilous service (and indeed of all the attendants) were such as to call forth our highest admiration and well-earned praises."

It is pleasant to learn that the two sisters got fifteen guineas each.

The end of the century saw the rise of nursing as a profession, with Mrs. Bedford Fenwick (who as Miss Manson was Matron here) as one of the leaders. She was the founder of the British Nurses' Association and of the Matrons' Council, the first organisations in the country for professional women. We have been fortunate in our Matrons, from Margaret Blague who "adventured herself to the great perelle of her life" during the Plague of 1665, down to the present. No note on nursing today at St. Bartholomew's would be complete without a reference to Miss Helen Dey (who retired in 1949) whose services to nursing have been rendered not only to her hospital but to the whole country.

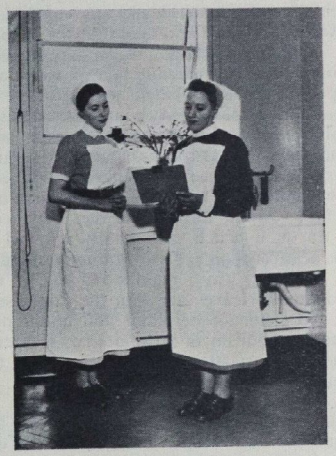
Winifred E. Hector.

Winifred E. Hector was born within living memory in Somerset, educated in Somerset and London University and resides in Somerset. (She has been staff nurse, midwife, night sister, ward sister, tutor and principal tutor here.) Her extra-mural interests include birds, botany, ferns, fungi, photography and driving slow cars. She is at the moment suffering from a severe attack of non-specific cactophilia, and her condition gives rise to some anxiety. Her window-box in the Square has elicited an Editorial, in the hope that her private venture might be institutionalised.

Perhaps the first part of this century marks a unique level in nursing. The accommodation was primitive; the sick nurses were tended in the notorious "horse boxes", separated by five foot wooden partitions.

The salary was negligible, the hours long, and the discipline rigorous. Only those who were determined to nurse, and actuated by the most powerful motives, passed this severe test. There were some lectures by the honorary staff on medicine and surgery and by Matron on nursing, but skill was taught and learnt at the bedside and it was here that the Bart.'s nurse gained her reputation.

However, the demand for nurses became so great, while at the same time opportunities for women in social service were so many in other fields, that the number of women able to endure such a training was insufficient. State Registration for nurses was introduced in 1919, and the idea of nursing as a profession as well as a vocation came to augment —we trust—and not to supplant our hospital ideal. If any of the *Journal's* senior readers regret this, they should remember that to be *laudator temporis acti* is to deny reality. Medicine and surgery change constantly at a challenging speed, and it affects our lives as nurses in every way. (For instance, at the time when I write there are more nurses off sick with prolapsed intervertebral discs than with septic fingers!) Each time I renew a course of lectures I rewrite them, dropping old material and adding new. It is useless to lament that one never sees a "good" case of lobar pneumonia now; we do not want to. We look forward with expectancy, as our medical colleagues do, to the future.



The Preliminary Training School was opened in 1924 with 20 students, and Miss Hitch was appointed sister tutor in 1926. The comparative youth of the teaching department is brought home to me when I realise that I am only the third sister to hold my present position. To recall the days of my own training, however, is to remember a different world, even though some of the sisters for whom I worked as a student are still my colleagues.

When I came to the Hospital in 1933, the Preliminary Training School was in Goswell Road, a savage brick wilderness ringed round with cats and small boys. There were twenty-six of us, of whom five were destined to wear sisters' blue uniform—surely a record. At the practical nursing examination each of us had to make a linseed poultice on teased tow. Why such a madly unpractical base was chosen I cannot guess. At any rate each of us presented dear Miss Irvine with this revolting offering between two warm plates; each was told to hold it up by one

corner, and had to watch it slowly and remorselessly disintegrate. We were told that hats were always worn in the Hospital precincts, and were anxious that we might have to wear them on trips about the corridors of the Nurses' Home. If a nurse went into the dining room in anything other than uniform, she asked to be excused by the sister at the hot plate, and was pardoned.

Dressings were done with swabs held in the fingers, though in the Surgical Unit forceps were being used, and this was thought rather an awkward and fanciful way of going on. A blood transfusion was a major undertaking, and was classically laid on two glass-topped tables each laden with articles for donor and recipient. My contemporaries will recall the first continuous transfusions with a little motor, and the occupational hazards of exploding Keynes' flasks. Surgical patients were habitually washed as long as they had stitches. About the twelfth day they were got up on a couch, and finally allowed to walk at a fortnight. Dire as this immobility was in many ways, regular reading of the ward reports leaves me with the impression that the incidence of major and minor pulmonary embolism is little altered, whatever some enthusiastic practitioners on the surgical side may say.

Throughout the thirties and forties the scheme of theoretical training remained unaltered. On one evening a week each nurse had a lecture at six o'clock to attend. Whether she was on day or night duty, having a day off or nights off made no difference. Usually she had a class from the sister tutor once a week in off duty, and if she was on night duty this was at 9 a.m., and an ordeal to teacher and student alike. During the war the lectures were duplicated at St. Albans, and keeping the two courses synchronised was more than difficult. It was not until 1950 that increased accommodation at the Preliminary Training School allowed us to institute a more modern scheme of theoretical training.

At the moment nurses receive their lectures in a series of study days, which they spend entirely in the classroom. For fourteen weeks in her second year, and again in her third, the student has a day of theoretical instruction. Two series of revision days, one for the Preliminary State Examination, and one for the Final Hospital and State Examinations, are also given. All are on day duty for this period, and as classes may run up to the sixties, and there are three study days a week, it is obvious that a great deal of hard work has to be done by the Assistant Matrons to make the scheme possible. It is popular with the students, whose co-operation and goodwill we have. For the ward sister it has obvious drawbacks, since most of her staff will be working only five days a week for her, and whose senior nurses may be absent for lectures on her operation day. We were prepared for many complaints with which we were ready to sympathise, but have had very few; the cheerful co-operation accorded the scheme has been deeply appreciated by the tutors.

This scheme will doubtless be modified when occasion demands it. If we want more teaching time, or want to make the planning of staff moves easier, it will have to be by the introduction of a block system, in which the student nurses leave the wards entirely for a matter of weeks for lectures. The idea is not superficially attractive; we are, after all, practical people, and to spend four or six weeks a year in the classroom is not what moved our students to take up nursing.

Lest any graduate readers should think that the nurses now learn much theory better suited to the medical student, I must say that the basic scheme and number of lectures is almost the same as it was before we started our new system. They are not taught more; they are taught better. The consultants' lectures are reinforced by classes, discussions, group work, practical demonstrations, films and visits to departments whose heads are unfailingly good to us.

Turning to the practical side of training, a difficulty is encountered that must be felt by the medical students too. It is that the constant growth of special units, all of them surgical, means that these wards are staffed by student nurses whose practical experience may lack balance. The time spent in medical wards is meagre beside general, thoracic, orthopaedic, gynaecological, neurological, ophthalmic and ear, nose and throat surgery. We are proud of the work done in these units and of our share in it, but it creates problems for those responsible for planning a balanced training.

Since my readers are medical men, perhaps reference should be made to the doctor's traditional views on nurse training, which are that far too much theory is taught, that the nurse needs a kind heart only, and that there are many so supplied who are not capable

of passing an examination. With reference to the first point, the syllabus is decided not by the Hospital but by the General Nursing Council, and careful study of it will show how reasonable it is. With regard to the second, it is simply not true that kindliness varies inversely as the intelligence. Any student of average brain can pass her State Examination with ease, and those of us acquainted with hospitals less fortunate than our own in their students know that a girl of below average intelligence is ill-adjusted in such a community. The belief that there are many excellent practical nurses who are poor at theory does not bear scrutiny. The best *theoretical* nurse at the Final Hospital Examination is also the best *practical* nurse on all but a very few occasions.

We might consider finally the traditional belief that nursing is not what it used to be. If taken literally this is undoubtedly true: there is a quite different conception today of the qualities and information expected of a nurse. It is salutary to bear in mind, however, the findings of a recent report * on the work of nurses in hospital, which indicate that three-quarters of the students' time is spent in satisfying the two or three needs common to all, sick and well alike. The entrants to the nursing school here are the best in the country, and if this account makes the teaching system seem rather impersonal, it should be added that we believe they need affectionate guidance more than criticism. Our students in this second Elizabethan age are to be the best practical nurses that the united efforts of all of us can make them.

* The work of Nurses in Hospital Wards. The Nuffield Provincial Hospitals Trust.

THE FUTURE OF ST. BARTHOLOMEW'S HOSPITAL

By C. C. CARUS-WILSON (*Clerk to the Governors*)

DURING the last half century there have been two periods of major reconstruction at St. Bartholomew's. The first was between 1903 and 1907 when the present Out-patients Department, the Pharmaceutical Department (more commonly known as the Dispensary) and new quarters for the junior resident staff were completed. The second period was from 1921 to 1937. Major works during this period included the new Queen Mary's Home for the nursing staff and the new Medical and Surgical Blocks to house 500 patients. In the Surgical Block were incorporated five new operating theatres.

St. Bartholomew's has retained its leading position amongst this country's hospitals for two main reasons—first, the pre-eminence and devotion of its doctors and nurses, and secondly, the willingness of the Governing Body at all times to spend its money wisely on the provision of new and up-to-date buildings for the better housing of the wards, medical departments and ancillary services.

C. C. Carus-Wilson

Educated privately, and at Trinity College, Cambridge, where he read for a mathematical Tripos. His period at Cambridge was interrupted by the first world war, during which he served in the Royal Marine Artillery. He took a degree when the war was over, and was called to the Bar in 1921. He practised as a Barrister until July, 1925, when he was offered and accepted the appointment of Assistant Clerk to the Governors of St. Bartholomew's Hospital, being appointed Clerk to the Governors in 1937. He is also a member of the North East Metropolitan Regional Board, and is Honorary General Secretary of the National Federation of Hospital Officers.

The First Difficulty

The question now being asked by all interested in the continued progress of the Hospital is whether the same opportunities for reconstruction and development will be made available under a nationalised service as under the voluntary régime of the past. Like all teaching hospitals St. Bartholomew's has three main functions, the treatment and care of its patients, the clinical teaching of the medical students of the College and the training of nurses. Each of these three functions demands its measure of consideration in any plan for the future development of the Hospital. Previously they have rarely conflicted. Now difficulties may arise. For the Ministry has determined that no teaching hospital shall contain more than 800 beds. The College, on the other hand, has stated that 1,000 beds is the minimum which can provide the full requirements of clinical teaching. The Board of Governors is with the College in this matter but for a different

reason. They see a mounting waiting-list, now nearly 2,000 as compared with an average list of about 300 before the war, and are satisfied that a maximum of 800 beds will not be enough to meet the patients' needs.

The grounds on which the Ministry has adopted this arbitrary figure for each teaching Hospital, regardless of the size of its Medical College or the demands on its services, are not quite clear. One of the reasons given is that 800 is the maximum figure for economical administration. But practical hospital administrators deny that this is so. Another is that the size of the hospitals in central areas must be restricted in case war comes. This seems very much a policy of despair. If one carried it to its logical conclusion no hospitals would be allowed in thickly populated areas at all. The greatest contributions to medical progress in the last century have been made in the teaching hospitals. It is surely unwise to jeopardise the opportunities of scientific advancement they can provide because of a hypothetical possibility that may never arise. Perhaps the real reason for the decision to adhere to a fixed maximum for all teaching hospitals is rather to be found in the craze for regimentation so beloved by the official mind. To such the idea that the Westminster should have only 300 students and Bart.'s 700 seems untidy and not to be encouraged. They would seem to prefer a number of average hospitals—but no great ones.

The foregoing is not a digression. It is necessary to state the facts as they exist because of their important bearing on the future plans for our Hospital. Whatever the Board (or the College) might regard as the requisite number of beds to meet our needs the National Health Act gives the final word unequivocally to the Minister. He provides the capital moneys required, grants the necessary building licences and permits and decides upon the starting dates. Even if the Board were willing to find the money out of its Endowments (as it has on occasion offered to do) it still has to await the Ministry's pleasure in regard to licences and permits.

The planning of the future development of the Hospital is, in the first place, a matter for the Planning Committee, which is a sub-committee of the Board. This has succeeded the old Reconstruction Committee of between the wars, and although a purely Hospital committee it contains a number of members of the medical staff who are also on the Council of the College and who are able to hold a watching brief on the College's behalf. The Matron of the Hospital, too, is a member of the Committee, and through her the needs of the nursing staff are made known to it.

Plans Before the War

Some four or five years before the last world war it had become apparent that a further period of reconstruction was overdue. Up-to-date wards were needed for the special departments, the accommodation for out-patients was becoming more and more inadequate and the provision of additional rooms for the nursing staff was urgent. The Governors were anxious, too, to provide a block for paying patients. To provide for the two first of these needs it was proposed to reconstruct the West Wing and to erect behind it an extension connecting it to the present Out-patients Department. Plans were actually prepared for this not inconsiderable work of reconstruction but the outbreak of war prevented any actual building from being started.

For the paying patients block the Governors had acquired land in Bartholomew Close adjoining the old Cloister of St. Bartholomew-the-Great ; and for a new nurses home they had purchased a site in the centre of the Close, a part of which had previously housed the Royal General Dispensary. Both these projects, too, had to be abandoned when war broke out.

The war itself further accentuated the need for additional buildings. A land mine in Bartholomew Close destroyed the row of small houses on the Little Britain boundary which had previously housed the Matron, the Steward and some 120 nurses and domestic staff.

Such, then, were the problems which faced the Planning Committee immediately after the war. They wisely decided that their consideration of the position must be divided into two separate sections first, the preparation of short-term plans for the rehabilitation of existing Hospital buildings as speedily as possible, and secondly, the long-term development plan to provide for the Hospital's future needs.

The Short-Term Plans

The short-term policy was theoretically a temporary scheme, though much of the work undertaken in pursuance of it will be valuable for many years to come. Particularly I should mention the reconstruction of the East Wing

to provide wards for obstetrics and gynaecology, the provision of dining-room accommodation for nurses and domestic staff on the lower ground floor of the Surgical Block, the provision of a large Clinical Lecture Theatre on the site of the old Anatomical Department, a temporary building for the Welfare Department and Lady Almoners, and the rebuilding of the Casualty Block and the former Nurses' dining-room adjoining to provide children's wards, a new Physiotherapy Department, a Cloakroom and Common-rooms for the women medical students and sundry other essential requirements.

Provision also had to be made in the short-term scheme for more Nurses' accommodation. The Ministry made it clear that a new Nurses' Home, large or small, was out of the question for the time being. The Board adopted the only alternative ; they leased premises which had previously been a hostel for overseas students in Bryanston Square, near Marble Arch. This is being used for Night Nurses, and contains approximately ninety rooms. It is, of course, inconvenient both for the Hospital and for the Nurses to have a Home so far away ; and it is costly because they have to be brought to and from the Hospital in motor coaches. It is hoped that it is only temporary, and that a new Home may soon be started as part of the long-term plan. This extra accommodation was, in any event, only a palliative ; more is badly needed to meet our present needs, and the Governors are searching for another building to accommodate a further two hundred nurses.

There are still two major works to be carried out under this short-term plan. A new gynaecological theatre is to be provided on the ground floor of the East Wing and will extend outwards at the back towards Little Britain ; and the West Wing is to be adapted to accommodate certain of the Special Department wards now housed at Hill End Hospital, St. Albans.

The Long-Term Plans

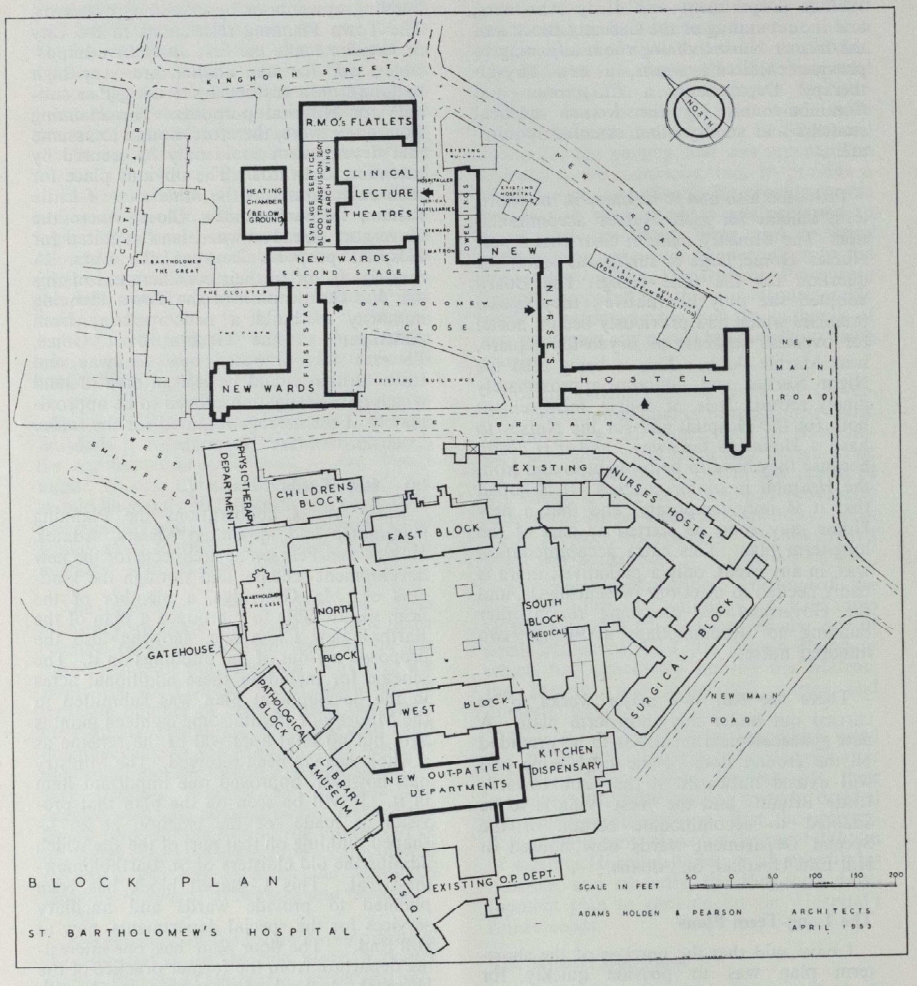
I have said that the purpose of the short-term plan was to provide quickly for immediate needs. The long-term plan, on the other hand, envisaged the gradual extension and development of the Hospital over a period, the length of which would depend on the opportunities for building, but which could hardly be less than twenty-five years for its completion in full.

The site of the Hospital in Smithfield is approximately 7½ acres. On such an island site there must come a time when future development can only be secured either by building upwards or by extending outwards. The Town Planning restrictions in the City of London make the first alternative impossible ; nor for that matter are very high buildings on a restricted site altogether suitable for Hospital purposes. The Planning Committee were, therefore, bound to assume that development could only be secured by extending outwards. The obvious place for such extensions was the other side of Little Britain, in Bartholomew Close, where the Governors already owned land acquired for Hospital purposes between the wars. A material factor in their consideration of this site was the decision of the Town Planning authority to build a new roadway from Aldersgate to the General Post Office. Between this proposed new roadway and Little Britain would be left an area of land which on investigation proved to be approximately of the acreage required for the future extensions of the Hospital.

(a) New Wards

Early in its deliberations the Planning Committee had appointed Messrs. Adams, Holden and Pearson as architects for the new development scheme, and through the kindness of Mr. Guttridge, a member of the firm, we are able to reproduce a plan of the Bartholomew Close site, showing also the proposed lay-out of the buildings on it. The scheme for including these additional acres in the development plan was submitted to the Ministry of Health some eighteen months ago, but no final approval of the scheme as a whole has yet been received. The Ministry has, however, approved one important item in it. It will be seen on the plan that provision is made for the erection of an L-shaped building on that part of the site which adjoins the old cloisters of St. Bartholomew-the-Great. This L-shaped block has been planned to provide wards and ancillary services for the special departments, now at Hill End. The floor plan has one interesting departure from the former practice of the Hospital. Instead of one large ward, with side rooms adjoining, a number of smaller wards has been provided.

In its consideration of the long term development plan, the Planning Committee



had perforce to decide the order of priority in which the work should be undertaken. The two first priorities were clearly accommodation for the special departments and an additional Nurses' Home. The L-shaped block provides for the former : it has been approved by the Ministry and the site is available. The Governors are now waiting for a starting date. The total cost of the building will be approximately £300,000 and it is estimated that it will take two and a half years from the starting date to complete. In addition to the special department wards referred to the block will contain one large clinical lecture theatre for the joint use of the Medical College and of the nurses, the necessary operation theatres, and a small diagnostic X-ray department to meet, in part, the needs of the patients admitted to the special department wards.

The beds in the block will be allocated as under :

Eyes	20
Plastic	10
Ear, Nose and Throat	30
Neuro-Surgical	20
Dental	4
Deep X-ray	6
Thoracic	24
Pulmonary T.B.	6

This makes a total of 120 beds, housed on four ward floors of 30 beds each. The ground and lower ground floors contain the necessary ancillary accommodation and the clinical lecture theatre.

(b) A New Nurses' Home

On the south side of Bartholomew Close the plan reproduced shows the space allocated for the housing of nurses. It is unlikely that the whole of this new Nurses' Home will be completed until a later stage of the development plan, but it is hoped that within a comparatively short time work might be begun on the first section, namely the portion facing Little Britain and immediately opposite the present Queen Mary's Home. Whilst, however, capital monies available for reconstruction and development are so limited it is difficult to be optimistic about the starting date. For its normal building programme the Hospital is allowed a sum of approximately £55,000 in each year. All of this must at present be used on the short-term plan, and if any progress is to be made with the long-term development in Bartholomew Close, special capital grants must be made available for the purpose. In the case of the L-shaped block the Ministry has agreed that when the work begins an additional sum of £100,000 a year will be made available to meet the cost. A new Nurses' Home can only be started in the near future if some similar additional capital provision is made.

As the Planning Committee recognised, one of the first priorities of the long-term plan must be the provision of this additional Nurses' accommodation. If the number of beds in the Hospital is to be limited to 800, then allowing for the requirements of the Out-patients' Department, the operating theatres and certain other purposes and also for the introduction of a " block " system of training which will take nurses in training away from ward duty for long periods at a time, the number of sisters and nurses to be housed in the future can hardly be less than 750. Add to this approximately 150 resident domestics, and the accommodation must be planned for a total of 900. Queen Mary's Home holds 300, and the remainder (other than those who will be returning from Hill End) are at present either housed temporarily in parts of the hospital badly needed for other purposes, or are scattered in buildings outside the Hospital such as Bryanston Square and Charterhouse Chambers. This very uneconomical and inconvenient state of affairs can hardly be permitted to continue indefinitely.

For these reasons the Planning Committee estimated that the new accommodation should be designed to provide 600 bedrooms or flats, the whole to be built stage by stage as circumstances permit. New and adequately sized dining-rooms and additional lecture rooms and classrooms are to be included.

The plan of the Bartholomew Close site shows additional buildings as well as the two first priorities already mentioned. It will be seen that the L-shaped Block is extended and becomes Z-shaped. The extension is required to house the Orthopaedic Department wards, for which no provision in the long-term plan has yet been made, and to meet any other demands which progress may dictate. This at once brings the Hospital authorities into conflict with the Ministry if the latter continues to insist on a maximum ceiling of 800 beds. It is hoped, however,

that by the time facilities for further building are available the Ministry may have reviewed its decision.

(c) Other Plans

The plan shows, at its extreme eastern side, a building providing flats for approximately 60 resident medical officers. Accommodation in the present Resident Staff Quarters has been inadequate for some years, and no provision has yet been made for accommodating the women medical officers who may be appointed to the House. These flats will occupy the upper floors of the building only, and beneath it new and more adequate dining-rooms for the senior and junior medical staffs are planned, with appropriate kitchen accommodation adjoining. Between these flats and the eastern leg of what it is hoped will become a Z-shaped block will be provided accommodation for a complete blood transfusion service and for an enlarged and improved syringe service, both badly needed. In addition space has been provided for clinical lecture theatres required by the Medical College. It is anticipated, too, that on this site it will be possible to make suitable provision for the research work which the Governors have always regarded as an essential part of the work of a teaching Hospital, and the cost of which would be defrayed out of the Hospital's Endowments, and would not be a charge on public funds. Certain ancillary services, too, will have to be accommodated on the site. It is unlikely that the present boiler house would be able to serve the needs of such considerable expansion as is visualised in the scheme, and space has been allocated for an additional boiler room or heating chamber.

As well as the foregoing there must be provided in Bartholomew Close such additional items as accommodation for the medical auxiliaries required to sleep in the Hospital during their periods of duty, and residential accommodation for the Hospitaller and certain other resident officers of the Hospital. The extensions in Bartholomew Close are to be connected with the main Hospital by a tunnel way under Little Britain, which so far as can be seen would connect the L-shaped Block with the basement of the old Casualty Block on the island site. It would be a convenience to have a second tunnel way connecting the two Nurses' Homes but no decision as to this second tunnel has yet been reached. If the whole scheme were finally adopted, it might, too, be possible at some time in the future to close Little Britain and to incorporate the Bartholomew Close site into the island site of the present St. Bartholomew's. This, however, is thinking rather far ahead, although it would clearly do much to simplify the arrangements of the Hospital if it could so be designed as one composite whole.

There are two matters I have so far left unmentioned. The first refers to the Pathological Services of the Hospital. The present Pathological Block facing Giltspur Street and West Smithfield is rapidly growing inadequate to meet the Hospital's increasing needs. At some time in the long-term development plan it will be necessary to re-house this Department and it is hoped to do so on the North-East corner of the site.

Mention, too, should be made of the Alexandra Hospital for Children with Hip Disease. Since the new Health Service came into being this Hospital has been designated a part of St. Bartholomew's. It is at present housed in quite unsuitable premises at Stockwood Park, Luton, a wartime expedient to ensure the greater safety of the patients. The Governors have prepared plans, which have been submitted to the Ministry, for the erection of a new Hospital at Nyn Park, Northaw. In view of the shortage of money for capital expenditure the Governors have undertaken to defray the cost of this new Hospital out of their Endowment Funds. It is earnestly hoped that it will not be long before this building can be started.

Such, then, are the Governors' plans for the future development of our Hospital. I do not doubt that their completion will take a long time and call for much patience. But when they are finished we shall have the satisfaction of knowing that for yet another long period in our history our patients will be ensured that best possible service which has ever been a Bart.'s tradition.

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JAMES GIBBS AND ST. BARTHOLOMEW'S HOSPITAL

By KENNETH S. MILLS, A.R.I.B.A., A.M.T.P.I.

ST. BARTHOLOMEW'S HOSPITAL is fortunate in having found for its rebuilding in the XVIII century an architect of the stature of James Gibbs. His is a name well known to those with an appreciation for fine buildings, and he has built many which give continuing pleasure. When he was first called in at Bart.'s he was one of the most renowned architects in the country.

JAMES GIBBS *after William Hogarth*

Gibbs conceived a scheme of rebuilding with the accommodation gathered in four separate blocks of approximately equal height and length round a spacious courtyard or quadrangle of some 200 feet by 160 feet approached through an archway in the centre of the north block. This he placed on the axis of the newly erected Smithfield or Henry VIII Gateway. The east, south and west blocks were designed to house wards only and were strictly utilitarian in design, and only internally was the north block allowed to depart from this standard. Externally, with minor variations, all the blocks were to be of similar design.

James Gibbs was born at Footdeesmire in the Links of Aberdeen on December 26th, 1682, the son of a Roman Catholic merchant of small estate. After attending the Grammar School and Marischal College in Aberdeen he travelled extensively on the Continent and studied under Carlo Fontana in Rome. Returning to Britain about 1709 he soon settled in London and made a name for himself by designing in a competent manner a number of important churches—St. Mary-le-Strand (commenced 1714); St. Clement Danes (steeple only) (1719); St. Peter, Vere Street (1721); St. Martin's-in-the-Field (1722) and All Saints', Derby (1723). The quality of his work had come to the notice of the college authorities in Cambridge and in the previous year (1722) the Senate House was begun to designs for which he was largely responsible. In 1724 the Fellows' building at King's College was commenced and about this time he erected several important country houses.

Kenneth S. Mills.

Chartered architect and town planner. Born 1921 at Goodmayes, Essex. Educated at Brentwood Grammar School and Regent Street Polytechnic School of Architecture. Awarded diplomas in architecture and town planning. Architectural experience in offices of Brian O'Rorke, A.R.A., and H. S. Goodhart-Rendel, P.P.R.I.B.A. Since 1946 worked on housing and town planning in office of large local authority, and latterly in section concerned with recording and preservation of historic buildings. Hobbies: study of history in all forms.

Gibbs was helped greatly in these undertakings by the patronage and friendship of the nobility, especially the 11th Earl of Mar, who financed his travels abroad, and the 2nd Duke of Argyll, as well as Sir Christopher Wren with whom he was always on good terms. His political leanings, being a Tory, also assisted in his obtaining work, especially early in his career when he was appointed the first Surveyor to the Commissioners for Building Fifty New Churches (his Catholic origin was not stressed at that time).

Gibbs' influence in the literary field was also felt, for in 1728 he published *A Book of Architecture* and four years later *Rules for Drawing the Several Parts of Architecture*, both of which had a big influence on early Georgian architecture. Thus in 1730 it can be seen that Gibbs, then 48 years old, was at the peak of his career which later was to be crowned with the building of the Radcliffe Library, Oxford, and St. Marylebone old church where, after his death on August 5th, 1754, at the age of 71, he was buried.

What are the qualities in James Gibbs which show themselves in a group of buildings of such restraint and dignity in composition, whose outward severity is tempered by interior detail in the Great Hall and the ground floor offices and committee rooms of such richness, technical correctness and good proportion?

A certain severeness and austerity or restraint in external ornament which is to be seen frequently in Gibbs' work, though not an uncommon characteristic in the buildings of other early XVIII century architects—in fact, a far more clearly defined characteristic in the buildings of Nicholas Hawksmoor and Sir John Vanbrugh—was possibly engendered by the severity of the Scottish landscape in which Gibbs had been brought up.

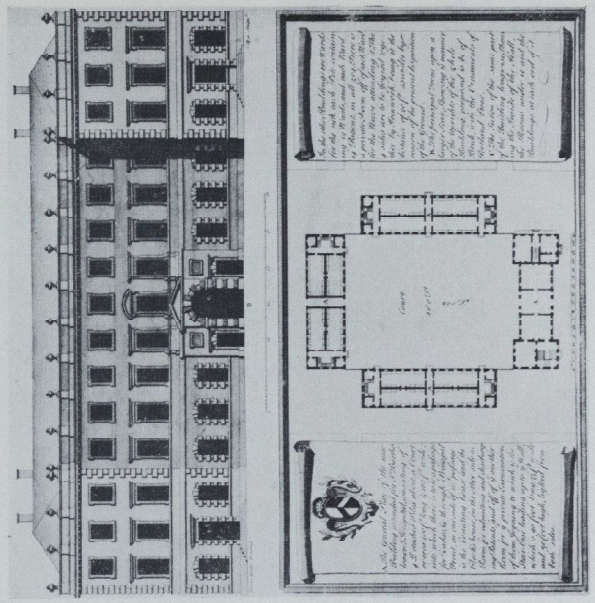
Gibbs' technical competence and reverence for classic detail came from the advantage which he had over many of his contemporaries of having studied classic architecture at its fountain-head, Rome. This also gave him first-hand contact with the Baroque manner, which is expressed in the designing of his first church, St. Mary-le-Strand, but which appeared less in his later works, and hardly at all at Bart.'s, except for a suggestion of that spirit in the ceiling of the Great Hall and in the wall elaborations of the Hall. This lessening of Baroque influence came probably, not from any personal choice of Gibbs, but from the hardening of English taste against the style. Baroque influence may also be discerned in the free scrollwork of the paintings executed by William Hogarth on the walls of the Grand Staircase leading to the Great Hall.

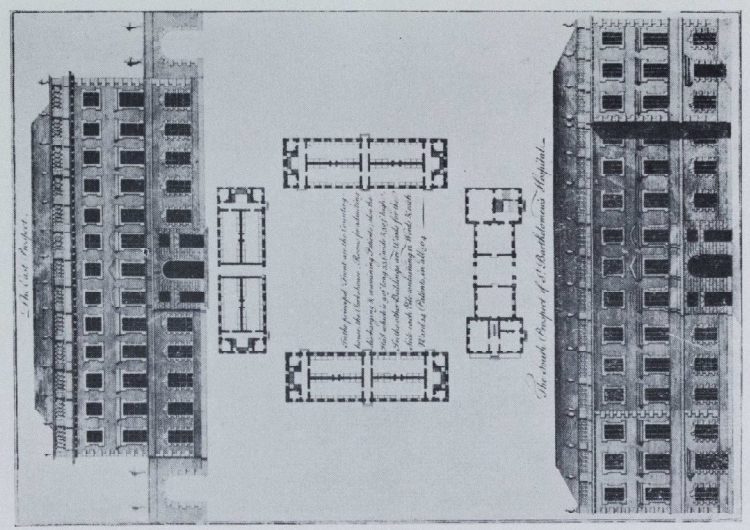
The solid background of Gibbs' training caused him almost always to avoid faults, though strict adherence to detail may have hampered his inventiveness and led him to substitute knowledge for thought. First-hand observation of the work of Andrea Palladio also put him to the fore in the Palladian movement.

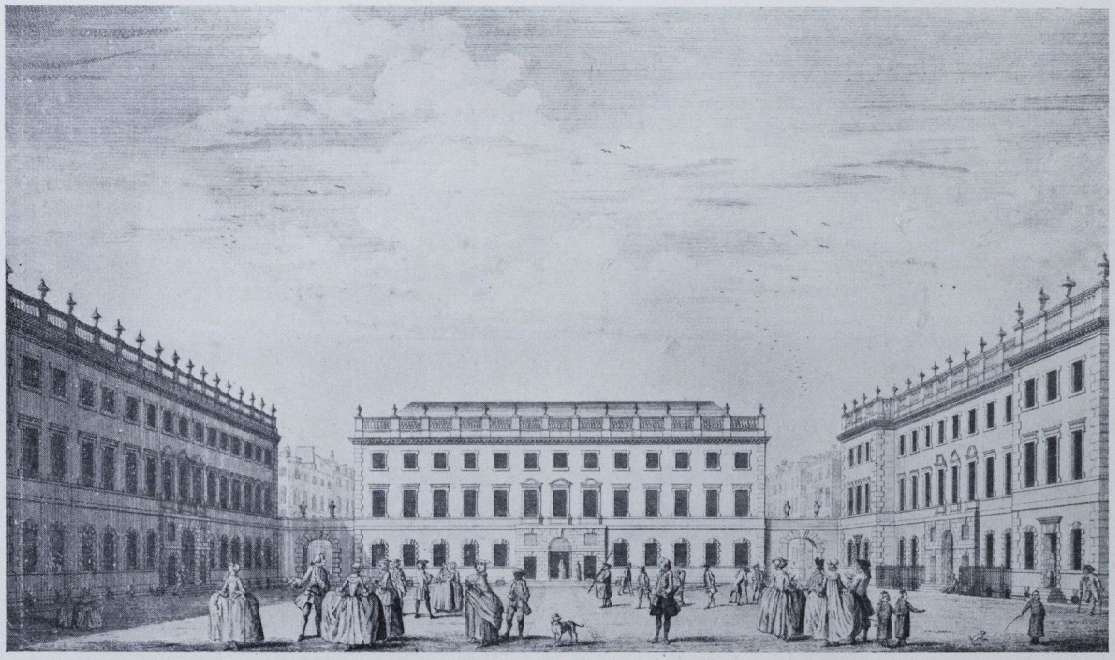
Gibbs probably had more academic knowledge than any other architect of his day and against a background of his own observations in Italy, carried on, perhaps more than his contemporaries, the traditions of Wren and Inigo Jones. Through him that tradition was kept alive later in the XVIII century by Sir William Chambers. It has been said sometimes that Gibbs was too tied to tradition and that it suppressed the spark of genius within him which would have given more originality to his work and freer vent to his abilities. However, Gibbs was perhaps, if not second in place to Wren in the period of English Renaissance, at least well to the fore of the leading architects practising in the first half of the XVIII century. His place might be contested closely by Nicholas Hawksmoor, who was Gibbs' senior by 21 years.

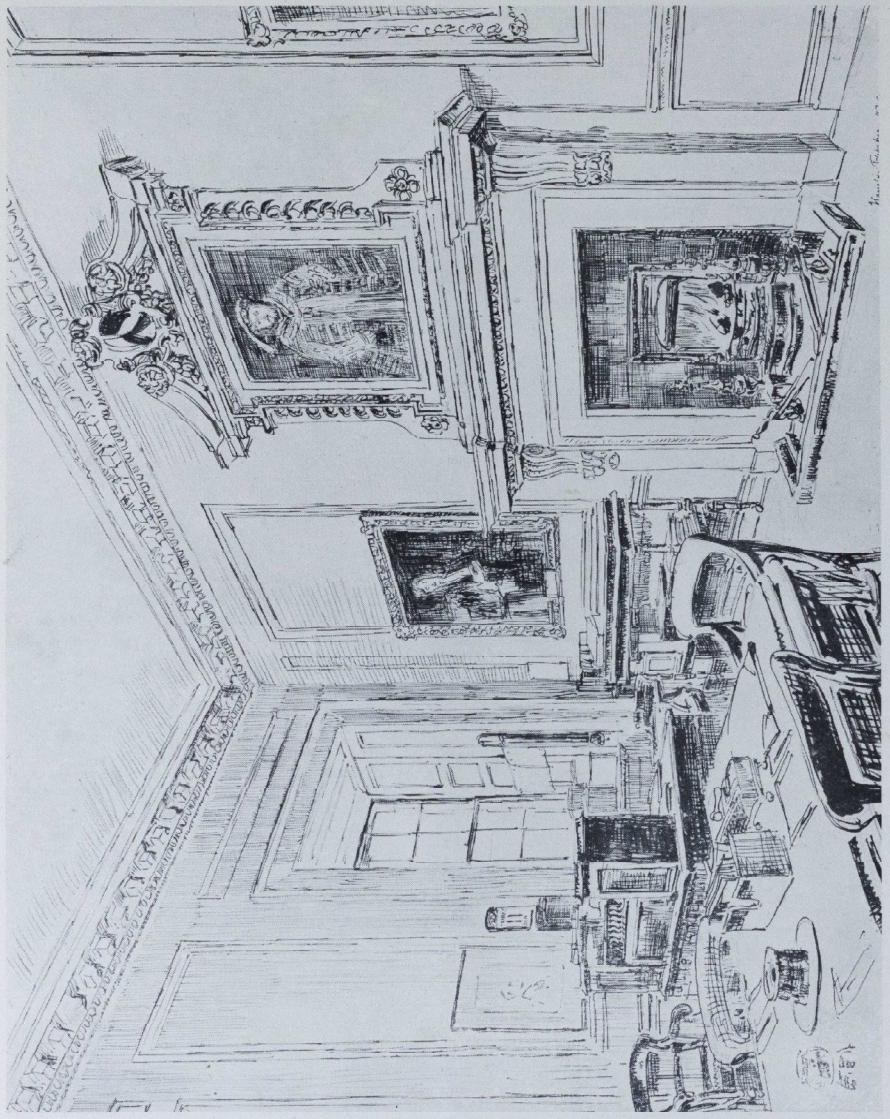
Gibbs, like the late Sir Edwin Lutyens in this century, had another great attribute, for he was a master of proportion. He had the ability to visualise a building as a whole and was able to carry out the design to completion in correct scale and without lapses into insignificance. His cultivated sense of proportion even shows itself to a smaller scale in the many monuments which he designed for Westminster Abbey and for churches in different parts of the country.

After more than two centuries James Gibbs' scheme of rebuilding is intact and most of the buildings forming that scheme still remain and serve the original purpose for which they were built—the tending of the sick. Regardless of St. Bartholomew's place in the history of medicine, its place in the history of English architecture is assured, for Bart.'s may well be considered as one of the most important of the secular buildings designed by James Gibbs, an architect of whose works this is the only example ever to have been erected in the City of London.









The Committee Room beneath the Great Hall: *Hanslip Fletcher.*

THE REBUILDING OF THE HOSPITAL IN THE XVIII CENTURY

by I. H. BACKHOUSE

On April 6, 1723, James Gibbs was elected a Governor of this Hospital; on July 3 he was admitted and the charge read to him. Only 22 days later the Governors, sitting in General Court, affirmed their decision to rebuild the Hospital and appointed a committee, with Gibbs as a member, to prepare a general plan and submit it to the next General Court.

We may admire the unashamed way in which the Governors enrol Gibbs as a colleague, and then saddle him with the responsibility for the new plan. Gibbs, by all accounts a genial, affable and well-liked man, was quite ready to accept the task, and was to prove one of our greatest benefactors, for he worked on the designs and supervised the building for over 20 years and would accept no fee for his services.

Either due to delays by Gibbs, who was very busy at this time working on St. Martin's-in-the-Field and at Cambridge, or because of the poverty of the Hospital, nothing further was done for 5 years, and no more is heard until August 1, 1728, when the General Court enlarged and reconstituted its planning committee and called upon it to produce "a Plann for the Rebuilding of this Hospitall, so that future Buildings may be Conformable to one Design and the whole in process of time become Regular and more useful."

The committee reported within 6 weeks with a plan to build, as a first instalment, a north wing which was to contain a large hall (the present Great Hall), a "Compting house" (present Steward's office), a "hall for the taking and discharging of patients" (present Clerk's office) and "a house for the Clerk to reside in and other convenient offices, the charge whereof, they reported, would not exceed Eight thousand five hundred pounds." This plan was approved and the committee was asked to prepare designs for the whole Square.

Gibbs worked on these plans throughout the following winter, and he presented them to the Governors on May 1 and again on July 24, 1729, when they were unanimously approved. The demand for beds was growing steadily at this time, and it is known that between 1716 and 1744 the number of patients annually cured and discharged rose from 3,000 to 5,000. Gibbs' plan was for an administrative north wing and for three other wings which were to contain wards only. "In the other Buildings are Wards for the sick, each Pile containing 12 wards and each ward 14 patients, in all 504. There is a private room off of each ward for the Nurse attending it."

The money for the rebuilding was raised by a subscription which the Governors and "other well-disposed persons" were invited to sign. The minutes of the Journal* 2 months later note: "It is ordered that our Clerk do wait upon every Governour who hath not already subscribed, with the subscription book and desire their Concurrence in promoting so good a Work." When enough had been collected a building committee was formed and instructed to enter into the necessary contracts.

The most important of these was with Ralph Allen, an enterprising business man who farmed an extensive posts system which brought him in £12,000 a year for 44 years and who also owned large stone quarries near Bath. Allen wanted to introduce this Bath stone to London, and he was ready to let the Governors have the stone they needed on terms which were fatally

* The Journal records the minutes of the meetings of the Governors and is kept by the Clerk. The building committee kept its own minutes and if these were still in existence we would know much more of the rebuilding and the part Gibbs played in it. For access to the Journal and her constant willingness to help me I am indebted to Miss V. Stokes, the Assistant Archivist.

tempting. "Seventeen Hundred Pounds of lawfull mony of Great Britain" was his price for the stone and workmanship on the first wing. "If any of the stonework shall fly, crack, moulder or decay within the space of thirty years" he was to make good the defect at his own expense, and this is precisely what he was called on to do in 1763. By 1815 the stone was in a sorry state and by 1845 beyond repair. In the 1850's it was stripped off and replaced with Portland stone at an outlay which closely approached the original cost of the *whole* building. Bart.'s was almost the only large building in London to be clothed in Bath stone, which proved quite unsuitable for the smoky atmosphere.

The north wing was begun in 1730, and the Great Hall and the Staircase were built by 1732. The ceiling in the Hall is by John Baptist St. Michele who was paid £160 for his work. The paintings on the Staircase were by another Governor, William Hogarth, who later said that he regarded them as an experiment by which he hoped to introduce "the great style of history painting" to England. "But as religion, the great promoter of this style in other countries, rejected it in England, I was unwilling to sink into a portrait manufacturer, and still ambitious of being singular, dropped all expectations of advantage from that source, and returned to the pursuit of my former dealings with the public at large." Which was just as well for posterity.

The north wing was in use for "the Discharging and taking-in of patients" in August, 1732. The names of the benefactors who had signed the subscription lists were painted upon the walls of the Great Hall in 1737 and 1738, and at the end of the latter year it was ordered that the portrait of Henry VIII in the Counting-House should be moved into the Great Hall "and Mr. Gibbs and Mr. Hogarth, two of the Governors, are desired to see the large Picture properly framed and fixed with Decent and respectfull ornaments." The Great Hall must then have looked very much as it does today—except for one thing. In the Journal of 1766 the complaint is solemnly recorded "that wet Linnen is frequently hung upon lines in the Great Court Room or Hall of this Hospital to dry, to the detriment of the Hall and discredit of the Hospital and the great displeasure of persons coming to see the room and Paintings." The Steward is ordered to see that this ceases.

Meanwhile the construction of the second wing was already well under way. This was the south wing, demolished in the 1930's to make way for the new medical block. An anonymous donation of £2,000, supplemented by the usual subscriptions, enabled the work to begin in 1736. The wing was completed in 1740. It is interesting to note the attention to detail given by the Governors who went in a body to approve the designs for the new bedsteads, and decided on sacking rather than board bottoms. They also ordered over a hundred large new curtains at 15/6 each. Our modern medical wards *still* use screens.

The third wing was the west wing, which was begun in 1743. In the event it took nine years to build and many difficulties had to be overcome. First, the foundations filled up with water, and this had to be pumped out and some piles driven. Then in December, 1743, "as the Cash of this Hospital is small at present, it is proposed not to give any Gratuities till the New Buildings . . . are compleated and paid for." This led to many protests from members of the medical staff who, after a century's uninterrupted payment, had come to regard their annually-awarded gratuities as part of their salary. They each petitioned for their retention, pointing out the great increase in their duties over recent years. What clinched the matter, however, and saved their gratuities, was that the new building was being paid for, not out of the ordinary income of the Hospital, but from voluntary gifts.

The main cause for the delay was the failure of Ralph Allen (through no fault of his own) to deliver stone. England had become involved in the War of the Austrian Succession, and the Channel, never safe at the best of times, was alive with privateers and hostile men-of-war. The only means of transporting Bath stone to London was by sea from Bristol, and what with the press-gangs, desertions by his seamen to the lucrative privateers, delays over convoys, the increased freight-charges, and the impatience of the Governors, Ralph Allen had a harassed time. At one point he throws up the sponge and tells the Governors to build with what materials they please, as he is already £500 out of pocket. But he is still ready to give

a further £500 towards the rebuilding. There is no reason to doubt him when he writes years later: "My proposal was not formed to obtain the least Profit to myself, but that I might be a considerable benefactor to that laudable design in which I shall in the whole expend at least £2,000."

Meanwhile Gibbs, who had been supervising the building and filling the unpaid but full-time post of Hospital architect for 20 years, was ailing in health, and at the age of 67 felt that the time had come for him to retire. The Governors, it is pleasant to record, were not slow to recognise their colleague's services. On Thursday, July 6, 1749, it is "Ordered that the thanks of the Court be given to James Gibbs Esquire . . . for the great services performed by him towards this Hospital, by Drawing several plans and designs of the new Building; and by his readiness at all times to advise and assist the Committee, in making Contracts with the several workmen, and upon all other affairs relating to the new Building; and also for his Generous and Charitable disposition towards the poor of this House, by declaring that he would not accept any acknowledgement, or satisfaction from the Committee for the same." Five years later, on his death, Gibbs left the Hospital £100.

Gibbs was later succeeded at the Hospital by the younger and better of the two Dances, George Dance, and the building continued under his supervision. The fourth wing was the east wing, the only one that still houses any patients, and it was to take 13 years to build. It was started in 1757 when the site was cleared, and the foundation stone was laid on April 27, 1758. War (this time the Seven Years' War) once more delayed the delivery of stone and Ralph Allen, who died in 1764, never lived to see the wing completed. But a more serious delay was due to the defection of the Treasurer, Tuff, who went bankrupt in 1760 and absconded with £4,000 of the Hospital's cash. Two wards were, at last, opened in October, 1769, and the new buildings finally completed, 40 years after they had been started, early in the following year.

In 1773 a contemporary, John Noorthouck, writing in his *History of London*, says of the new Hospital: "It is now altogether one of the most pleasing structures in London." Looking at it, as we have to, through the grime that London's smoke has given to the stone, and the patches from war damage, we can still, 180 years later, agree. Built with limited funds for a strictly utilitarian purpose, the buildings still manage to transcend their function, and to give to a medieval hospital a Georgian air of elegance and stability. For these competent and distinguished buildings, Bart.'s owes James Gibbs a deep debt of gratitude.

IS SEX INFECTIOUS?

by C. H. ANDREWES, M.D., F.R.C.P., F.R.S.

I am asked by the editor of this journal to do an article for its Coronation number. He is also asking a lot of other old Bart.'s men to do articles, but the others are all extremely high-toned characters like dukes, and even surgeons. Now I am not in this class at all, being only a slightly prominent back-room boy, and the way I figure it is he wants me to write something very learned and obscure so that he can crack up his journal as being high-browed as well as high-toned.

The other day I am forgetting all about this request and am reading a thing in the current number of the Journal of General Microbiology* by Doc Hayes entitled "Observations on a transmissible agent determining sexual differentiation in *Bacterium coli*". This guy says that an infectious agent like a bacteriophage infects simple-minded *B. coli* and endows them with sexual appetites and potency. Now this guy Hayes is an Irishman so you might figure it was all a leg-pull, but in the same journal is an article by an Italian and two Americans, called Cavalli, Lederberg and Lederberg and they pitch just the same yarn. And since Italians and U.S. citizens are agreed by one and all to be very reputable characters indeed, I suppose this is all right. However, the articles in question

*J. gen. Microbiol., 1953, vol. 8, p. 72, in case you don't believe me.

make fairly heavy going, even though I am extremely interested in the question "Is sex infectious?", and I am presently reaching out for something lighter to read and I find a story by a guy called Damon Runyon. This is all about Broadway and guys and dolls and rods and snatching and scratching and this and that and one thing and another. But after a while I get too sleepy to read even this, so I doze off and the dreams I dream seem to have Damon Runyon and the Journal of General Microbiology a bit mixed up together.

Once upon a time (my dream goes) ever so long ago there is an Autotrophic Micro-organism called Plato the Pure living in a primeval slime. And since he only propagates by binary fission all his progeny of the same clone (or clan as the Scots say) carry the same name. He propagates by binary fission because he's taught to do so and all his thoughts are pure and the idea of kissing a doll bang on the smush on a dark night never enters his noggin, partly because he has no noggin and there are no dolls, though there are plenty of dark nights at that, and all being wasted. Now Plato is very happy wrapping himself around the primeval slime whenever hungry, except for some very unpleasant guys called bacteriophages. These are very unpleasant characters indeed who do not honestly scratch for themselves but shoot their way through an autotrophic micro-organism's cell wall and make merry hell in the cytoplasmic contents thereof and finally bust it all up completely. Now Plato the Pure and his friends finally devise means to thwart these bacteriophages, either by bullet-proofing their outer walls or by learning how to take away a phage's rod when he gets inside so as to demote him to a pro-phage. Pro-phages can be tolerated as long as they keep out of the way and you don't trip over their tails when engaged in the ticklish business of binary fission. Still, not even the most harmless phages are really welcomed.

One day a particularly nasty phage called Percy the Pimp gets together with his friends and concocts a plan to make themselves more acceptable to the bacterial cell. This involves disguising themselves in genes.

I guess I'll have to explain what these genes are. When an organism like Plato the Pure wishes to binary fiss, he sorts out his component parts into pairs (called pairs of genes), so that each half of himself will have a complete set: and all bacteria take great pride in their genes. When a phage decks out his nether limbs in a pair of genes, especially blue genes, he looks more than somewhat attractive and any bacterium, so Percy the Pimp reckons, will be glad to welcome him inside his cellular wall. And so it happens and Percy the Pimp's plan is all the rage with one and all. For when Plato the Pure finds a strange gene inside him he feels most peculiar and gets all excited because it really is a most agreeable feeling indeed.

After a bit he and his friends begin to think why bother about Percy the Pimp? Every so often a bacterium hauls off and dies and after it autolyses odd genes are left lying untidily about in the primordial ooze. So Plato starts quickly snatching these odd genes when no one is looking and he gets just as big a kick as when Percy introduces them, bringing his own unwelcome company through the cell wall at the same time. Later on, Plato and a blonde bacillus get to giving each other birthday presents of genes they don't especially need for themselves. And very soon Plato the Pure doesn't do a lot to deserve his epithet and people begin calling him plain Plato. But this gene swapping racket turns out most excellently for one and all, for quite apart from getting kicks out of it, it gives bacterial evolution one whale of a boost and the humblest micro-organisms get to going places and turning into protozoa and higher fungi and one thing and another.

Finally a big moment comes when two of them are close together in a corner, swapping genes, when, lo, there is a solution of continuity of their adjacent cell walls and what happens next I can't tell you because of the Lord Chamberlain. What's more the other germs soon get the idea. Such things can't take place without comment and remark and before long a watch committee is formed of 2 matrons, 3 bishops, 4 borough councillors and a night sister and they begin plugging the slogan "Back to binary fission!" They have some ideas of stopping the whole thing with antibiotics but of course that cuts no ice: sex is here to stay.

The watch committee does, however, get the thing regulated. There happens about that time to be a craze for American square dancing and people are rather easily persuaded that when they want to exchange genes they shall organise these in a sort of ritual dance. The Virginia reel is favoured at first, but soon a very pretty new dance is invented. It goes to a song with the refrain "Don't tread on my toeses" and the dance gets the name Mitosis and one and all are dancing it ever since. And so it goes on and on. The ritual gets a good deal more complicated in the last few thousand years and now one is supposed to have things like parsons and rings, and even champagne and bridesmaids. Many people enjoy all this; but no one thinks of putting up a statue to Percy the Pimp who started it all.

I tell of this dream because it contains a lot of valuable information which may be of use to students taking examinations: it may help them to pass and become doctors or slightly prominent back-room boys or dukes or even surgeons.

Christopher Howard Andrewes

M.D. (Lond.), F.R.C.P., F.R.S. Born June 7, 1896 *(L.O.A.)*, son of the late Sir Frederick Andrewes. Educated at Highgate School and Bart.'s. President of Abernethian Society, 1921. H.P. to J. H. Drysdale; Chief Assistant Medical Unit, 1922-23 and 1925-26. On staff of National Institute of Medical Research since 1927 and now its Deputy Director. In charge of World Influenza Centre (W.H.O.), and of Common Cold Research Unit at Salisbury. Has indulged in life-long pursuit of viruses to earn his living, and of flies and other insects for relaxation. Author of "Is Sex Infectious?" and other scientific papers.

THE SKULL BENEATH THE SKIN

Some medical references in two plays by John Webster.

By S. P. Lock

OF ALL the great Elizabethan dramatists, perhaps the least is known of John Webster. He is thought to have been born in the fifteen-seventies and in one of his prefaces styles himself as "one born free of the Merchant Tailors' Company." It is possible that he later became the parish clerk of St. Andrew's, Holborn, and probable that he died about the year 1625. He collaborated with various of the lesser-known dramatists of his day, but is chiefly remembered for four plays of his own, of which "The White Devil" *(published 1612)* and "The Duchess of Malfi" *(published 1623)* are still revived.

It would be tedious to detail the plots of these two great works. Indeed he who would do so must read them with close attention several times, so rapid is the turning of friend into foe, so great the final carnage. As Eliot was to write some three hundred years later:

> "Webster was much possessed by death
> And saw the skull beneath the skin;
> And breastless creatures under ground
> Leaned backward with a lipless grin."

Both the plays, however, have a woman as the dominant figure. Vittoria Corombona, or the White Devil, an adulteress who lightly has her husband's neck broken, stands as much above the other characters as the gentle Duchess of Malfi who, cruelly wronged by her brothers, finally chooses her own manner of death with superb detachment. This is a characteristic of all Webster's women: whether angel or fiend, one cannot but admire them. Vittoria Corombona meets her death no less boldly than the Duchess:

> ". . . I'll tell thee what,
> I will not in my death shed one base tear;
> Or if look pale, for want of blood, not fear."

As with "Hamlet" and "Macbeth," sagas of ambition and violent death would soon produce satiety were it not for the language they were clothed in. In this respect Webster has gone further than Shakespeare. He cuts sub-plot to a minimum and allows little in the way of lyricism or humour, whether incident or speech, to divert him from the telling of these dreadful tales. This preoccupation with a single level—a characteristic he shares with Milton—demands a finely turned style having rich diversity within its self-imposed limitations. This possession he undoubtedly has and it raises him far above the other purveyors of the Elizabethan high tragedy. His characters are never pasteboard: they may be gloomy, cynical, cruel, lustful, but they are always splendidly vital and interesting. Be he ever so loathsome a

villain, how can one not admire a man who exclaims in his death agonies:

"... O I smell soote,
Most stinking soote, the chimnie is a fire!
My livers purboild like scotch holly-bread;
There's a plumber laying pipes in my guts,
it scalds!"

Charles Lamb neatly summed up Webster's genius thus:

"To move a horror skilfully, to touch a soul to the quick, to lay upon fear as much as it can bear; to wean and weary a life till it is ready to drop, and then step in with mortal instruments to take its last forfeits; this only a Webster can do."

THE WHITE DIVEL,

OR,

The Tragedy of *Paulo Giordano Ursini*, Duke of *Brachiano*,

With

The Life and Death of Vittoria Corombona the famous Venetian Curtizan.

Acted by the Queenes Maiesties Servants.

Written by IOHN WEBSTER.

Non inferiora secutus.

LONDON,
Printed by *N.O.* for *Thomas Archer*, and are to be sold at his Shop in Popes head Pallace, neere the Royall Exchange. 1612.

Both the plays are mines of information concerning contemporary life, and Webster has numerous references to the church, the law, and natural history. Remarkable, too, are the number of medical references and it is now proposed to deal with some of these. You will find elsewhere in this journal an account of the historical background to these references: suffice it to say that the turn of the century saw the advances made on the Continent and in England itself consolidated and made part of the general knowledge of every literate man. Leonardo da Vinci, Vesalius and Fallopius had been responsible for placing anatomy on a firm grounding based on dissection and accurate description, Paré and Felix Würtz had written books on general surgery, while Paracelsus and Jean Fernel had finally banished astrology from the realms of scientific thought.

Webster himself thought little of the medical profession. We encounter three doctors in the two plays. One is mad, having "forfitted his wits with jealousy" at his apothecary who he says "makes alum out of wife's urine, and sells it to Puritans that have sore throats with overstraining." Another is foolish enough to tell Duke Brachiano that the poison he has taken defies his therapeutic skill. In his rage the Duke exclaims:

"Most corrupted politic hangman
You kill without book: but your art to save
Fails you as oft as great men's needy friends."

Perhaps the doctor here remembered the old adage about the last laugh; earlier in the play he is "a poor quack-salving knave" who will "shoot pills into a man's guts shall make them have more ventages than a cornet or a lamprey." Another character addresses him thus: "Let me embrace thee, toad, and love thee, O thou most abominable loathsome gargarism, that will fetch up lungs, lightes, heart and liver by scruples (*gargles*)."

Of clinical description there is not all that much of value in the plays. True there is mention of the pox and the falling sickness (epilepsy) but more often than not Webster is ridiculing the profession for the rigidness of its tenets. About this time examination of the urine had fallen into disrepute; it is said that an empiric had been known to prescribe merely on sighting a urine specimen at an apothecary's shop and learning the symptoms from the apothecary. Webster has one of his characters observe sourly:

"... Doth he study physiognomie?
There's no more credit to be given to th' face
Then to a sicke mans uryn, which some call
The physitians whore because she cozens him."

Again the doctor in the "Duchess of Malfi" who tries to cure the Duke Ferdinand's madness, suggests that he has "some forty urinals filled with rose water: he (the Duke) and I'll go pelt one another with them." The cause of the Duke's madness is at doubt. The doctor pronounces the disease to be lycanthropia—a disease in which those afflicted imagine themselves to be transformed into wolves, stealing into churchyards at night and digging up dead bodies. Ancient accounts have it that sufferers had human flesh on the outsides of their bodies and wolf's flesh within. This led some doctors to put the theory to practical test ... "but knowing their own error, and the innocencie of the poore melancholie man, they committed him to the surgeons to cure, in whose hans he dyed within fewe days after."*

But we must be fair to our dramatist. No obstetrician could wish for a more succinct account of the early symptoms and signs of pregnancy than are given by Bosola in the "Duchess of Malfi."

"... I observe our duchesse
Is sick a dayes, she puykes, her stomacke seethes,
The fins of her eie-lids look most teeming blew,
She waines i' th' cheeke, and waxes fat i' th' flanke."

As one would expect there are references to the plague scattered through both works. Plague had broken out in London in the autumn of 1592 and continued into late 1593: by December of that year it had caused the deaths of about seventeen thousand inhabitants in London. There was a further epidemic, also with appalling mortality, in 1603. It was natural in such times of panic that any new method of treatment, however ludicrous, was eagerly seized upon by the terrified mob who had been unable to flee the city. One of the more reputable ideas, which Webster mentions and which had been recommended by the College of Physicians, was the application of live birds to the plague's buboes, being held there until dead from the passage of the poison into their bodies. In 1615 the "English Huswife" advises: "If you be infected with the plague apply hot bricks to the feet, then to the same apply a liue pidgeon cut in two parts," while earlier in the century the rector of St. Olave's, Southwark, had written: "Doth not the ordinary experience of laying live pigeons to plague-sores and taking them presently dead away, and that one after another, demonstrate mortal infection?"

* *Histoires Admirables: Goulart, 1606.*

THE TRAGEDY OF THE DVTCHESSE Of Malfy.

As it was Presented priuatly, at the Black-Friers; and publiquely at the Globe, By the Kings Maiesties Seruants.

The perfect and exact Coppy, with diuerse *things Printed, that the length of the Play would* not beare in the Presentment.

VVritten by *John Webster.*

Flora. ——*Stupid*——
——*Candidus Imperti si non his vtere mecum.*

LONDON:
Printed by NICHOLAS OKES, for IOHN WATERSON, and are to be sold at the signe of the Crowne, in *Paules* Church-yard, 1623.

The only hospital in London which would receive plague cases was the pest house in Finsbury, and this is probably the same as that mentioned in the "White Devil," with the underlying implication that the poor patients did not all die of the disease. They were said to have been strangled in their beds by the nurses for their few possessions.

"No woman keeper i' the world
Though she had practised seven year at the pest-house,
Could have don 't quaintlier."

As is natural in an age in which poisoning had been brought to a fine art, there are many references to this: in fact several characters meet their end in this manner. There is mention of stibium (antimony) and cantharidies, as well as the Spanish fig which at that time was a popular vehicle for these two poisons.

Lastly, there are hints at the strange ways anatomical subjects were come by in Webster's time:

"Worse than dead bodies which are begged at gallows

And wrought upon by surgeons, to teach man

Wherein he is imperfect."

and:

"I will stamp him into a cullis, flay off his skin, to cover of the anatomies this rogue hath set i' th' cold yonder in Barber-Chirugeons Hall."

It was in the middle of the sixteenth century that formal teaching in anatomy had been started. By an Act of Parliament of 1540 the bodies of four executed criminals were allowed annually to the Barber Surgeons for dissection, and by a further Act, Queen Elizabeth had given similar permission to the Royal College of Physicians in 1565. John Caius was reader in Anatomy at the Barbers Hall at this time. He had studied the subject with Vesalius at Padua and was now called upon to perform the public dissections, well recognised as an entertainment, which was not later to escape Webster's all-seeing eye.

Thus it came about in Webster's lifetime that, as with many of the other arts and sciences in this country at that time, medicine was in a ferment of new ideas and techniques. The influence of the mediaeval writers had at last been overcome, and these new discoveries were to pave the way for even greater ones in the coming century, such as those of William Harvey, and to set secure the foundation of modern medicine itself. There is no need to postulate, as has been done many times with Shakespeare, that Webster was a doctor, or indeed a lawyer or a soldier; the very diversity of his knowledge makes choice between one of these professions difficult, if not impossible. He was only one of many truly cultured "whole men," who could write an air for the lute, compose a poem in Latin elegiacs, understand the recent scientific advances, besides acquitting himself well with foil or poniard. It is to be hoped that the dawning of the second Elizabethan age will see a revival of this ideal, and an end to the extreme specialisation which has disfigured the present century.

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MORNING FLIGHT

Come dawn,
With cold grey passionless advance
Tread softly, softly as the sighing of the breeze
Going before;
Trumpet of new day:
Half-light moving in the fastness of night:
Shadow fingers stretching across earth's sleepy brow
Through phantom tresses of the dark.
And soft, for on the whisper of the dawn
The gentle throbbing of their flight is borne;
Cool air beating
On the flat lands as they pass:
High in the emptyness,
Fantasies in vapour,
Wild sweet life, lonely in the vastness of the sky.

E. A. J. ALMENT.

THE FUTURE OF GENERAL PRACTICE

by LINDSEY W. BATTEN

General practice is the art, profession and calling of the general practitioner (it is significant that I cannot today write "of the doctor"). It consists in the general and continuing care of patients. "Will you take care of me and be my doctor?"—or, better still, "of us and be our doctor?"—says the discerning patient, and the doctor who says "yes" and does it, is a general practitioner. It is, I suppose, because I have been this kind of doctor for over thirty years that I am invited to turn prophet and survey the future, but I am very conscious that my first-hand knowledge of general practice, though longish, is narrow, being almost confined to my own experience in one "residential quarter" of London. In extenuation I can say that I have, especially in the last few years, heard and read news and views of practices and practitioners, rural, urban and suburban, and met, in committee and elsewhere, many doctors of wider and more varied experience than I can claim. I hope my mind has been broadened. I do at least recognize the limitation I have acknowledged.

The first question for the commissioned prophet must be, "Has general practice any future at all?" and the answer seems to me uncertain.

Perhaps the same could be said of the physician's general medicine and the surgeon's general surgery but, even so, the implications for those who profess and practise these arts are not strictly parallel to the implication for the general practitioner.

True, if subdivision and specialization go quite uncurbed, the time may come when no single member of the diagnostic, therapeutic or operating teams of that brave world will deserve the name of physician or surgeon. But that time is not yet. For the present if one department of medicine or surgery contracts another opens and it seems reasonably certain that surgeons will practise surgery and physicians medicine, even though their individual fields or plots contract or change, for some long time to come.

With general practice it is otherwise. "General," not "practice" is the operative word. It is notorious that the range or scope of general practice has shrunk or been curtailed. Curtail it or let it shrink a little more and the art, profession and calling must perish and with them the man who practised or followed them. "Thou shalt look after his place and he shall be away." The general practitioner is not a necessity in the same sense as is the surgeon or physician. If medicine is nothing more than an applied science his place can be taken by an institution or by a team of medical technicians.

In a not unthinkable world every citizen could register not with a practitioner but with a hospital, like an expectant mother "on the district," and receive domiciliary, out-patient or in-patient medical attention, according to need and circumstances, from an appropriate officer of the hospital. To a convinced materialist and collectivist, moreover, such a plan might seem a consummation devoutly to be wished. Short of this, the scope of practice could be so nibbled and whittled away by well-intentioned clinics that, though still existing in name, the practitioner would become no more than the finger-post to which he has already sometimes been likened—a dispenser of medical comforts, a public medical referee, a turnstile-attendant at the doorway to the Universal Providers.

A subtler danger, cognate but not identical, is that by too great insistence on "team-work" general practice which, if my definition be accepted, is as much *personal* as *general*, could be disrupted by subdivision. The patient, in this case, would register not with an institution but with a collective, six-headed, twelve-handed practitioner. The individual would be sunk in the team. The thesis that because no one man can possess all medical knowledge or master all diagnostic and therapeutic skills, no one should hold

Lindsey Willett Batten

Born 1889. M.B., B.Ch. (Cantab), M.R.C.P. Doctor-relations include father, uncle, great-uncle, sister and son. Education: classics at school (Blundells), pre-clinical sciences at Cambridge (Sidney Sussex), medicine and surgery at Bart.'s (Drysdale and D'Arcy Power). Qualified, September, 1914. Six months Medical Receiving Room Officer, four years R.A.M.C., Western front (with half-time interval for typhoid). Back to Bart.'s. H.P. (Fletcher and Langdon Brown), Chief Asst. Children's Department (Thursfield). Practice in Hampstead. Private and Panel until June 1948, Private only since; Partner since 1947. Hospital work also until war. Married, five children. Enjoys gardening, camping, choral singing and much else.

himself out to be a general practitioner, seems to me to be a product of confused thought; yet it is a familiar doctrine.

The White Paper of 1944, foreshadower of our N.H.S., quoted approvingly the Medical Planning Commission organized by the B.M.A.: "The days when a doctor armed only with his stethoscope and his drugs could offer a fairly complete medical service are gone. He cannot now be all sufficient." Taken literally, without asking if there ever were such days, this is true enough, but the implication that no man working singly can now honestly profess general practice I believe to be false.

The doctor armed with the "scopes," specula and diagnostic tools in common use, standard consulting room equipment, penicillin, sulphonamides and a hypodermic syringe, if he be a man worthy of his profession and has been well taught and trained, can both diagnose and treat the great majority of the maladies he will encounter and can provisionally diagnose and correctly refer the rest. Occasional help from radiologist and pathologist he should be able to count on as a matter of course. Recently a consultants' committee, commenting on this matter, remarks ". . . all hospital work is team work . . . its absence from general practice is an anachronism." It may be so but each day's work seems to me to proclaim that it is the special virtue and property of the general practitioner to be prepared to be consulted and to give appropriate help in *any* disorder of the body and in not a few of the mind and spirit. Only when his patients can turn to him personally in any kind of trouble is he truly their doctor.

Of course he cannot do it all himself; *of course* there must be team-work, but the team required is an *ad hoc* impermanent team, consisting of appropriate specialists and the practitioner himself, who should be its centre, if not captain, and who should resume personal responsibility for his patient the moment the need for the team has passed.

Happy partnerships, harmonious groups, are manifestly good. It is right to rub shoulders, exchange ideas, compete and, on occasion, consult with fellow practitioners. To work together under one roof might promote these good things but the general practitioner *team*, designed to replace the individual doctor, while not, alas, an anachronism, seems to me not an advance but a retreat from the best yet attained.

Much of general practice is, rightly and inevitably, psychiatry (or somatopsychiatry) and even in hospitals I suppose psychiatry must be an individual job, but consider a patient with a thoroughly somatic disease, say a carcinoma of the colon. We will make it an early one and come upon the subject of it as a hospital out-patient. How did he get there? He got there because he trusted his doctor enough to consult him about certain changes of bowel habit. His doctor knew him for a reliable witness and had time to take a careful history. True, he examined him but he needed not even a stethoscope, only his eyes and hands, a couch and perhaps a finger-stall. Time and knowledge were the essentials of his equipment. Could a G.P. Team have done better? It might easily have failed to get consulted at all. But that is not the end. In hospital this patient does need a team and, rightly, he gets one, perhaps several. When they have done their best he goes home and now the picture changes again. In hospital he was a case of carcinoma of the colon but now he is a man—a father, son or solitary man—with cancer, active, latent, perhaps cured. A multitude of questions, both medical and personal, immediately arise for decision. Does he need a team of doctors to answer them? He does not; but he and his family do need badly one good doctor of their own. Only their doctor can, among other services, guide them through that Vanity Fair of charlatanism through which their road must now pass. Let us hope they have a doctor and trust him.

So when doctors, urged to be modern and form teams, "show a reactionary spirit" there may be more to it than mere pig-headedness.

Other dangers to general practice have arisen from the impact of the social revolution and the ideas behind it on the profession and practice of medicine. A reviewer in a recent number of *The New Statesman and Nation* alludes to "the end of humanism and the disappearance of the belief in the kind of individualism which has dominated our society since the Renaissance and the Reformation" as to acknowledged facts. I hope this is an overstatement, but be that as it may, a conception of social justice not easily distinguished from "the same for all" unquestionably inspired the architects of our National Health Service and all too easily

the pursuit of "the best for all" may end in "the best for none"—the elimination of first-class work. It is obvious that a doctor trying to give tolerable service to the 3,500 people for whom he is responsible may well find it hard to give more than tolerable service to any of them. I, personally, believe that, in medicine as in every department of life, the very best, if only for some, must be not only tolerated but encouraged if the good, not the third-rate, for all is ever to be achieved. Quality, not quantity, must somehow be recognized and rewarded. This may come but at present that terrifying power, the "Spirit of the Age," thinks otherwise and it seems clear that if a high standard of practice is to be maintained we, within the profession, must by our own efforts preserve and nourish it. People, Press and Parliament lack both the knowledge and the vision.

I fear it is a fact that the public does not know, what daily experience of practice teaches, that it needs good doctors more than it needs *materia medica* and that there can be no substitute for them; patients who short-circuit their doctor constantly come to grief.

"There is no remembrance of former things", and if we fail to supply what is needed, though not demanded, the very conception of the doctor—"the flower, such as it is, of our civilization", Stevenson called him—will perish. If, on the contrary, we insist on maintaining a supply of good men who will in turn insist on practising their profession in its fullness despite all discouragement, may we not, in the end, create the demand?

We have missed chance after chance. The history of our profession in the last ten years does not bear thinking on but there are signs of a stirring. Perhaps Dr. Collings's conditional prophecy of "the elimination of general practice as an effective agency of medical care" stung us more shrewdly than we care to admit; in any case following the Cohen Committee's report on "General Practice and the Training of the General Practitioner", which endeavours to formulate what *should* be, a B.M.A. committee, mainly of general practitioners, has been working for near three years to discover what *is* and to suggest what *might* be. It has nearly completed its labours. These are hopeful signs, but perhaps more hopeful still is the formation, and the response to the formation, of the College of General Practitioners. That 1,900 established practitioners should, within four months of its foundation, join and subscribe to a college pledged not to promote their interests but to maintain and raise the quality and standing of the art they practise and the calling they follow, is more than encouraging; it is inspiring.

Yet the task remains, a task in which all branches of the profession and not least our medical schools must bear a hand if it is to be carried through. General practice is not for the most brilliant brains—neurology is fitter—but it is for, and it demands, the best men. Integrity of character and intellect, health of body, at least a tolerance of or, better, a real liking for his fellow men, kindness, common sense, a clear head and a love of the Hippocratic Art are the doctor's basic needs. His teachers are responsible for training him to use eyes, ears, hands and the common diagnostic tools, to take a history and assess symptoms, to recognize what he sees, hears and feels, to know the common disorders intimately and have a nodding acquaintance with the rare ones, to have some notion of the workings of the human mind and its ever-present influence on the body. They also should begin to teach him to use his embarrassingly complex, costly and powerful therapeutic armament with skill and discretion, though experience will teach him more.

A good man thus trained, unless captivated by some one department of medicine or surgery, is wasted as a specialist. General practice cries out for him. It will both tax his powers and satisfy his needs. A diagnostic, therapeutic or human problem to be solved will confront him daily and there is good evidence that even a full list need not debar him from tackling it.

The future of general practice will depend, I believe, upon whether, in the next few years, the best men engaged in it stand their ground and upon whether they are joined by worthy and willing recruits who have chosen this fine province of medicine, trained themselves for it and are determined to stand their ground too.

What will in fact happen depends, in the main, on whether the medical profession as a whole thinks it worth while to preserve its own backbone. Who knows? The countenance of the Spirit of the Age may change again.

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Shown at an inquest by any H.P.,
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Strict anti-sepsis of Lawrence or President,
Temper of Lockwood in Theatre C:
Breezy and bracing as Cromer and Sheringham,
Vigour of Horton-Smith Hartley, or Herringham,
Humour eccentric, which renders the former odd,
Dash of the diffident manner of Ormerod,
Recently qualified candidate's luck,
Opsonic brilliance of Stringer and Stuck,

Take of these elements all that is fusible,
Melt them all down in a pipkin or crucible,
Cool, and if crystallisation then starts
The ultimate product's a Student of Bart.'s

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Notice his Rawling-like peace and repose,
The encyclopaedial universality
Characteristic of Norman Moore's prose,
Horror of patients, who terrible visions see
When with D.T.s they're about to collapse,
Garrulous gifts of a Gill, a sufficiency,
Ditto of Dropsy, a trifle perhaps:
Rigour of Matron, enforcing propriety
Boldness of Bruiser reflecting skin flaps,
Soupçon of soft, but McAdam-like piety,
Language you hear when a ligature snaps;
Hard-worked, but healthy probationer's stamina,
Prejudiced mind of a College examiner,
Pride of those persons who happen to head a list
In an exam, like the annual gold medallist,
Junior house surgeon's powers of bluff,
Also a trace of—well that is enough!

Quickly assemble these fruits of analysis,
Screen out the facts, and discard all the fallacies,
Re-integrate them as well as you can,
And the final result's a Bartholomew's Man.

R. B. PRICE.

This Gilbertian parody was never printed in 1909 *when written, as there were too many personal allusions. The libellees are no longer alive, but not yet perhaps entirely forgotten.*

Lawrence and President—names of wards.
C. B. Lockwood, 1856–1914—Surgeon
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Sir Wilmot Herringham, 1853–1936—Physician
J. A. Ormerod, 1848–1925—Physician
Stringer & Stuck—Caterers
L. B. Rawling, 1870–1940—Surgeon
Sir Norman Moore, 1847–1922—Physician
R. Gill, 1856–1933—Anaesthetist
"Dropsy," J. H. Drysdale, 1862–1951—Physician
"Bruiser," W. B. Clarke, 1850–1914—Surgeon
W. McAdam Eccles, 1867–1946—Surgeon

JOHN FROST, 1803–1840

by PHILIP GOSSE

One cannot but feel that had John Frost received a thorough and orthodox education, and been subjected to some degree of discipline in early life, he might well have eventually achieved considerable success in life instead of frittering away his undoubted talents only to end in failure and obscurity. Of John Frost's parents nothing is known except that they were in business of some kind and lived near Charing Cross, where he was born in 1803. The fact that he was a twin, and a seventh month one at that, may have accounted for his delicate health, and for his being spoiled as a child. When he was old enough to leave home he was sent off to a school at Langley, not far from Windsor, which was all the education he ever received.

From his earliest days the boy had expressed a desire to become a doctor, and on leaving school he became a pupil of Dr. Wright, the apothecary of Bethlehem Hospital. But this arrangement did not last long, for a quarrel resulted in young John abandoning the study of medicine for that of botany. To quote his own words: "It was a long time my chief ambition to distinguish jalap from rhubarb, little thinking I was to become the wonder and admiration of the profession."

In taking up the study of botany he did so only in relation to its uses in medicine, and it was this which at the early age of 18 gave him the idea of forming a society of medical practitioners and botanists, to be called *The Medico-Botanical Society of London.*

Philip Gosse
Born 1879, son of Sir Edmund Gosse. Educated Haileybury, Trinity, Cambridge and Bart.'s. M.R.C.S., L.R.C.P., 1907, M.D. (Durham), 1927. Naturalist to Fitzgerald Expedition to the Andes, 1896-7. Late Medical Superintendent of the Radium Institute. Innumerable publications, mainly on pirates, apples and naturalists, but including one in 1926 on T.B. Adenitis treated by radium. "Why I have failed in life is—too many other interests." Hobbies: "a new one every few years," but have included digging fronds, jam making and collecting totems. Recreation: Capt. West Wratting Bowling Club. Clubs: Savile and Fountain.

The principal objects of this society were to be, "the investigation of the properties of plants, the study of the materia medica of all countries, and other allied subjects, and the adjudging of pecuniary and honorary rewards to original investigators, as well as to disseminate by correspondence and publication the discoveries of new medicinal plants."

Without any sort of qualification, either medical or botanical, with no family or other influence to help him — so necessary for success at that period—the enterprising youth did not hesitate to unfold his plan before two of the most distinguished medical men of the day, Drs. Bree and Maton, as well as several other leading physicians. Dr. Robert Bree, then aged sixty-two, after successfully practising medicine at Northampton and Leicester, had been compelled through severe and frequent attacks of asthma, to relinquish his profession, which makes it all the more surprising to learn that in the following year he was able to accept the offer of the command of a company of regiment of militia. However, he soon after returned to medicine, specialising in the treatment of asthma, and became a Fellow of the Royal Society.

Frost's other patron, William George Maton, M.D., was a distinguished as well as fashionable physician, and also a botanist. His success in life started when, walking one day in Weymouth, where he then practised, he was accosted by an equerry who summoned him to Queen Charlotte, who asked him to name a plant which one of the princesses, fond of botany, had obtained. This he was able to do, and the occasion proved the turning point in his career, for soon after he was appointed physician extraordinary to the Queen, and later to Princess Victoria.

By some means or other young Frost managed to gain the interest and support of both Dr. Bree and Dr. Maton, and on January 16, 1821, was born the *Medico-Botanical Society of London.* Yet these two benefactors were to prove but the two first

and lowest rungs on the ladder to fame and fortune, for John persuaded Dr. Maton to introduce him to King George IV, who was so impressed by the young man's enthusiasm that later on he actually consented to become patron of the Society.

It was through Dr. Bree, however, that John Frost contrived to enlist a most valuable first President. This was Sir James McGregor, director-general of the Army Medical Board, and a man of outstanding merit. The enterprising 18-year-old founder of the *Medico-Botanical Society* next got himself appointed Director, as well as lecturer in botany, to the Society, both posts being honorary. With a Royal Patron, an extremely capable President, and an indomitable Director, the new society quickly grew in numbers—the latter being quite ruthless and unabashed in soliciting distinguished persons to become honorary members. In no time at all, so it seemed, the young Director could —and did—boast that he had collected no fewer than eleven sovereigns, all the Royal Family of England, upwards of twenty members of foreign Royal Families, several of the Ministry, many of the English nobility, all the foreign ambassadors save one, and last, though far from least, several of the most distinguished men of science, as well as "an infinitely large proportion of the most eminent philosophers of every nation."

And all this while, the indefatigable Director was busy collecting the autographs of his more distinguished victims. He had specially made for his purpose a handsome album which he always carried about with him. Each signature in it occupied a whole page, and was surrounded by a wreath of "artistically painted flowers." This unique and valuable treasure was, alas, lost at the time of the collapse of the Society, and no trace of it has ever been found.

Gradually, a library was formed of botanical books and manuscripts, as well as a collection of over seven thousand dried specimens of plants. Honours soon came to be bestowed on the Director, though it was whispered that in most cases these were addressed to him but intended for the President, though they never reached him. Of academical distinctions he was soon able to place a handsome array after his name. Thus, in a printed copy of an *Oration* delivered by himself as Director of the Society, at the commencement of their seventh session, he describes himself as "F.A.S., F.L.S., F.S.A., M.R.Inst.G.B., R.Asiatic S., Secretary, Royal Humane Society, Director of the Medico-Botanical Society of London, and Hon. member Med. Soc. of Baltimore." This nine-page reprint was dedicated "to H.R.H. the Duke of York."

In the following year, in a reprint of a "brief introductory lecture on the Science of Botany"—ten pages only—and dedicated to the King, after describing himself "of Emanuel (*sic*) College, Cambridge," to which college he had applied for admission, but never went—he writes "lecturer on botany at St. Thomas Hospital." A year later, on the title-page of a pamphlet entitled *The Mustard Tree mentioned in the New Testament*, he still claimed to be "of Emmanuel College," this time spelled with two "m's," and added the letters F.H.S. to his previous list. This trifling contribution to botanical knowledge he dedicated to the Bishop of London, William Howley, afterwards Archbishop of Canterbury, who will be remembered for having laid it down that King George IV "could do no wrong, either morally or physically." Two other titles Frost was fond of using were "lecturer in botany to the Royal Institute," and "lecturer on Geology at the Argyle Rooms."

Up till now everything had gone well for John Frost. His dream-child, the *Medico-Botanical Society* was flourishing. He himself was its Director. He belonged to a dozen or more learned societies and was able to wear—and lost no opportunity of doing so—a number of orders and decorations, mostly foreign, it was true, but all the same very gratifying to his self-esteem. And though only twenty-six years of age, he was on friendly terms with many famous scientists, and even with members of the aristocracy. He lectured to crowded audiences on botany and geology; and all this without one single academic degree or qualification. And that book of autographs! In addition to all these, there was his secretaryship of the Royal Humane Society, gained for him through the influence of Doctor Maton, with an ample salary and a comfortable house, rent-free, in Bridge Street, Blackfriars.

Indeed, his cup was full, or nearly so, for he had decided to study medicine, and had already entered his name at Emmanuel College, Cambridge, with the intention of taking the degree of M.D. And then came the first reverse.

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(Hanson, I.R. and Hingson, R.A., Curr. Res. Anesth. 29:136 (May/June) 1950)

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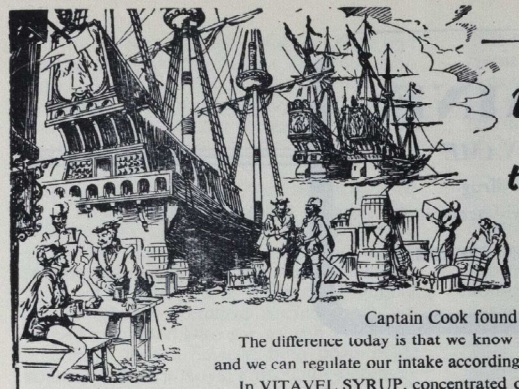

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The truth is, Frost had overreached himself when he applied for election to the Royal Society—to be unanimously black-balled. There is a West Indian proverb which well sums up the situation. It runs: "The higher monkey climb, the more him expose," and monkey Jackie had climbed very high indeed. Matters were not improved when the twenty-six year old Director and Founder of the Medico-Botanical Society was so ill-advised as to write an offensive letter to the Secretary of the Royal Society.

However, his own Society continued to flourish and to attract more and more new members, particularly physicians and botanists, and its meetings were well attended under the able chairmanship of Sir James McGregor, backed up by the indefatigable Director. But trouble was brewing; the day of reckoning was at hand.

It all began with the resignation, in 1828, of the President, and the appointment in his stead of the fourth Earl of Stanhope, which had been brought about largely by the untiring exertions of Frost himself. Much is explained by the author of John Frost's obituary notice.

"Unfortunately for himself," he wrote, "Mr. Frost possessed an incalculable share of arrogance and presumption. He was, moreover, inordinately vain, and as fond of display as a petted child; these failings daily led him to the commission of numberless extravagances and obtained for him the hatred and contempt of many members of the Society."

At the first meeting after the election of Lord Stanhope as President, when the hall was full and the members seated, a hush fell as a small side door opened and on to the platform walked the stately procession, headed by the Director, followed by the two secretaries, Drs. Foote and Sigmond, with the new President bringing up the rear. On the entry of the august Chairman, looking "every inch a King," the members and visitors rose, and only resumed their seats when His Lordship waved his hand for them to do so. An original and charming feature of the meetings of the Society was due to the thoughtfulness of a member, Mr. Humphrey Gibbs, head of a big firm of florists. He used to decorate the hall with masses of choice plants and flowers, "tastefully arranged, and in the winter months giving the room all the freshness and gaiety of spring." He also supplied each member with a fresh nosegay to take home with him.

The new President, Earl Stanhope, was a nobleman of the old school, of fine presence and great dignity. He made no claim to be either a philosopher or a scholar, like his distinguished father and son, but he was greatly interested in all medical matters, in an amateurish way, particularly in anything new, such as Mesmerism, and was a frequent visitor at the popular séances of Dr. Elliotson of the North London Hospital.

It was another meeting of the *Medico-Botanical Society* which was destined to settle the fate of young Frost. This was held on September 27th, 1829, at the Society's rooms in Sackville Street. The President, Lord Stanhope, being abroad at the time, it fell to the Director to go through the accounts and deliver the annual oration. But to the surprise of the crowded audience the Director stepped on to the rostrum wearing full dress and "adorned with a dazzling display of orders and distinctions on his breast, consisting of various honours, both domestic and foreign, which he had acquired in his correspondence with foreign courts, but which many thought belonged more properly to the President than to him. This unreasonable display," continues his biographer, "tended greatly to increase the rancour of his enemies, and the dislike, hitherto but partially concealed, soon broke out in open manifestation."

Shortly after the return of Lord Stanhope to England, at a meeting of the council held in his own house, it was decided that the office of Director be declared abolished. A general meeting was then held, at which his Lordship presided; and it must have been particularly galling to the Director to find his most pitiless accuser the very man he himself had invited to fill the vacant post of President.

After a long and laboured harangue, in which he accused Frost of various derelictions and transgressions against the laws of the Society, the President concluded by moving that "the said John Frost should deliver up his insignia of office, and all the property of the Society in his possession." To this charge the accused replied with great spirit, but at an adjourned meeting held on January 8, 1830, Lord Stanhope again presided and once again violently attacked the Director; indeed, went so far as to propose his immediate expulsion from the Society, which, after some debate, was carried—"and then Mr. Frost found all his projects unexpectedly

blighted, himself expelled from the Society which he had formed, and for the advancement of whose interests he had devoted so much of his time and labour."

As is so often the case, his misfortunes did not come singly. Hitherto nothing had gone wrong, except for that unfortunate misunderstanding of the Royal Society, which no doubt he felt could be put right some later day—but now another blow fell. By some means or other he had recently obtained, how it is impossible to say, the post of Surgeon to his Royal Highness the Duke of Cumberland, and he had that title engraved on his card. On the strength of this he, most unwisely, resigned his well-paid post as Secretary to the Royal Humane Society, with a rent-free house, and the news of this quickly drew a crowd of eager competitors for the vacant post.

In the meanwhile rumours had reached the Duke of Cumberland that his protegé was a presumptuous adventurer and no surgeon, and the appointment was at once cancelled. Frost, now seriously alarmed, immediately applied to the Royal Humane Society to be reinstated as Secretary, but the members of the committee "preferred a change." To quote once again the writer in the *Gentleman's Magazine*: "After these unfortunate repulses, Mr. Frost found himself a comparatively deserted and insignificant individual, which melancholy change seriously affected his health, but notwithstanding, he still continued to exert himself in the cause of humanity and science."

Three such major disasters might well have crushed a man of less courage and self-confidence. But not John Frost. The very next year he established the Hospital of St. John at Clerkenwell, where it still has its headquarters. He also found time and energy to help promote the Royal Sailing Society.

Not satisfied with this he, in the following year, 1832, successfully approached the Lords of the Admiralty to grant him permission to establish *H.M.S. Chanticleer* as a hospital ship off Millbank for sick watermen, and with his old flair for patronage he soon had enlisted a body of distinguished supporters for his scheme. Truly, one can but admire his perseverance, for in spite of all his recent rebuffs he contrived to obtain not only the King for Patron and the Duke of Leinster for President, but, in the list of directors appeared such illustrious names as the Dukes of Bedford and Buccleuch, the Earl of Clarendon, Admiral Lord James O'Brien and Admiral Lord Gambier, and many others of rank and distinction.

But this very galaxy of fame, nobility and wealth, was only to lead to Frost's undoing. Naturally, a considerable sum of money was required to fit the vessel up as a hospital ship, but depending upon his illustrious patrons for support, he was so very rash as to become personally responsible to a heavy amount, and at length, finding himself disappointed and in danger of arrest for debt, took to his heels and bolted to Paris, where he lived for some time under the assumed name of James Fitz-James—no humble "incog." such as Jones or Smith for John Frost. Soon he was on the move again, this time to Berlin, where he practised medicine under the name of Sir John Frost, and married a Swiss lady, a daughter of Madame Josy, author of a book on Switzerland, by whom he had no children. After only a few years' successful practice he died in 1840, at the age of thirty-seven.

We cannot, I think, do better than call once again upon the writer of his obituary notice in the *Gentleman's Magazine* to bring to a close this brief account of the life and activities of a very remarkable character.

"Mr. Frost undoubtedly enjoyed considerable talents, united to great perseverance, and a degree of self-confidence, in some cases amounting to impudence. In illustration of this it may be mentioned that in applying to Prince Leopold to become a member of the *Medico-Botanical Society*, after meeting with nine successive positive denials, he still continued his application, and on a tenth trial succeeded in effecting his object. Mr. Frost's chief faults were his extreme presumption and unbounded pride and vanity; but when we consider the very early age at which he accepted such distinguished honours, some little allowance may surely be made (since, in the end, these failings caused his ruin, we may pity rather than condemn), and lament that in the plentitude of his self-conceit he forgot the surest way of obtaining respect for himself was by paying respect to others."

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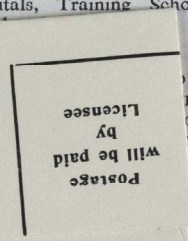
AFRICAN INTERLUDE

By EDWARD R. CULLINAN

SINCE the last war I have twice toured Northern Rhodesia, Nyasaland, Tanganyika, Uganda and Kenya. The tours followed invitations from the Secretary of State for the Colonies, made possible by the generosity of the Nuffield Foundation. Most of my time was spent visiting Colonial Medical Officers, especially those living in outlying districts. Also, I was able to visit eighty Government Hospitals, thirteen Mission Hospitals, twenty-six Dispensaries and several Military Hospitals, Overseas Food Corporation Hospitals, Training Schools, Public Health [illegible] and



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In the Army, during the war, in these big countries which occupy nearly a million square miles, the most prevalent medical diseases in both Europeans and African Natives were malaria, dysentery and enteritis and upper respiratory infections ; in that order. I have excluded venereal diseases and tropical ulcers, both serious problems in African Natives. After these, the prevalence of other diseases differed markedly in the two races. Digestive disorders were nearly five times, skin disorders three times and psychoneuroses over twice as frequent in Europeans. It was interesting that the morbidity from peptic ulceration in Natives rose with their degree of education and responsibility. Peptic ulcer was rare in the Native private soldier, but not uncommon in the Native sergeant-major. The killing diseases of African Natives at that time were tuberculosis, meningitis and pneumonia, which accounted for nearly 40 per cent of the total deaths.

When considering diseases in Central and East Africa the stress should be on medicine in the tropics rather than on tropical medicine. For example, pneumonia and respiratory diseases are the bugbears of the African, and alternate, according to the season, with malaria in importance.

Up in the copper-belt of Northern Rhodesia are the "boom-towns." The present prosperity of the mines is reflected in the revenue of the whole country. Here, in the growing native townships, one can see urbanisation at its birth.

At Kitwe, the Government has built a fine Silicosis bureau, where all recruits to the mines, white and black, have their chests investigated ; this is repeated, if they are "scheduled" workers, at yearly intervals. There is not much silicosis in these copper-belt mines, but the bureau gives an excellent opportunity for studying other chronic chest diseases. Dr. Robert Paul, the Chairman of the Bureau, told me that they saw no cases of carcinoma of the bronchus in the African miners. This is interesting because the men are inveterate smokers. They like a strong cigarette. I acquired a packet of 20, at a penny a packet, including the duty, and having smoked them wondered whether I should live to see another day.

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The following remarks refer largely to the prevalent diseases in the five countries. Although I was already familiar with some of their medical problems, what I have to say must necessarily be brief and superficial. One does not become an expert on East Africa by a brief sojourn in its territories. Much misunderstanding exists about East Africa. Indeed, there are some who still seem to view the White Highlands of Kenya as sites of super-sophistication, while in the deeper parts of the bush missionaries gently simmer in cooking pots.

In the Army, during the war, in these big countries which occupy nearly a million square miles, the most prevalent medical diseases in both Europeans and African Natives were malaria, dysentery and enteritis and upper respiratory infections ; in that order. I have excluded venereal diseases and tropical ulcers, both serious problems in African Natives. After these, the prevalence of other diseases differed markedly in the two races. Digestive disorders were nearly five times, skin disorders three times and psychoneuroses over twice as frequent in Europeans. It was interesting that the morbidity from peptic ulceration in Natives rose with their degree of education and responsibility. Peptic ulcer was rare in the Native private soldier, but not uncommon in the Native sergeant-major. The killing diseases of African Natives at that time were tuberculosis, meningitis and pneumonia, which accounted for nearly 40 per cent of the total deaths.

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healed lesions are seen. Recently, a survey of pulmonary tuberculosis has been made in Kenya, and local surveys in parts of Tanganyika, Uganda, Northern Rhodesia and Nyasaland, but the real size of the problem is not yet known. Most of our early knowledge of pulmonary tuberculosis in East Africa comes from Kibongoto, a flourishing sanatorium for the study and treatment of the disease. It is situated on the lower slopes of Mount Kilimanjaro, whose rounded snow-capped peak, 20,000 feet above sea-level, hangs like a fairy lamp above it in the moonshine. Kibongoto is an example of the splendid work which can be done by one man in Africa, given the enthusiasm, the opportunity and the time.

Yaws is an old-fashioned disease, and only a few foci now remain, chiefly in the poorer districts, as for instance in the north-west corner of Tanganyika, bordering on Ruanda Urundi.

This is not the place to discuss venereal disease in Africans. The problem is a large one, not so much in the settled life of the villages, but particularly on the edges of the towns. Because of the difficulty of persuading any Native to have continued injections, the one-shot penicillin treatment of syphilis is gaining much favour; not in the hope of curing the disease, but of making the patient safe for the community.

From the copper-belt we go to Ndola and Broken Hill (the place of Homo Rhodesiensis).

In most parts of East Africa, health remains good with reasonable care. For example, of the 400 admissions to the European hospital in Broken Hill in 1947, 110 were malaria, 65 respiratory disorders, 55 skin diseases, and the remaining 76 midwifery cases.

Then to Lusaka, the capital city, and from there we fly to Fort Jameson, a town near the Nyasaland border, nestling in wooded mountain country very like the Austrian Tyrol. People in Fort Jameson have strange hobbies. Mr. X had a friend who collected skulls of rats and his dog was forbidden to enter his friend's house. The animal had once disgraced itself by eating skull No. 39. Another man collected lice.

Wild animals are still dangerous in Africa. In one afternoon, at Fort Jameson, I saw a man who had been gored by a buffalo, a child who had been mauled by a leopard and another man who had been savaged by a lion.

Nyasaland is a beautiful country, fertile and well-farmed, with great granite mountains rising from behind the foreshores of the lake. The native people are delightful.

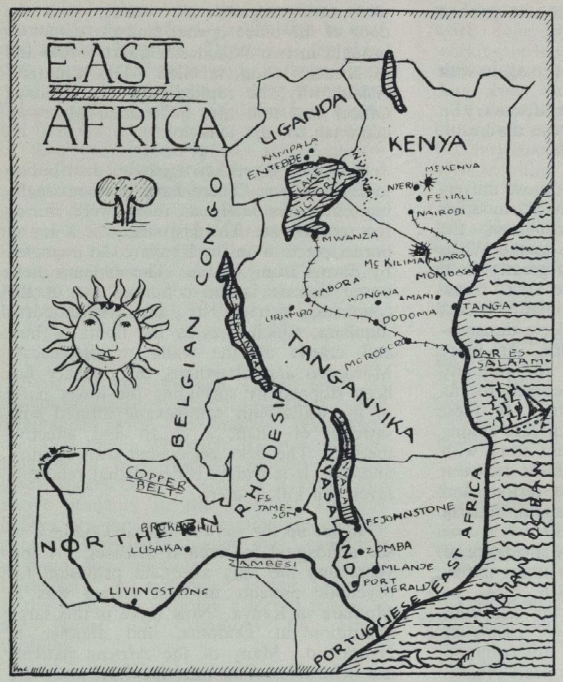
Although the Governments have many centres for the treatment of leprosy, much of it is done by the Missions. The good results of sulphone therapy in the nodular type of leprosy are impressive.

The splendid work and the extent of African Missions, whatever their denomination, is not always fully appreciated at home. To cite an example, the White Fathers have missions in thirty-two countries in Africa and seven hundred houses. At one of their missions near Lilongwe there is a church, a monastery, a convent, a native convent, a boys' school, a girls' school, a maternity hospital and a hostel for expectant mothers.

All along the hindshore of the lake, as along the coastal strips of Tanganyika and Kenya, infestation with schist. haematobium is widespread. Along Lake Nyasa, over 80 per cent of the native population is affected. Fortunately, a large number of these people live happily with their parasites and show no active signs of urinary bilharziasis. Infestation with schist. mansoni is less common, although there are certain known foci such as to the north of Lake Nyasa. Cases with mansoni infections and large hard cirrhotic livers are seen post-mortem in various parts of Africa, but I have never yet been able to get a pathologist to say definitely that the parasite had caused the cirrhosis.

Infestation with hookworm, roundworm and tapeworm is widespread. Hookworm, of course, is most prevalent in wet districts. It produces anaemia when infestation is heavy, and the anaemia responds to iron.

There is not space for me to tell of the lovely places we visit in Nyasaland, such as Zomba and its mountain trout stream, or Mlanje mountain, so superb for rock-climbing. Fort Johnson, at the bottom of the lake, with its airstrip covered with ant-hills, is a romantic station. The beauty of the river, the sunsets, the water-birds, the luscious fish one catches on spinners, the crocodiles, the hippos and the nights disturbed by the cough of the leopard, stretch credulity to the limit. My host picked up a crocodile egg from the foreshore. The egg hatched in his hand and the newborn crocodile bit him in the thumb.



It was here that I stood by a tree under which David Livingstone had preached, but if truth be told, the number of such trees is as great as the number of oaks which hid King Charles. Down in the south is Port Herald, a lonely spot, where lives a serious man who seldom laughs. A friend, worried by his isolation, went to visit him. After an arduous journey, he arrived, and crossing a patch of bush, held out his hand and said: "Ah, Doctor Livingstone, I presume." "No! No! No!" replied the man, "the name is Creel."

Let us fly from Nyasaland to Dar-es-Salaam, the capital of Tanganyika, and then leave the sweltering heat of that old German port and go along the coast to Tanga. It has a smart new airport. Four years ago, except for the runway, there were only two sheds. One had a single counter with three labels—"Customs," "Health" and "Immigration"—the other had three doors labelled "Europeans," "Gentlemen" and "Ladies."

Speaking of ladies, I must refer to the desire of Indians, of whom there are so many in East Africa, to be polite. An Indian patient, complaining of earache, was asked how he had treated it. "With milk," he replied. "What sort of milk?" said the doctor. "Woman's milk," replied the Indian. "What!" said the doctor, horrified. The Indian, recoiling, said, "I beg your pardon, sir, I meant lady's milk."

Cutaneous anthrax on the face and neck is seen among the hide-carriers of the ports. It responds well to treatment. Elsewhere I have seen intestinal anthrax, which occurs often after eating a dead and infected cow. In one village in Kenya this ceremony takes place every year, in spite of repeated warnings. Natives must have considerable immunity to the disease because the mortality is quite low.

In hot coastal places such as Tanga, coryza, bronchitis and otitis externa rank in importance with malaria in Europeans.

Above Tanga, in the Usambara mountains at Amani, beautifully situated in the old German arboretum, is the East Africa High Commission Malaria Research Station, under the direction of Dr. Bagster Wilson. It used to be lower down at Muheza in the sisal country. It was there that I met the man who hated sisal. He was one of the greatest sisal experts in the world and had a deep and emotional loathing for the plant, and believed it hated him. He told me that one night, when he had been inspecting the heart of a plant, a sharp outer-pointed leaf had

deliberately curled itself round and stabbed him in the seat.

In Amani I was impressed once again with the great scope for medical work and research in Africa, where one discovery in hygiene or medicine may improve the health of tens of thousands of people.

Malaria in East Africa is almost universally caused by infection with plasmodium falciparum. Widespread throughout the countries it has now crept up to the White Highlands. The season varies greatly from region to region and in some areas transmission may be almost perennial. Natives who live in districts where malaria transmission continues for six months or more throughout the year develop an immunity to malaria. This immunity depends for its being on frequent re-infection. In these peoples malaria is a very mild disease among adults but it is a quite different story with their children. Malaria in infants between birth and the age of two is a serious and maybe killing disorder. Then again, malaria is a serious disease among natives who come from non-malarious areas. The incidence of blackwater fever is low. Thus in one native hospital in Tanganyika, 3,646 cases of malaria were admitted during the year with twelve deaths, but only two cases of blackwater fever. Malaria is still common among Europeans. Most European inhabitants are malaria-conscious concerning drugs, but, unfortunately, not concerning mosquitoes. Many now take Paludrine, but many remain heedless to avoid being bitten. Dr. Bagster Wilson thinks that, at present, Paludrine is a more convenient suppressive than anything else, though it is known that parasites may develop resistance to it. The malaria mosquito appears to be controlled absolutely by D.D.T. The amount of anti-malarial work done in the towns is extensive and many of them can now boast that they have no malaria at all.

We return to Dar-es-Salaam and see some cases of pneumococcal meningitis, a disease in Africans which is peculiarly difficult to treat. Pyomyositis, epidemic thrombophlebitis and abscess of the spleen are other medical enigmas for the curious.

Let us now start up the Central Line of Tanganyika and first get off the train at Morogoro. It was in Morogoro I heard the story of the late Dr. Kauntze. As Director of Medical Services, he had just inspected the hospital. He and the Medical Officer were sitting together afterwards, when the door of the office opened and the dispenser brought in two Winchester quart bottles full of boracic lotion, labelled "Dr. Kauntze." Asked why, he replied that the Medical Officer had told him he wanted plenty of eye-wash for the Director.

Relapsing fever has a patchy distribution in East Africa. There have been no really big outbreaks lately as there were during the recent war. The last one was a louse-borne infection on the Kenya coast imported by dhows from Arabia. The endemic tick-borne disease is the common one of the countries, carried by the ornithodorus moubata, which lives in the floors of huts and crawls up the walls at nights. At Morogoro and elsewhere, this menace has been stopped by sprinkling the lower parts of the walls with gammexane diluted with sawdust or chaff, a cheap and effective method. The ticks get coated with sawdust and die. It is widely believed that relapsing fever can kill *in utero*.

Higher up the railway line at Dodoma we see a hospital for mental diseases. A few years ago the only adequate provision for psychotic patients in East Africa was at Muthare in Kenya. Now there is this large institution at Dodoma, and another in Nyasaland. Many of the African patients are schizoids. The affective psychoses are found among the more cultured. At Dodoma, too, there is a criminal mental institution, called Broadmoor, the only one of its kind in East Africa. Most of the inmates are murderers, and here I met and talked to the old lady who had been one of the Singida Lion-women. She was rather sweet.

There were two big outbreaks of plague near Dodoma in 1952. These were stopped by a rigorous anti-rat campaign and by giving streptomycin to human contacts. Streptomycin proved to be an almost one hundred per cent cure in patients with bubonic plague, even when they were in coma.

Further up the line, at Tabora, we come near to the sleeping sickness country. Here in the bush is the tse-tse fly, morsitans, which causes the rhodesiense illness. There was a big flare-up in the district in 1949. Antrepol cures the disease if given in the first few weeks, and anthracide injections of cattle now make it possible to move a herd through an infected area to a newly-populated fly-free clearance.

Tropical ulcers on the legs are seen throughout East Africa, particularly in sizal and suchlike districts. Dryness of the skin, dirt, trauma, infection and, perhaps, malnutrition all contribute to their formation. Once developed, they are difficult to treat; but four years ago I saw a splendid example of their prevention. It was at Urambo, a ground-nuts clearing, which one approached along a road with a huge notice board at the side saying "De-tse-tse yourself." There, the medical officer had arranged that the headman of each gang had a number of elastoplast dressings wound round his stick. Immediately one of the men pricked or cut his leg the headman stripped off a dressing and put it on the wound. There were no tropical ulcers.

Now by road through Trinidi (with its trypanosomiasis research station), and Shinyanga (with the famous Williamson diamond mine), we reach Mwanza, with its magnificent new research station on the lovely shores of Lake Victoria Nyanza. The native students in the Hospital Dressers School are having an examination. In the general knowledge paper one candidate answers the question: "Who is Oliver Lyttelton?", by writing: "Oliver Lyttelton is the man who is doing a locum tenens in the House of Commons for James Griffiths."

Across the lake, we come to Entebbe in Uganda. As I stood in the porch of its fine hotel, I made a stupid remark to a man. "It's a lovely day," I said. He looked at me as though I was mad. It's a lovely day there for every day of the year. This is the country of Buganda, and the native people are prosperous and well-dressed. Uganda is relatively small and compact, and has a large number of native doctors in its Medical Service.

Let us spend a few days in the exhilarating atmosphere of Makerere College and Mulago Hospital at Kampala, where the enthusiasm for research and teaching is so great. They are doing much to make history in medicine in Africa. Their studies on malnutrition in infants (which, in its gravest form, is called Kwashiorkor) and on liver fibrosis in adults, are examples. This is not the place to discuss the relationship of malnutrition to hepatic cirrhosis, but cirrhotic livers are common in adult Africans, and, probably as a result, carcinoma of the liver.

It is time for us to tour the west and north of the country. We visit many a country hospital and see the vast amount of good work done by two medical officers, one working in the hospital and the other in the surrounding district.

In Europeans, simple diarrhoea without blood is common. Widespread outbreaks of bacillary and amoebic dysentery are seldom seen in either race.

The "umba" fly, the simulium, is found in various parts of East Africa and transmits onchocerciasis. The fly breeds in waterfalls over little rocks in the rivers of the forests. It can be eradicated by dripping D.D.T. into the streams.

We must return to Entebbe. There is no time to tell of the romance of the Rockefeller Yellow Fever Research Institute. The epic story of the Church Missionary Society Hospital, founded by the late Sir Albert Cook in 1897, is too well known to need re-telling.

Let us travel round the north of the lake to Kenya, stopping first at Jinja where they are building the great Nile Dam. Here, I saw a travelling dispensary, a one-man enterprise. It had been almost too successful, dealing with 50,000 new cases in one year.

One Medical Officer with a few volunteers had gradually cleared miles and miles of bush infested with tse-tse fly, palpalis, along the banks of Lake Victoria at Jinja, and re-inhabited the land with thriving villages.

We enter Kenya into the Nyanza Province, a well-to-do farming area. Here we see the new rural health centres taking root. Dispensaries are dotted all over East Africa, centres run by one or more qualified African dispensers, who take great pride in their establishments. I remember at Karatina in Kikuyu country, when hundreds of people were waiting for treatment at the dispensary. The dispensary was spick and span, although our arrival was quite unexpected. I remarked on the absence of flies. The dispenser, a fine African, looked at me with scorn and replied disdainfully: "Flies depend on how a place is kept. For instance, I never allow sputum to lie about on the floor"!

The rural health centre is something different. Here the Native people have to do something for themselves, and the staff, which is African, includes a special grade hospital assistant, a midwife and a health visitor who circulate round the nearby villages. One of the smartest centres I saw was run by a man called Melchizidek.

This brief article is not a suitable forum from which to discuss the relative claims of public health and curative medicine. It is not an over-simplification, however, to say that the African will not be convinced by the white man's advice on methods of preventing disease, unless he has concrete evidence that the white man can cure disease.

We cross the Rift Valley into the lovely Kikuyu highlands; beautiful lands, where the climate always seems like a fresh, sunny June day in England. We go through coffee farms and sisal plantations and through the Kikuyu Reserve at Nyeri, Fort Hall and Kiambu. Kikuyu women, far from handsome, dressed in white or highly-coloured shawls, walk along the roads plaiting baskets much as European women would knit. They carry enormous loads on their backs suspended by a strap around their foreheads. Their men folk wear old blankets and walk along ahead alone, mostly carrying nothing: they direct operations. The native reserves in Kenya are large and in some of the best country of the colony. Then we arrive at the lower slopes of Mount Kenya at the bottom of the forest-belt, which extends right round the mountain. An ascent of this mountain is no light undertaking. You start by walking up through three thousand feet of forest, at first through giant cedars and podocarpus and later through bamboo. The whole forest is dark and deathly silent, though teeming with large game. Then you come out on to open moorland which becomes more and more covered, as you go higher, with giant groundsel—a large, foul-looking plant which looks like dried and rotted cabbage on the end of a revolting stalk. Finally, at about fifteen-and-a-half thousand feet you come to the rocks. You are faced with a fifteen hundred foot rock climb to the twin snow-clad peaks, severe enough to have beaten many a strong party. You cannot do this today; murder stalks the mountain.

Below the forest in the cultivated lands one sees the startling effect of the capricious rains. In one place the maize is lush: a few miles further on it is withered with drought.

Typhoid fever is endemic in East Africa but there are few epidemics.

Tick typhus is a disease of Europeans in which the effects of chloromycetin are dramatic.

Our driver, Mahomet, takes us back to Nairobi at enormous speed. This powerful and ferocious-looking Asswan spends his spare time doing embroidery and dress-making. In the modern city of Nairobi, it is difficult to imagine one is in Africa, but the arrival of three young and beautiful Masai maidens, laughing and chattering on the station platform without a stitch of clothing, causes embarrassment to all but them. The train winds down through game country for three hundred miles to Mombasa. It is told that a station-master on a local station once sent a message up on the night train to the station-master at Nairobi which read: "There are seven lions prowling about my platform. Kindly send one rifle and seven rounds of ammunition."

Sadly, there is no time to discuss the social services with their ante-natal, child welfare clinics and training establishments; the immense scope for public health; nor medical research and its endless possibilities, not only by special research workers but by the ordinary medical officer.

The courage and enthusiasm of the medical officers is a stimulus to us all. They have unlimited opportunities for good in almost any direction in which they turn; a wonderful life for those who like it.

We came out by Constellation but we return by the more leisurely flying-boat, crossing the Pyramids and the green delta of the Nile, the length of the Western Desert to Augusta where the people are singing opera while rebuilding their houses, and as we go to bed the hotel barber plays his mandolin in the shop below. Next day we fly beside a quiescent Mount Etna, across the centre of France and the Channel to the grey waters of the Solent. A perfect landing and we are ushered into a waiting-room. One by one we are taken into a large room, alone with the Customs Officer. A benign man, he bends forward, leans on one elbow, looks one quietly in the eye and in the voice of the confessional says: "Tell me all." Yes, we are home again.

These tours were extensive and made possible by great co-operation of those concerned, both at home in the Colonial Office and in East Africa. I take this opportunity to record my very grateful thanks for that help, and for the most generous hospitality I received from all, and particularly from the Medical Officers and their wives.

North Face, Mt. Kenya. *Photo*: A. Firmin

THE NEW BUILDINGS AT CHARTERHOUSE

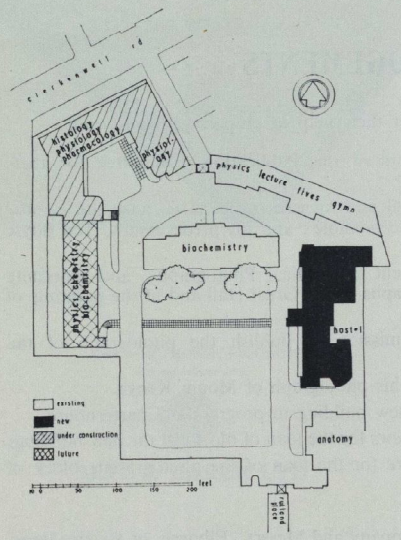
By C. E. MORRIS (*Secretary of the Medical College*)

THE College authorities decided that the reconstruction and expansion of the Medical College, which suffered severely through enemy action during the war, should be divided into two main stages:—

(1) The erection of a College Hall of Residence.

(2) The erection of a new laboratory block.

The College Hall, which was started in March, 1949, was completed in December, 1951, and contains, in addition to residential quarters for 100 students, a refectory, student recreation rooms and cloakrooms. In the basement of the building are the domestic services which will in due course supply the whole of the new laboratories with heat, light and water.



A tunnel has been cut under the lawn and will ultimately connect the Hall with the new laboratory block.

The plan for the new laboratories covered a greater area of land than the College possessed and not wishing to encroach upon the College lawn additional land was acquired, fronting on to Clerkenwell Road, together with part of the Master's Garden of the adjacent Charterhouse. The laboratories, when complete, will cover the whole of the additional site and also the site of the existing Physiology building.

The construction of the new laboratories was divided into two stages. The first stage was to be completed on the newly acquired land and to contain the Departments of Physiology, Pharmacology and Histology. The second stage was to be erected on the site of the existing Physiology building and to contain the Departments of Physics, Chemistry and Biochemistry.

The first stage of the laboratories was commenced in September, 1951, and was divided into three building phases. Phase 1 being the excavation of the whole site and the construction of retaining walls. Phase 2, the erection of the steel framework to ground level of the whole of the excavated site and the completion of the East Wing, which will contain two lecture theatres, a demonstration theatre, Physiology research laboratories, offices and stores. It is hoped that the East Wing will be completed early in 1954. Phase 3, the completion of the North and South Wings, containing lecture theatres,

Physiology teaching laboratories, Pharmacology teaching and research laboratories, Biochemistry research laboratories, animal rooms and an animal operating theatre suite. It is hoped that the complete stage will be finished by 1957.

As the second stage cannot be commenced until the Physiology building has been demolished and this demolition in turn is dependent upon the completion of Stage 1 as a whole, any delay in the building timetable must inevitably delay the completion of the whole scheme and it would be imprudent to attempt to forecast the completion date of the whole project, particularly as many essential building materials are still in very short supply.

In addition to the main building scheme outlined above the College is proposing to construct two hard tennis courts and a car park on the sites to the east of College Hall. It is hoped that these will be completed by October, 1953.

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Dr. Geoffrey Bourne and the other members of the Publication Committee for their constant encouragement and advice.

R. J. Knight, the Manager, whose successful and unceasing efforts to raise the income of the *Journal* have alone made this special isssue possible; and his predecessors, Ted Boyse and John Blow, who began the happy story.

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Mr. A. Firmin for permission to reproduce his photograph of Mount Kenya.

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"Dicasso," a Smithfield meat tycoon.

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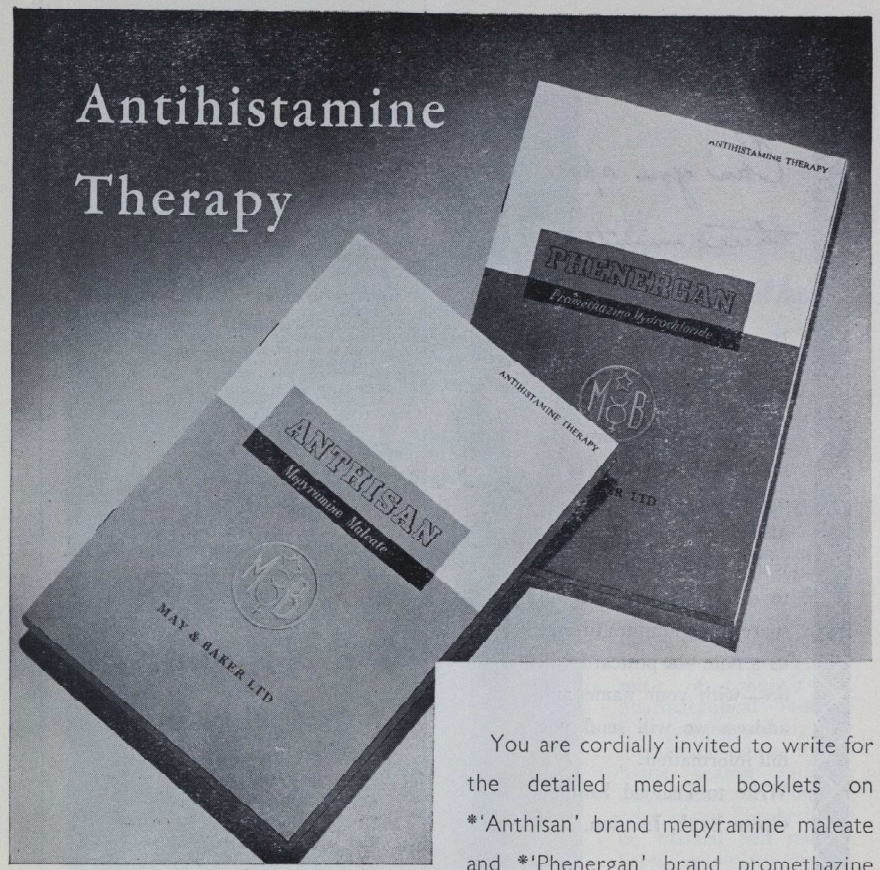

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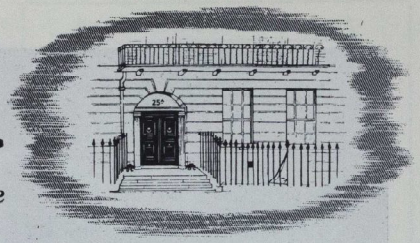

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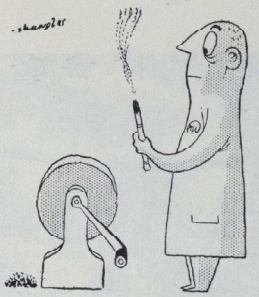

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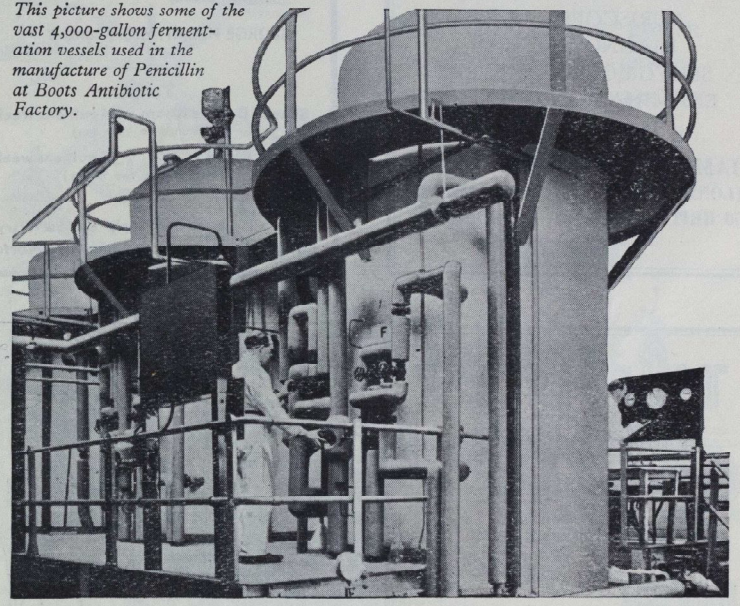

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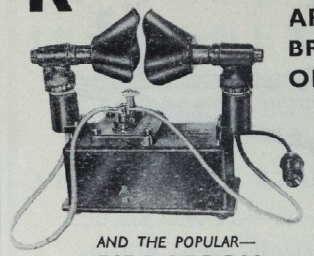

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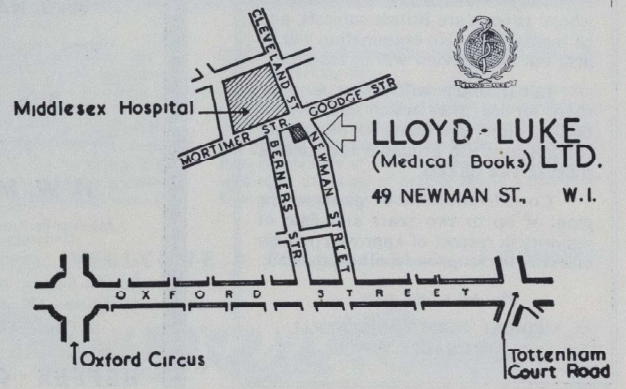

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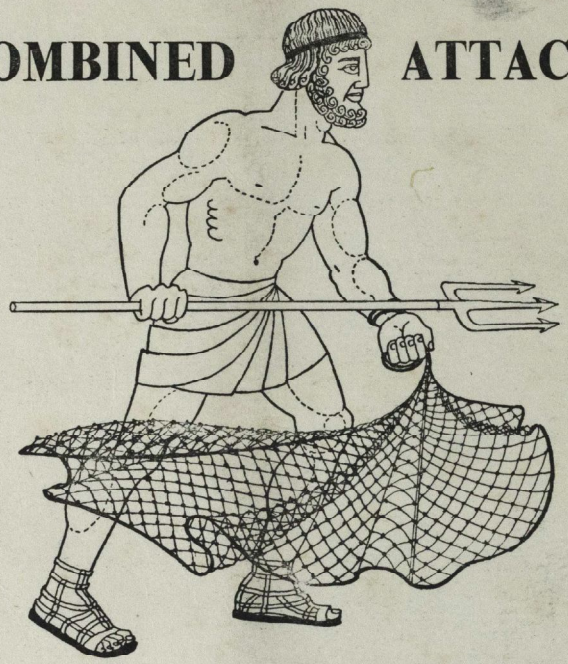

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