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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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No. 1

EDITORIAL

THERE is printed in this number of the Journal an account of the recent discussion on Medical Education that was arranged by the Abernethian Society. It was the most stimulating evening in that society's recent history, and its success was greatly assisted by the presence of several members of the teaching staff, including the Professor of Surgery, the Professor of Medicine, and the Dean. They all showed great tact and courtesy in not daunting the expression of undergraduate opinions. It is astonishing how many sensible things were said during the course of that one evening.

And now what will happen? Who is going to do anything about it all? Does anything ever change in this Medical College? Some things certainly have changed. Women have been allowed in, and there is a hostel. When plotting revolution, we should remember that there has already been a fair-sized rising. We talk about the need for less didactic teaching, for a broader education, for a better college spirit. Things change, but at what rate do they change? The answer is not in metaphysical speculation, but in the library.

For, in the early numbers of this Journal, there are to be found not only formal accounts of formal lectures, learned articles on learned subjects, frivolity, examination lists, bawdy poems and obituaries, but also an undercurrent of editorials, unsigned paragraphs, and anonymous letters. It is these that seem to give a picture of what the staff and students of those times were thinking. Here you find the sort of talk that you would find today at coffee time or sitting beside the fountain, the kind of thing that is said after dinner in the hostel.

The third volume of the Journal covers the year October, 1895, to September, 1896. At the summer prize-giving Sir James Paget

spoke of "the vast improvements which during the past few years had been brought about in the School and Hospital." The Warden, at the same function, told his audience that "the position of the Medical School as the leading Metropolitan School of Medicine is still maintained." That is what the staff in those days were saying. The things the students were saying about the staff is suggested by a satire in which the members of the football club go in deputation to a high official of St. Barnabas' Hospital, asking if they may have a real ball instead of a bundle of rags. The high official replies: "I certainly think your request is most reasonable and fair . . . but we old Tories move very slowly, so you must excuse me if I say that this season you must go on as you are." There was a fairly modern feeling that gods have feet of clay, as this poem shows:—

"You practice self-possession
And you mustn't turn a hair
When your cases all go badly
But just publish them as 'rare'."

The satire on the high official was prompted by opposition that had been expressed against women members joining the Dramatic Society. There were, of course, no women students, but someone suggested that the female parts in the plays might be played by friends, if properly chaperoned. In a letter signed Dowager Duchess, students were advised to "keep closely to the old modest and unpretentious lines of the Christmas Entertainment with students in the ladies' parts, and should a dramatic performance be given with ladies, let it be entirely disconnected from the hospital, and entirely outside its precincts."

The rugger club was not all that it should have been. Someone signing himself Rugger, wrote to say: "It is now, I think,

the third year in succession in which I have heard the prophetic student holding forth in the square on our extreme likelihood of annexing the Cup. I fear the prophetic student has conceived the idea of sliding into success as easily as an oyster into the maw of an Alderman. . . .” People were calling for a better College spirit. Quidam Medicus answered Neo-Pessimist in an angry letter headed “Esprit de Corps.” He wrote: “I entirely differ from his insinuations of the usual laziness of Cambridge men. . . . Why have I esprit de corps? Because I am a ‘gentleman,’ or try to be. . . .” One of the troubles was the presence of cliques. “I mean the formation into sets, which try as far as possible to be exclusive, of a number of men of similar tastes and habits. For instance, here are some: The various athletic cliques, the Varsity clique, the pious clique, the sporting clique, and the clique of excessive imbecility.”

People stressed the need for a broad education, for education to teach a way of thinking. An editorial put it: “We cannot too strongly impress upon our freshmen the extreme importance of the double aim of their training—to make them *men* as well as medical men.” Someone suggested that once a year a general practitioner should be invited to lecture in the hospital. His subject was

to be the problems of medical ethics met with in Practice.

A cartoon shows the dress then favoured by undergraduates. A double-breasted fancy waist-coat and drain-pipe trousers were fashionable flauntings. Lincoln Cranborn, in one of his dialogues, has a character who says: “The intense style, I regret, is becoming prevalent; I mean, long hair, a vacant look, and gold eye-glasses; it denotes a craving for distinction that is most unhealthy in the young mind.” There was another matter that students discussed, the dowdiness of the black and white of the College colours, “which are not colours at all.”

And there was even a feeling of the sameness of things. Someone writes describing View Day: “Much as usual, too, was the procession of Governors marching in solemn state from ward to ward, headed by the Treasurer and Matron; the same questions asked, the same answers given, and alas! the same old chestnuts that Adam cracked before women took to bloomers.”

In the year 2000 the students will still deplore the College colours, and laugh at the more pompous forms of dress. But will they have a tutorial system, or an education that is more liberal and broader than ours? What will be the rate of change?

* * * *

Bartholomew Fair

From the Hospital Journal, August 29, 1699.

“This Court being informed that during Bartholomew Fair time severall Hazard Tables, marble boards and other inventions for gaming are used within the great Cloister of this Hospitall, And that many persons do play att the Same att very unseasonable hours in the night time, And thereby occasion great disorders, disturbances and Ryotts, for prevention whereof It is thought fitt and ordered that the Porter to this Hospitall doth give notice to all persons that keepe hazard Tables, Marble boards and other gaming within the said Cloister of this Hospitall not to permitt and suffer any persons to play after twelve a Clock att night. And it is likewise ordered that the Porter doth cause the Cloister dores to be lock’t up att that time and this order duly observed.”

Out of the In-tray

Every so-often (or not-so-often) someone tidies the Journal desk. Disturbing the strata of succeeding years, one came upon a strange sealed envelope which was inscribed, “To some future editor, for publication if he dares.” It was sealed up again.

There was also unearthed a mass of material sent to the Journal by advertisers, quacks, and propagandists, who have at one time or another esteemed us, approached us or implored us to consider. There is so much fervour, so much with which one sympathises, so little with which one agrees.

Not only was there discovered a Moral Welfare pamphlet on the problem of the Unmarried Mother, but also an article by a past editor of this journal on “How to get a girlfriend in Cambridge, or Where there’s a will there’s a woe.”

Case Books

In the corner of the library by the Journal desk, there is a locked cupboard that has on its door a brass plate. On that plate the following words are inscribed:

“Case books and medical letters from the Practice of James Kingston Barton, M.R.C.P. Lond. who was a Perpetual Student of the Medical College of St Bartholomew’s Hospital, from Oct 1 1870 to Nov 4 1941.”

And in that cupboard there is fascinating reading for some future medical or social historian. Dr. Barton was a good and successful general practitioner, and all his life, year after year, he carefully entered in these bound volumes the case histories of his patients. He was interested not only in the illnesses of his patients, but in their lives and careers, their successes and their failures. So he read the daily papers, and the journals of fashion, and when ever he found anything that had been written about one of his patients, he stuck the cutting into his case book. It is these cuttings that make the books as strangely interesting, and as poignantly sad as the Forsyte Saga.

And, strangely enough, John Galsworthy was one of Dr. Barton’s patients. There, glued into one of the volumes, are letters with Galsworthy’s signature, and cuttings that review the first nights of his plays. Dr. Barton also knew Shaw, and there is an entry, “Aug 9 1884. Shaw, Bernard, Esq., Wt 9 st. 10½ lb., Ht 5 ft. 11½ ins.”

One turns over the pages of a vanished society. The richest woman in England dies, there is an early polygraph tracing, a photo of three children in the Rotten Row, an account of a private Polo tournament, a lung X-ray. Furniture is sold at Christie’s and a portrait given to the National Gallery; there is an ECG, and adhering to it is a cutting from the Court Circular.

Journal Appointments

R. E. Nottidge has resigned from the post of Editor, and Griffith Edwards has been appointed in his place. R. J. Knight has resigned from the position of Business Manager, and in his place David Fairburn has been appointed.

Dr. Geoffrey Bourne continues to serve as Chairman of the Publications Committee. Successive editors have had good cause to be grateful for his advice and experience, and to thank him for the kindness and patience with which he shapes discussion.

The Best Show in Town

The clinical lecture theatre (familiar to Bart.’s men of older vintages as ‘the Rooms’) sheds something of its gloom, one Wednesday in the month, when it becomes the scene of an almost gladiatorial show—a Clinical Pathological Conference. The bleak strip-lighted benches overflow. Registrars are seen happily standing or sitting on the steps. In the front row the lions of medicine and surgery at Bart.’s wait eagerly to try conclusions with each other and with the principal performer, who at the start can be seen sitting slightly apart and just a little less eager than the rest.

From when the fun begins to the hushed moment when, with an air of coolly mysterious but mischievous superiority, the pathologist reduces chaos to order and presents the post mortem findings, the periodic cheering and laughter would hardly suggest a clinical meeting. The reputation that once belonged to Consultations of being ‘the best show in town’ has been inherited by these Conferences. Nothing else, certainly not Chislehurst, so regularly draws so many Bart.’s men. It would be hard in fact to find anything else that so combines excitement, suspense and instruction or so encourages a cheerful *esprit de corps* throughout the Medical College.

Only one thing is lacking, an apt and agreeable name. Earlier this year this column suggested that the name of ‘Consultations’ might be passed on directly to the new Conferences. But at least if we must keep the present cumbersome title, isn’t Clinical Pathological Conference a more musical and reasonable form? Soon, one fears, we may be known as the St. Bartholomew-Hospito-Medical College.

Congratulations

to Dr. and Mrs. G. D. Kersley, on the birth of a daughter, Dian Alison Durant, on 7 December, 1953, at Bath.

* * * *

The Journal wishes all its readers a

Happy New Year.

* * * *

MEDICAL EDUCATION

AN ABERNETHIAN SOCIETY DISCUSSION

On the evening of Tuesday, November 24, 1953, the Abernethian Society held a discussion on Medical Education. The meeting was in the Recreation Room of the College Hall, and this room was full. Sitting on the stage was the Chairman (Professor Christie), and the three opening speakers, who were Mr. Robertson (first assistant on the Surgical Unit), R. E. Nottidge (a past editor of this journal), and Duncan Thomas (a past senior secretary of the Students' Union). There were soft lights and a blue ceiling, and through the door loomed the bar. Indeed, later in the evening, when there was an interval, we were to see the interpretation that a medical student gives to five minutes when he has a glass of beer in his hand. The answer is Multiply by Four. There were no dull moments or long pauses in the discussion, which was at all times lively, but at the same time tolerant.

Mr. D. J. Robertson said that in selecting students it was difficult to recognise the right sort of man from among a bunch of sixteen- or seventeen-year-olds whose heads were full of that triad—physics, chemistry, and biology, and who consequently had a poor general education. It would be a good thing if students did not do these pre-medical subjects at school. The most important quality to look for when selecting a student was an undeniable sense of vocation.

The curriculum should be designed with the fact in mind that most medical students became G.P.s. More and more had to be learnt; the introduction of the pre-registration year was a tacit admission of the need for more time. The clinical period was better devoted to the development of an enquiring mind than to an exhaustive study of minutiae. More active steps should be taken to correlate the basic sciences with clinical medicine.

There were two methods of clinical teaching: the didactic approach, which produced well informed students greatly lacking in practical experience and, secondly, the method of teaching based on the principle of apprenticeship. The second method, of

which the Bart's style was a variant, demanded much more of the student, but for the better student this was the better method. Yet Mr. Robertson thought that the present system of teaching in Bart's could be improved if there was more supervised teaching in the form of small groups where papers were read and discussed. Lectures should not be a mere regurgitation of the contents of the standard textbooks, and preferably should be given by members of the staff with an aptitude for this method of teaching.

Finally, the speaker reminded the meeting of the methods of examination employed in the finals of the Faculty of Medicine in London University. There, examinations are always of an external variety, a student invariably meeting an examiner from another school. This system effectively prevented any one school making radical changes in its teaching programme.

Mr. Nottidge said that the great deficiency in medical education was a controlling idea. The law demanded that medical schools should turn out efficient G.P.s. While everyone recognised that this was now an impossible ideal, they had so far failed to agree on an alternative and attainable aim.

Since, in the twentieth century, medicine was no longer concerned merely with disease but with the well-being of the whole man, the student's years should take him beyond the study of disorder alone, to the study of man and his environment as a whole. The aim of the total understanding of human kind should underlie all medical education.

Mr. Nottidge suggested three directions in which the present system might change. Firstly, the curriculum should be made more plastic. Nothing had been more dynamic than medicine in recent years. The medical curriculum on the other hand, had become overloaded because of its rigidity.

Secondly, the course should be better coordinated to one end. The division of clinical from preclinical was harmful as it tended to remove students from the atmosphere of scientific discipline just when they most

needed to rely on it. The division of anatomy from physiology, and of medicine from surgery, if they were not harmful, were certainly wasteful and time-consuming.

Lastly, medical education should become more general. For so many of the most important qualities that doctors needed—those of personal character and social skill—were only developed by a course which besides being a first class technical training, was also a good education. Students should be prevented from studying at school specifically for the second M.B., and at medical school their education should be made a university and not a technical college one. Contact was needed between student and student, and between student and staff, on the broadest possible social basis.

Mr. Duncan Thomas said that it was certainly asking a lot that a student should be "cultured, broadly educated in the humanities, intelligent and intellectual, of transparent integrity, humane and sympathetic," which was how Sir Lionel Whitby had recently described the ideal medical student. He felt that reality was a long way from all these most admirable sentiments. All medical students should be encouraged to avoid specialisation whilst still at school.

The pre-clinical subjects badly needed overhauling, with a view to integrating the courses far more. Students should be taught human biology in its widest sense, and form and function should be taught and regarded as one integrated whole, with man as the focus of attention.

The complete absence of a tutorial system was a major fault in the clinical training at Bart's. He thought that with the large number of registrars and research assistants in the hospital, a tutorial system could quite easily be instituted. There was also a definite lack of encouragement for students to develop their critical faculties: there was too much dogmatic teaching. Too little was expected of students—if the chiefs demanded more of their clerks and dressers, more would be given.

Our training in social and preventive medicine could only be described as scanty; neither did he feel that psychological medicine received an emphasis commensurate with its importance. The new scheme at Bart's whereby students could, if they wished, spend a period of time with a G.P., was to be warmly welcomed. It seemed only reasonable that the G.P.'s should have some

say in the training of the future recruit to their ranks. He thought it would be an excellent thing if the hospital were to run its own model practice.

He concluded by saying that he hoped Bart's would be ready to adopt the ideas and concepts of value that were evolving out of the present-day reviews of medical education. Our already good training could undoubtedly be made an even better one.

Professor Christie, the Chairman, before throwing the discussion open to the floor, summed up what the three main speakers had said. He also gave an account of a scheme for pre-clinical training that had been worked out by the medical schools, but which had been dropped after opposition from the Headmasters' Conference and the University Grants Committee. This scheme had proposed the integration of chemistry, physics, and biology with anatomy and physiology, so that work done at school would no longer give exemption from the first M.B. course.

The Chairman then invited speeches from members of the audience.

Mr. Black said that if a man did his National Service before starting his studies, he was very old by the time he qualified. Yet it was best to get the Army over with before beginning Medicine. No science should be taught us until we left school. The speaker wished that he had been taught classics at school. There was plenty of time for physics and chemistry later on.

Mr. Doherty said it was inhuman that a boy who came here keen on Medicine should for three years be kept right out of the hospital, with his teachers deploring any mention of the clinical applications of pre-clinical science. Perhaps it would be possible for the nursing that is at present being done by students during the introductory course, to be done during their pre-clinical years.

Mr. Struthers talked of the danger of being unscientific, of forgetting one's scientific training when one reached the wards. The lecturing technique here was in some cases imperfect. Lecturers, to say the least of it, should brush up their elementary technique, and not stand in such positions as to obscure the blackboard. The teachers should be taught how to teach.

Professor Christie remarked that during the war, when there was a shortage of teachers, the experiment had been tried at

Hill End of students teaching each other, even conducting one ward-round a week. The scheme had worked well.

Mr. Millard said that our medical education here was extremely good. He regretted the tendency that some people had to denounce it as "archaic." It was the envy of other schools. Evidence of its merit was that it worked. When people said that they wanted the education given here to be broader, what exactly did they mean? The people who advocated breadth should be less vague. All the lectures in London University were open to us, and it was up to us to go to them if we wanted to.

Mr. Harris said that we should not content ourselves with the study of disease, but we should study men and their environment. Heaven knows, the speaker said, we have got enough lectures as it is, but the G.P. scheme should certainly be enlarged. What lies ahead of a man when he qualifies is a large question mark. A man naturally tries to stick to a hospital, because he knows what hospital Medicine is like. General practice is strange and unknown and therefore the student hesitates to enter it. If we could have the chance of experiencing the sort of life that a general practitioner leads, then we would no longer have the feeling that what lies beyond the hospital can go hang itself, and there would not be so many people struggling for hospital jobs.

Mr. Barnes disagreed with the previous speaker. He did not want to study men and their environment. He had come here to study medicine, not to learn the facts of life. Was it not inconsistent to advocate the separation of school teaching and preclinical teaching, and at the same time to ask for the fusion of clinical and preclinical teaching? Let people broaden their minds while they study dogfish. Experience in the Radcliffe Infirmary showed that not every one benefited by clinical tutorials. Holidays should be longer.

Mr. Scott Browne said that there were too many students for one chief. Consequently an apprenticeship system would be difficult to work. The chiefs encouraged the students in little except work. Where were they on Regatta days? There was much talk about general education, but there was not much encouragement for it.

Mr. Dawson agreed with the previous speaker. Broad teaching could be killed by hurrying. To expect a busy chief to run a firm and look after his own practice and at the same time find sufficient time for teaching was perhaps expecting too much. Inevitably, teaching was left to the second strings. He felt that the teaching staff had not always got the latest papers at their finger tips. More journals should be taken in the library.

Professor Christie then asked if any members of the teaching staff would like to speak. After some suspense, there arose the Dean, who came forward and stood on the platform.

The Dean (Mr. Tuckwell) said that no one had got down to the fundamental trouble, which was that all students were different. We had all sorts of types in the Medical College. It was impossible to find a curriculum that would suit all the different sorts of people who came to Bart's to receive their medical education. Students should receive a general education up to the age of sixteen or seventeen, and should be able to matriculate on the General Certificate. There should be two years of preclinical study. A lot has been said about tutorials and lectures. It was practically impossible to *teach* clinical Medicine. It had to be *learnt*. People should not spend so much time worrying over papers that they could not get hold of. The proper place to read a patient up was in the museum. There was no need to read right through a textbook. Rather, when a student saw a case, that was the time to go and read it up. People did not spend enough time looking at patients in wards other than their own. After 6 p.m. was the time to have a look round the wards. Finally, the Dean said that University exams should not be internal exams.

Dr. John Hunt, Honorary Secretary of the College of General Practitioners, said that in fifteen out of the twenty-eight British medical schools, arrangements were made for students to see something of G.P. practice. The doctors, as well as the students, learnt from these schemes. If a student was introduced into a patient's house as an "apprentice," he was not regarded as an intruder. A week of that sort of training not only made better G.P.s of students, but it could make them into better specialists or consultants.

Mr. Malpas was of the opinion that it was better for a student to do his military training after qualifying.

Mr. Dawrant advised against doing service in the R.A.M.C. It was better to get right away from Medicine, and to spend the time in the Gunners, or in the Signals. The clinical course should be lengthened. For many centuries the student had been a wanderer, and this was a good tradition. The student should travel. In Heidelberg, if a student felt attracted to the teaching of some other professor, he just packed his bags and went away for a year. The midwifery appointment could very usefully be done abroad. Mr. Dawrant had written to Copenhagen, and the University there was keen to make arrangements for English students to go over. Perhaps Bart's could offer a scholarship to Duke University, North Carolina. Students from Duke came over to Bart's for paediatrics, and the arrangement could perhaps be made reciprocal.

Miss Womersley said that more use should be made of cine and sound recording in teaching.

Mr. Pearce suggested that pathology should be studied at an earlier stage in the course.

Mr. Backhouse said that students were not worked hard enough. His first clinical appointment had been as dresser on the Surgical Unit, and those had been the three months of hardest work in his life. Since then it had been a steady decline and fall. Except for one or two spasms during midwifery, the pace expected of him had grown slacker and slacker. Students should do some of the pathological investigations on their own patients. Chiefs should expect much more of their pupils.

Dr. Duff considered that in Bart's the relation between the student and teacher had reached a happy mean. In America the student slapped the chief on the back and said "Well Doc, what's new?" In the Scottish Universities, the teacher tended to be a tin god. The student should be given a chance to do simple research with a G.P. Good G.P.s living near a hospital should be appointed as extramural clinical tutors.

Professor Sir James Paterson Ross said that the problem should be looked at from the student's point of view. The teaching was good, but not good enough. It was a mistake for a chief to try to cover the whole subject. Proper discrimination and selection was needed in teaching. The course, if that was done, could perhaps be shortened. Pathology

should be taught as a preclinical subject. He believed that this could be done, and there would still be time for people to play games. He had been impressed by the way in which students in the U.S.A. worked up their cases and presented them, this forming the basis for a seminar or discussion. The time to go abroad was probably after the first house job, by when the student would have better judgment of what he saw. Sir James was not sure that a week spent with a G.P. during clinical training was useful. The student was best taught in hospital, where he was shown gross disease. In general practice he would see mostly patients who were near normal, and from these it would be difficult to learn. There was not time during the clinical course for much G.P. or psychiatric teaching. The level of the evening's discussion was an encouragement to those who were responsible for the selection of entrants to the Medical College.

Mr. Viner suggested that a library should be kept open for those who wanted to read books and journals after dinner.

The Dean said that in favour of doing military service after qualification was the army's shortage of doctors. When a student applied for a place in the hospital, and he seemed young for his age, the army was sometimes a good place for him to grow up in.

Mr. Hewer said that we should all be proud of being Bart's men. If people wanted to spend a week with a general practitioner, they could do it during the holidays. The danger of a bad tutor was a disadvantage to the tutorial system.

Professor Christie then summed up. The sense of the meeting was:—

1. Against specialisation in school.
2. That teaching must be integrated.
3. That the tutorial system should be introduced.
4. That teaching should not be dogmatic.
5. That, with the word of caution from Professor Ross, there should be G.P. teaching.
6. That most agreed that the length of the course could be shortened.
7. Generally in favour of service in the Forces after leaving school, rather than in the R.A.M.C.

and, finally, in the words of Sir James Paterson Ross "the teaching is good, but not good enough."

CLINIC. BENNETSVILLE, SOUTH CAROLINA

1948

by NELL COMMAGER

YES'M, thas him, over yonder under them Carnation Milk babies. . . . He named James Parker. . . I don't know how old. He started rentin' from you twenty-three years ago. . . . Well'm, he too old to *do* much. He done tuk care of all them babies since about three years ago, though'm. . . . Well'm, we had to leave 'em with somebody, times we was in the fields. 'Sides, he plumb magicked them children—when he there, they won' look at nobody else. Fightin' and carryin' on over whose turn it be to git up in his lap; them filthy babies—they enjies him to spit. One of them take his spit-can off a ways and, less he coughin', that Jim hit he it ever' time. This year he done los' the sleight, some way or ruther. . . . Which children? Well'm, my five, and Alec's baby since his growed daughter went North to College, and that no-count Ellie's c'lection, and some that jest comes and goes. My grown Jason, he always there somewhere, kinda souperinvisin'. We puts Jim's chair out in the sun, up there by the chicken coob, and them babies play in the dust round his feet. He set there rockin' and rubbin' his head against the wire. He *enjied* to do it, Miz Furman: they wasn't no harm was it? . . . Naow, Miz Furman, you so kind and all, and you *knows* I wants to do what you tells me. I brang that Jim today, 'cause you heard about him, and he lookin' so pohly and downheart, but I got my work, ma'am. Them babies is just as healthy as I ain't. They just as healthy as them Carnation Milk babies. And that Doctor Hood, he come all the way from Starr, North Carolina, ain't no use botherin' him with all them healthy babies. . . . Oh, *Yes'm*, ef you can see yo' way to come git 'em, you welcome to 'em. Next week? Mine'll be ready. I can't make no vouch for that Ellie. Can I leave Jim settin' there? You all aren't figurin' to hurt him none are you? He a good kind of man.

* * *

I declare I don' see why they painted up this room and filled it with comfortable chairs

and things, and then up and invited the niggers in to smell the place up. They come slouchin' in and smile charmin' at Miz Furman, just like they hadn' burnt their steps for firewood last winter, pertending like they pay their rent reg'lar, like white folks. They got their own movin' picture show, and their own school, 'pears like they ought to be allowed *not* to have something, for once. Gittin' free treatment, ain't they; don't hurt 'em to wait on the sidewalk—they used to cotton sun.

No, Lousie, I think you wrong, there. I ain't so all against niggers now, as I was. Times are changin' some, and you *got* to change with the times; you know that. I got nigger neighbors, you know, and they right decent people. Their children talk nice and wear tweed suits and aren't any worse than ours underneath. Then on my other side I have that Ruby woman. She's white as milk, and what good do it do us? The other day, Miz Furman's sister had a brand new toilet put it on Ruby's place, so first thing that Ruby done was to hold a party and all them wild folks celebrate by flushin' all the rags and things they could git a-hold of, and that toilet's bust for good now. And some low-down man razoored from elbow to wrist into the bargain. Those kind of people is generally wrong about everything, you know, and they the only ones hatin' niggers jest 'cause they're black, now, I reckon. They're the ones with hurt feelin's, like about this waitin' room. They children *got* to play with niggers or nobody, so they whups 'em and cheats 'em instead. Our men got the kind of jobs that cheap nigger labor can't touch, so we ought to quit hatin'. All the white folks round here don't smell all *that* sweet, with all their white tubs and swimmin' pool. 'Sides, the niggers all keeps to themselves, like they is now, all sittin' under that poster of Carnation Milk black babies. Nobody has to have signs saying right out "colored" or "white"; it ain't either necessary or decent, when you come to think about it.

Well. But, Amy, look there at Miz Furman. She used to be such a lady, all those sisters. That lovely big house, and the parties under the trees, and buggies, and all ten children to college. And the Charleston cotillions, and God knows what all else. They had such white hands and tiny feet. But look at her now; tough lookin' and all hot. She talks so loud and bossy, and laughs with just anybody. Still, I told her I'd come round. That time Davy hurt his back she didn't even mention rent money for two months. Be back 'tereckly.

* * *

I certainly should have come and helped Aunt Nell more often while I was down here. It's so unlike anything in New York. I'll have plenty to write about for English, but that Mrs. Paine will say I'm embroidering again. All these people, *all* of them, come to the clinic as some kind of personal favour to Aunt Nell. It's ridiculous; they don't seem to know enough to care about whether they have spots on their lungs. She must know everybody in the county, I guess. Most everybody scorns everybody else, and it really was funny when the chain-gang showed up, to watch everybody in the waiting-room taking mutual pleasure in scorning the Criminals. I had never seen the chain-gang so close before. Mother says when they were all little, on Sundays they'd go for rides in the Surrey, and at crossroads they'd see wagons with the chain-gang in *cages* in the back. They've got laws even about the chains now, though. Anyway, the 'chingang' came in the door and helped me fill out cards for them, with such paternal interest. They were mostly colored, but all seemed to like each other fine. I guess they think they'd better get along with each other, since they've got about as low as anybody can. All those Russian novels about outcasts of society really couldn't have come from a warm climate—ridiculous to try and imagine them with tan dust and red clay and tall trees. After that, they sort of filed around into the back yard, and waited quietly until Dr. Hood was ready to fluoroscope them. Not at all terrifying. They had to come. Because their cook was taken to a TB sanatorium last week. They were really just like children on an outing, anyway until they got near the dark-room. One of the men who went in first, came out and announced: 'You better wish you didn't have to go in there; that

doctor, he press a button, and out fly a green skeleton, and kiss you smack on the mouth!' I heard him and told Aunt Nell, because the others were really scared, and she laughed gaily and made them listen. Then she said I'd go in with them, and if a little Yankee girl wasn't scared of Doctor Hood, they'd look pretty silly if *they* were. Some of them went all brave and silent, and some laughed and joked, just like the kids at school when exams are being handed out. Anyway, the rest of us got in there in the dark, and pretty soon Aunt Nell said: 'Willy Jackson from Hamlet?' The big negro standing next to me bestirred himself and answered 'Yes'm?'

'Where'll you be next month, so we can find you?'

'I reckon I still be with 'er chin-gang, ma'am.'

'But I thought the chain-gang was only for petty offenses, I mean, little crimes, Willy?'

'Yes'm?'

'Well, Willy, what have they got you in for, for so long?'

'I knifed a man.'

What drama! I bet none of the kids at school ever had a murdered say 'Scuse me, Missy,' to them. I wish everybody'd hurry up and finish, now. It's after five already, and I have to dress for Janny's party. It's nice the doctor's named Hood; such a wonderful literary contrast between the Ku Klux Klan, and the things this Hood does—also reminds you of his leather gloves and apron, somehow. . . .

When everybody had left he let me try on the gloves; said they weigh ten pounds each. He has awful sores on his arms, where they don't reach. Overwork, he says. We had four cases of TB today, and I helped take the four patients next door to the hospital for permanent x-rays. Mine was an old, old coloured man who just *sagged* into the wheelchair we brought, and wheezed and moaned. I felt important wheeling him, at first, but his cough rattled so that it made me want to spit, too. He couldn't seem to see very well, and wasn't interested in anything. He didn't even notice when I almost tipped him out on the curb. Once he moved his finger into a sort of point at his spit-can, and said: 'Hit do shine.' The funny thing was, though, that we forgot to put the names on the permanent x-rays, but Doctor Hood read them off like most people recognise faces. He and Aunt Nell were awful cross. They sat down in her office and started talking about next week

already, and somebody's babies. I'll be back in school next week. There sure is a *lot* of talking down here, though. You can't rush anybody. Mother said that once Daddy came down for a visit, and Granny told him about some smart lawyer she thought he'd like to meet, and added that he was pretty no-count, even if he was brilliant. Daddy said why, and Granny said he'd rented from Miz Newton for *twenty* years without paying

any rent. Daddy said briskly, why didn't Mrs. Newton tell him to pay or live elsewhere. Granny said, gently and reprovingly, 'Oh, she hesitates . . .' And Aunt Nell never tells anybody, the way Daddy would, please come down and have your lungs checked free. She has to coax and charm people into caring about their lungs. Anyway, I almost went on back to the house without her. I was in a hurry.

PERTHE'S INCISION

When attacking gall stones tucked
In the biliary duct,
Surgeons used to cut and sew men
All the length of their abdomen,
And without compunction leave a
Scar from Dan to Beersheeba.
Once at such an operation
(Helped by slight inebriation)
Dr. Perthe with abandon
Changed the scheme that he had planned on,
Half way through his first incision
Stopped, and made a quick revision,
Suddenly conceived a wangle,
Turned the knife at a right angle,
Deftly dodged the larger gut,
Right across the rectus cut.
Raising this three-cornered flap,
Through the wide resulting gap,
Like a hunter on safari
Suddenly he spied his quarry—
View halloa! At last he had a
Close-up of that coy gall bladder!
Good old Perthe! Even if he
Owned he felt a trifle squiffy,
Out it came in half a jiffy!

Thus he made his master stroke,
Made it as a kind of joke,
Never dreamt his playful freak
Would become a new technique.
Never was there humour broader!
In the words of Harry Lauder:—
"Dinna make me laugh so hairy"
At the comic cuts of Perthe!

R. B. P.

NOTES ON SOME SURGICAL DRESSINGS

by J. R. ELLIOT

Pharmacist to the Hospital

WOUNDS have been treated by man since the earliest of times and much has been written concerning the methods used to heal them, but little progress was made in the preparation of dressings used by surgeons before the nineteenth century. Such naturally occurring materials as sponges, mosses, spiders' webs and feathers were used for centuries to serve as compresses beneath bandages, and to arrest bleeding. Raw cotton, however, was not popular with either surgeons or the general public as it had the bad reputation of carrying diseases.

The first material prepared particularly for use as a dressing was lint. Lanfranc, writing at the end of the fourteenth century, made frequent mention of the use of lint for the application of medicaments to wounds but he did not make any claim to be the originator of this material, although no earlier references to its use, or preparation, can be found. Moreover, he used the term lint to mean two distinct preparations, the first being the scrapings of old linen cloth in the form of a mass of short soft fluffy fibres; this type of lint persisted in England until patent, or sheet, lint took its place early in the last century. The second form was made by unravelling linen cloth into short threads, giving a preparation resembling the modern cotton waste used by engineers. This material was also called charpie and was more popular on the European continent, although it was still mentioned occasionally in English surgical works up to about 100 years ago. Abraham Rees, in 1819, mentions that lint in dossils (cylindrical pieces), or pledgets (oval-shaped pieces) could be plugged into wounds to keep the outer edges apart until healing had commenced in the deeper parts, and for this purpose it was recommended that they should be tied with thread to assist in their removal at a later time. These pieces were often coated with ointments or balsams to assist in the healing process. Dry lint was also packed into wounds to arrest haemorrhage and was used in compresses beneath bandages. It was also said to be "highly necessary" for keeping air away from wounds, and to protect them

from being knocked. In passing, it might be mentioned that, in the old days, an important non-surgical use for soft lint was as tinder in tinder-boxes.

It is not possible to date with certainty the appearance of lint as we know it, that is, a cloth which has had a nap raised on one side by scraping with a knife, but William Cade King, Esq., a Governor of this Hospital, submitted a sample of this "patent" lint to the House Committee in April, 1816, and it was resolved that the surgeons of the Hospital should be asked to report upon it.

Owing to the high price of hand-woven linen, it is unlikely that new cloth was specially linted much before 1800, the time when the cotton gin, and power-driven spinning machines and looms first began to be developed. Again, new hand-woven textiles were not soft enough to be used as dressings, thus from Lanfranc onwards it is often stated that the linen used upon wounds, or for making lint, should be prepared from old and partly worn cloth. The high cost of materials also made it necessary for dressings such as lint and bandages to be washed and used again. It is little wonder, therefore, that infection was rife in hospitals, and that a correspondent to the *Lancet*, in 1875, found it necessary to make the bold suggestion that the frightful effects of blood-poisoning ought not to be risked in order to save a hospital a few pounds a year by entrusting the purification of such infected bandages to a washer-woman. Even so, it was not until four years later that a direction was published in "Queen's Regulations and Admiralty Instructions" stating that, "should sloughing ulcer break out," all used dressings should be thrown overboard, but bandages were still to be steeped in boiling water and thoroughly washed.

Until dressings could be made on the manufacturing scale, cheaply and in sufficient quantity so that they could be classed as expendable, little real progress was made in surgery, and in this connection two names, Gamgee and Lister, stand out far beyond all others in this country.

Lister's first experiments in antiseptic surgery, reported in the *Lancet* in 1867, described the use of lint dipped in liquid carbolic acid, and even if such material was washed and used again, it must have been much less liable to carry infection than any other previously used dressing. Very soon after that time he prepared, or tested, a large number of medicated lints and gauzes, some of which were made just before use, while others were prepared beforehand. As soon as these medicated dressings were required in large amounts it became impossible for the old pieces to be salvaged and re-medicated as their production had passed into the hands of commercial manufacturers. The only medicated dressing introduced by Lister which remains with us today is boracic lint, the traditional pink colour of which is the direct descendant of the cochineal which he used to differentiate his boric lotion from the carbolic lotion. Incidentally, Lister did not allow boric lint to come into contact with wounds, but used it outside his waterproof protective to keep infection away from the antiseptic dressing used at operation.

Gamgee, at this time, was working along the line that wounds were best treated by dry and infrequent dressings, combined with rest and pressure. In order to obtain a comfortable distribution of pressure beneath his compressing bandages, Gamgee decided to use cotton wool, such as used by jewellers, but as this was not capable of absorbing fluids to any great extent, he covered it with a layer of picked oakum which had been submitted to a carding process. This latter substance was considered to be the best absorbent dressing of the period, and far superior to tow, which had been used since the fifteenth century: in fact, one manufacturer of a brand of carded oakum known as "Tenax," claimed that it was even superior to lint for this purpose.

It was not until 1879 that the *Lancet* recorded the manufacture of an absorbent cotton wool, made by removing all grease from raw cotton. Although the method used was not mentioned, it was probably one which involved treatment with alkali, followed by a bleach, before being carded into a flecce. It was thus not likely to be so highly contaminated as the raw cotton from which it was made. Gamgee was then able to demonstrate how well this new product would absorb discharges, even proving superior to oakum. His next move was to

envelope absorbent cotton in pieces of tiffany, an open-weave cloth used, at that time, by gardeners to shade their greenhouses from strong sunshine. At first, this experiment was not successful, because the tiffany had not been bleached, and was, therefore, not able to act as an absorbent layer. When an absorbent gauze was developed and used to surround absorbent cotton wool, a very popular and satisfactory dressing was obtained. This material was made by Messrs. Robinson and Son, of Chesterfield, who co-operated with Gamgee in its development, and it is still marketed by them under the name of "Gamgee Tissue."

Thus Sampson Gamgee was largely instrumental in having gauze treated so as to render it absorbent, although the use of loosely woven cloths as dressings was not an original suggestion. Similar materials, such as muslin and window curtaining, had been used for application in either single or multiple thicknesses, several years earlier, both here and on the European continent.

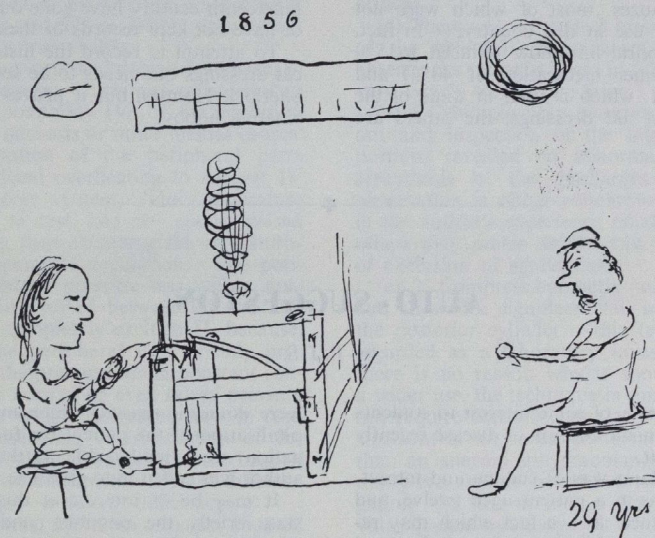
By this time, to meet the competition from cheap cotton dressings, lint makers were offering to hospitals lints containing more or less cotton fibres instead of the traditional material made wholly from the more expensive flax. Eventually lint made entirely from cotton became the standard article, although flax lint, made from pure linen, could still be purchased until the beginning of the present century. In the United States the use of cotton for the manufacture of dressings was encouraged, no doubt, by the cotton growers of that country. Similarly, we can imagine that, as there was no linting industry in the States, textiles such as gauze were more readily produced on their ordinary looms. It is possible that this may have been an important reason why American surgeons did not use lint, and surgical practice throughout the world has been greatly influenced by this fact.

The substance termed "marine lint" differed considerably from ordinary lint, and was simply tow impregnated with tar; it was said to be a cheap and useful antiseptic dressing.

The search for absorbent dressings in the 1880's led to the introduction of pine-sawdust in muslin bags, and dried compressed sphagnum moss which had been treated with an antiseptic. This latter substance is probably capable of absorbing and holding more liquid, weight for weight, than any other

dressing, and in this connection, it is interesting to note that in 1953 an attempt was made to revive the use of sphagnum moss, enclosed in gauze bags, for incontinent patients, but no commercial source could be located. By the end of the last century the use of tow as an absorbent wound dressing had almost ceased, but it was still required for padding splints. For this purpose it was

operate, it is rather to discover the causes of the pestilence and banish them as far as possible from this field of action. The desiderata to be secured are: pure air, healthy conditions and strict cleanliness generally." He concluded his lecture by asking: "Is it rash to affirm that the future practice of surgery will be most successful when it is carried on, not where antiseptics



Drawing by William Bradbury Robinson of himself, aged twenty-one, seated on a soap box inventing the Power Lint Machine. Hannah Salt is seated at a hand Lint Frame, and has a swollen ankle through working the treadle (as drawn, see black spot). The year of the drawing is 1856. (Published through the kindness of Mr. Victor Robinson and taken from the records of his family business. William Bradbury Robinson was his father.)

no longer necessary for the softest and finest tow to be bought, and tow made from jute, which was much cheaper than flax tow, was found to be quite acceptable.

In spite of the great advances made by the introduction of Lister's antiseptic methods, Mr. Savory, in an address to the British Medical Association in 1879 stated that at Bart's during 1876-8 there were only 18 deaths from blood-poisoning after 1,235 major operations. It was claimed that this low figure was attained because "the surgeon's duty, under ordinary circumstances, is not to find what are the most dangerous sanitary conditions under which he dare

are most largely used, but under conditions least in need of antiseptics?"

Thus we hear, from one of our former surgeons, one of the first pleas for asepsis, as opposed to antiseptics, even before many of the antiseptic dressings were devised. Seventeen years later, C. B. Lockwood, another of our surgeons, in "Aseptic Surgery," described Jamain's aseptic method of wound treatment in which all instruments and dressings were required to be sterilised by moist or dry heat. Lockwood, at that time, used a mixture of aseptic and antiseptic techniques, but as knowledge was

gained in the former methods, especially in the sterilisation of dressings by autoclaving, less and less use was made of those containing chemicals. Even so, the British Pharmaceutical Codex, 1923, described no less than 29 antiseptic cotton wools, tows, lints and gauzes. The rapid trend toward aseptic methods is shown when it is seen that these had been reduced, by 1949, to one antiseptic cotton wool, two antiseptic lints and five antiseptic gauzes, most of which were not required for use in this country. In fact, apart from boric lint (now reduced to 5% from its former medication of 40%) and euflavine lint, which is used in some of the standard first aid dressings, the others are

unlikely to retain their position when the new Codex is published this year.

It has only been possible in these notes to deal, in outline, with the history of a small number of the more important dressings, but there is much to be done in this field before the complete story can be told. In many cases the nature of the dressings employed was poorly described by the users, and many of the early dressings manufacturers of the nineteenth century have gone out of business or have not kept records of their methods.

To attempt to record the history of surgical dressings one needs to be something of a Sherlock Holmes, but it proves to be a fascinating hobby.

AUTO-SUGGESTION

by P. J. S.

A case-history of some interest to students of the mechanistic concept of disease recently came to light.

The complaint was of sudden and intractable weakness in a patient aged twelve, and of undetermined sex—a fact which may recall the recent exhibitions of prejudice and morality in the lay press—in this case the anatomical evidence was equivocal, but the pattern of behaviour, particularly in recent years, suggested a female tendency.

The onset of weakness was sudden, and occurred in the afternoon, in the course of fairly strenuous exertion. There were no premonitory symptoms, there was no history of trauma, and recent examination had not revealed any signs of organic disease. The weakness was marked, not progressive, unaccompanied by any pain, persistent, and was neither relieved by rest nor increased by exercise.

There was no evidence of disturbance in the other systems, with the possible exception of an increased thirst. There was no relevant previous history, and the patient was totally unable to suggest any explanation of the condition.

A preliminary examination had failed to reveal any other abnormality, and as there

were domestic reasons which made the hospitalisation of the patient for further investigation seem inadvisable at this stage, the author was called in to give a second opinion.

It may be of interest at this juncture to state briefly the possible conditions which came to mind.

I. A disturbance of metabolism due to:

- (a) a dietary deficiency;
- (b) a deficiency due to partial obstruction;
- (c) an unbalanced intake;
- (d) a respiratory deficiency or obstruction leading to partial anoxia;
- (e) an impairment of oxidation due to

- (1) blocking or failure of the discharge at the motor end-plate
- (2) inadequate concentration of substrata.

II. An impairment of circulation.

III. A disturbance of temperature regulation.

IV. Excessive energy loss in the form of heat.

V. The psychogenic factor.

Further speculation at this point would have been unprofitable, but it was considered justifiable to introduce this formidable list in illustration of the approach to diagnosis. The results of examination follow immediately.

The patient looked clean, well cared-for, and bright, and the general appearance was in no way inconsistent with the age. There was considerable overall pigmentation of a yellowish hue, with a few depigmented areas chiefly confined to the dorsum. On careful inspection no superficial lesion or external sign of injury was visible.

There was evident and demonstrable weakness of movement, which was considered to exclude the possibility (V) of the condition being due to neurosis or other mental causes. Careful palpation of the peripheral parts revealed no local overheating to suggest IV—loss of energy as heat. The temperature was normal at rest, and not unduly raised after exercise, thus excluding III—a disturbance of temperature regulation. The peripheral circulatory pressure was within normal limits, and varied between 20 and 50; this did not completely exclude II, because, of course, the peripheral flow is only proportional to the pressure under constant conditions and a normal or even raised pressure is compatible with a decreased flow in conditions of narrowing or obstruction of the peripheral tubules. Percussion at the base of the petrol tank elicited the normal dullness, excluding I (a)—a dietary deficiency.

Attention was, for these reasons, focused upon the remaining subdivisions of I in the differential diagnosis, and a process of systematic elimination continued.

(b) Radiography is not always essential to the diagnosis of obstruction, and in this case insufflation of the fuel canal from its proximal end produced the normal fluid sounds and thrill at the distal end. It should

perhaps be mentioned that post-cylindrical obstruction, a rare condition, was excluded by auscultation at the posterior ostium, where normal discrete sounds were heard.

(c) Unbalanced intake is usually either congenital or iatrogenic, and unless the history suggests recent interference, should only be a diagnosis of exclusion, when a therapeutic test may be performed by observing the effect of constriction and dilatation of the jet orifices.

(d) There was no evident gross obstruction of the external air passages, and in its absence the remarks made in (c) above apply very largely to this condition.

(e) 1. Multiple plug eversion was carried out and inspection of the intra-cylindrical portions revealed no abnormality and no arrhythmia of the discharges—the latter observation is not a conclusive one, but is in the author's experience reliable, although others may prefer oscilloscopy as a method of exclusion of agalvaniasis.

(e) 2. Compressionometry was performed and showed a significant fall in pressure in the posterior cylinder—this test is usually regarded as a laboratory investigation, but there is no reason why it should not gain a wider use, the technique is simple and does not require constant practice, whilst the instrument is no more cumbersome to carry than an aneroid sphygmomanometer; vacuumetry is a similar though less specific investigation—on this finding a diagnosis of valvular lesion was made.

Subsequent laparotomy confirmed this diagnosis, the lesion proving to be a fracture of the helical retro-valvular lumbricoid, which was replaced at the same operation, and this completely alleviated the weakness.

Like every tale this one has a moral, and like all the best tales this one leaves the reader to draw it for himself.

“SO TO SPEAK . . .”

4-D

You must see that marvellous Mexican film of Einstein's.—*Cultured voice.*

IN PRAISE OF . . . SKI-ING

by JOHN HOWKINS

It is a curious thought that the Alpine sport of ski-ing was originally made popular over fifty years ago by a nation whose annual snowfall averages a few inches of muddy slush except in the remote Cairngorms. For many years the giants of the golden age of British ski-ing such as Mackintosh and Bracken, under the able tutelage of Arnold Lunn, dominated the Alpine scene and, when I first visited Switzerland in 1919, the prosperity of the Winter Season depended largely upon the English invader who had established proprietary extra-territorial rights over the winter sports centres. Ski-ing has now become a great international pastime in which the central European has surpassed our erstwhile prowess by virtue of his easy and frequent access to the great Continental ski fields, but we can still enjoy the glories of the past and the pleasures of the present in an annual pilgrimage to the scene of our former triumphs. If, in the future, a sufficient number of English enjoy and support this thrilling pastime, we may again see a properly trained and adequately financed team of our young skiers in the forefront of the great ski-ing races. It is not unreasonable that one day a member of this team may be recruited from the recently rejuvenated Bart.'s Ski Club.

The fascination of a Swiss holiday starts in the cold fog and rain of a Victoria noon; the breast pocket bulging with the unaccustomed pressure of passport and foreign currency and the heart beating a little fast at the ominous weather report of the Channel passage. But the real thrill and the high spot of the journey is the entrainment in that most magic of all trains, the Orient Express, peopled by the ghosts of beautiful international spies and the babel of Continental tongues. Through the dusk of Northern France, the long night journey starts: aperitif, dinner, Paris, sleep, douane, passports, and then imperceptibly dawn—a Swiss dawn of unreal green light on the slowly brightening peaks until the full glory of the mountain scene is revealed beyond Lausanne. Outside is a fairyland of pine tree and chalet, mountain and snow, wood-smoke, coffee and cigar, and everything unbelievably neat and clean. Almost regretfully

the Orient is exchanged for one of those tiny mountain trains and the last breath-taking lap of the glorious journey begins. Up giddy gradients through gorge and tunnel, over waterfall and under great frozen icicles and into ever-deepening snow and brighter light the track twists always higher until suddenly before the travellers' eyes gleams the supreme splendour of his own delectable mountains. To gaze for the first time on these superb monsters is an unforgettable experience which the passage of the years can never dim and from the contemplation of which is derived a deep spiritual satisfaction.

Each one will have his own impressions on alighting from the mountain train—the dazzling light, the warmth of the sun, the mountain air, the crystalline purity and dryness of the snow, the bells on the sleigh horses, the brilliant colours of the skiers' costumes, the village street, the gay brown-faced people and the never-to-be-forgotten smell of the hotel floor polish. This is a precious moment to be carefully savoured against the dull, drear days to come.

The idea of coming to Switzerland was to ski and the bewildered novice will see gorgeous creatures of either sex performing the most hair-raising feats of speed and control on the slopes. He will be agog to emulate them and, though this takes time, a great deal of fun can be obtained in this painful process. At last, he is able to navigate the gentlest slope without digging a large grave by performing that safest of ski-ing turns, the sitzmark. A tremendous amount of exercise can be taken in a day's ski-ing. A good runner can easily descend an aggregate of 20,000 feet by synchronising his arrival at the bottom with the departure of the next funicular to the top. But the exercise taken by these aces is nothing to the antics of the beginner who will be far stiffer after his first day than he was after his first equestrian excursion. This energetic sport can best and most safely be enjoyed by the young athlete of either sex whose bones are tough and muscles strong. Any intending participants will be wise to undergo a period of training for those muscles which are especially needed for ski-ing, such as the anterior

tibials, peronei and quadriceps. Under the expert guidance of an instructor, it is amazing in how short a time the clumsy beginner, completely out of control, begins to enjoy the easier local runs and he will then know that most lovely experience of having lunch in the high Alps under the blazing sun as he contentedly munches the enormous selection of foods that the hotel provides. His eyes can feast on a magnificent panorama of peaks most of which are over 4,000 metres. London, Bart.'s, patients, exams., the dour struggle for existence, international problems and his own personal worries are so far away as to belong to another world. He puts on his skis and, with increasing confidence, control and speed, to the soft hiss of his blades on the crystalline snow or the more noisy patter that they make on the piste, he eventually reaches the bottom breathless, glowing, triumphant, hungry and thirsty. The evening is pleasantly passed,

drinking, dancing, singing, sleeping, or recounting in great detail the thrill of that last breath-taking schuss through the glade, where, with the speed and accuracy of an arrow, the Alpine hero projected himself into space over unsurmountable hazards, turned with complete nonchalance and perfect control round a fallen companion and so ended the perfect run of a perfect day—no fall, of course. A modest estimate of his speed will fall somewhere between the maximum of his chief's car and last year's record for the Gornergrat Derby.

And so each day passes always better than the one before until at last fit, tired, bruised but triumphant, he sits once more in the Orient, but going the wrong way. The party of skiers has become strangely silent but their minds are busy with a simple sum—how many weeks till next year and how to raise the wind for the next trip.

A MOZART CONCERT

United Hospitals Festival Choir
Philharmonia Orchestra

A concert will be given on Wednesday, January 20, 1954, at 7.30 p.m., in the Royal Albert Hall.

The programme will be as follows:—

Overture: The Marriage of Figaro.

Horn Concerto, No. 4 (K495). *Soloist*: Dennis Brain.

Symphony No. 40, in G minor (K550).

Requiem Mass, with *guest soloists*.

Conductor: COLIN RATCLIFFE.

Tickets—2s, 6d. to 10s., from the Royal Albert Hall (KEN 8212).

LETTERS TO THE EDITOR

RALPH CROWLEY

The Editor,
St. Bartholomew's Hospital Journal.

Dear Sir,

The late Ralph Crowley was an outstanding man in wisdom, character and learning.

He applied for the post of House Physician after qualifying, but his name could not be put forward because of his religious principles. He did a couple of house appointments and applied a second time and again could not be considered.

He took another appointment and gained his M.D. degree and thus armed was accepted by Sir Dyce Duckworth, who later boasted of his good fortune.

Crowley's cousin, Egbert Morland, also a Friend, who became the editor of "The Lancet," followed him and the writer, a third Free Churchman, became his Junior House Physician.

Clerking under Ralph Crowley was an education in far more than medicine. His attitude to the Nursing Staff was delightful, the patients in Matthew and John Wards adored him and welcomed his cheerful smile. We, his clerks, were enthused by his personality, individual interest and the infinite patience he had in training our observation.

His services to the City of Bradford and his national service under Newman are matters of common knowledge, but his breaking of the barrier which prevented full entrance into the profession was his first great accomplishment.

His enthusiasm and example have remained an inspiration to me through over half a century of General Practice.

Yours sincerely,

PENRY ROWLAND.

Wellesley House,
Colchester.

MEDICAL EDUCATION

The Editor,
St. Bartholomew's Hospital Journal.

Sir,

I was an interested member of the audience at the discussion on medical education held in College Hall last Tuesday, and I offer my congratulations to the Abernethian Society and all those who helped to organise this excellent meeting. It was refreshing to see so much enthusiasm and to hear

the very stimulating discussion which took place. Practically all those who have talked to me about this meeting have commented on the high standard of the contributions made by the set speakers and the members of the audience.

During the course of the meeting I felt an urge to take part, but decided to wait for a lull in the proceedings. No lull came, and my piece remained unsaid. However, I hope you will permit me to make a few comments on topics which were discussed, and on one not discussed or even referred to, at the meeting in College Hall.

Changes in the curriculum and general teaching. Many interesting suggestions were made but, as pointed out by Professor Christie and the Dean, our college and the university have already considered many of the points raised. In some cases it has been found that there is no general demand for the special facilities requested. There are several changes which many of us would like to make in the pre-clinical curriculum, to ensure better integration of the course, but these changes could not be made, either for financial reasons or because they could not be fitted into the general framework of the courses in the London M.B. examinations. Wherever possible, however, the relevant syllabuses are being made as flexible as possible to allow considerable latitude to the various medical colleges.

Interchange of clinical students. Most of us who have been abroad to study and do research hold the opinion that an individual usually derives the maximum benefit from such experience if he has completed his graduate course and has had at least two years' post-graduate experience in his home country before going abroad.

Apathy. In my view one of the most difficult problems which faces us in relation to the education of our medical students is the apathy which exists amongst many of the present generation with regard to activities which are not directly related to examination subjects.

I believe that this session there has been a slight but significant increase in enthusiasm for games, etc., and I think that I can safely add that this improvement will bring as much pleasure to the teaching staff as to the students of our college. With the interests of the Students' Union in my mind, I suggest that the present might be an opportune time for the Students' Union Council to consider ways and means for fostering and encouraging this developing interest and enthusiasm.

Yours faithfully,

A. WORMALL.

Dept. of Biochemistry and Chemistry.

SPORT

FOOTBALL

For some time now there have been no reports from the Soccer Club in the Journal, largely because our results were so depressing we were ashamed to submit them for publication. Nor have we found it easy to recover from the position to which we so easily sank last season. As Virgil says:

... Facilis descensus Averno.

Sed revocare gradum superasque evadere ad auras,
Iloc opus, hic labor est.

Aeneid 6.

Recently, however, there has been something of a renaissance and we are now in the happy position of winning more games than we lose. These were the matches we played in November:

SAT., 7th, v. OLD OWENS (away).

Won 6-2 (King 3, Gould, Pilkington, Viner).

This was a rather indifferent game on a sloping pitch with a strong crosswind that made ball control difficult.

WED., 18th, v. SWISS MERCANTILE COLLEGE (home).

Won 6-0 (King 4, Gould, Pilkington).

The language difficulty has always prevented us from finding out just why the Swiss should want a Mercantile College. Our guests played true Continental-style football which helped to produce a very fast game.

SAT., 21st, v. ST. GEORGE'S (home).

Won 6-2 (Gould 4, Dr. Grassby, Roberts).

A pleasant game.

WED., 25th, v. ST. MARY'S.

Won 10-1 (King 4, Berry 3, Gould 3).

It is difficult not to sound a trifle smug when writing of this match, for Mary's have a reputation. For this match anyway they had no answer to the short passing game and at the interval we were 4-1 up. Afterwards the score mounted steadily and we gradually migrated further and further into our opponents' half until, with a heavy white mist of a chill November evening beginning to form and our goalkeeper plaintively demanding a sweater, we reached double figures just before the end.

SAT., 28th, v. ST. THOMAS'S (away).

Won 4-1 (Gould 2, Berry, Pilkington).

This was undoubtedly the worst game of the season so far for we played on a sodden pitch with a ball that rapidly became heavy and greasy. We are looking forward to getting back to our own well-drained, well-kept ground at Chislehurst.

RUGGER

Bart's v. Old Alleynians. Lost 10-0.

Bart's were unable to score their first win of the season at Dulwich, although somewhat improved after the advantages of a tour. The game was uninspiring and many chances were thrown away by both sides through fundamental mistakes. The Bart's play lacked planning and there was too much pure individual effort. The forwards played better than has been seen this season, but there is still much fire and hustle missing from such a strong-looking crowd of men. The loose scrumming was particularly weak although Macadam worked hard to stimulate the pack to look for the ball, bind and heel quickly. This ideal was never attained. Graham used his height in the lineouts to advantage and Tamlyn had a good game at wing forward.

Only Davies could show any form in the three-quarters where he used the element of surprise and sidestep well, but he was not backed by any other player in the team. Charlton gave a much better service from the scrum and showed more of last season's promise. The penalty kicking was noticeably very poor.

The Old Alleynians scored their first try on the right wing when Capon ran round the end of the line and raced for a try unharmed. The second try was scored from a crosskick which was misfielded under the posts to give the O.A. pack a walkaway try and also showed up the poor covering by the Bart's forwards at that stage.

Team: D. K. Downham, J. Williams, M. J. A. Davies, J. K. Murphy, B. Badley, G. Scott Brown, C. A. C. Charlton; I. Macadam, H. Jewel, D. Dobson; D. W. Roche (capt.), K. E. A. Norbury, G. W. Tamlyn, M. N. Graham, D. Mulchy.

One consolation to the season has been the victory, for the second year running, of the rugger boat. Congratulations.

The Editor wishes to remind club secretaries that reports should be sent to him or to the Sports Editor by the first day of the month previous to that of publication.

HOSPITAL APPOINTMENTS

The undermentioned appointments to the Medical Staff will take effect from the dates indicated :

Orthopaedic Department Registrar	Mr. A. J. Harrold, F.R.C.S., from January 1, 1954 (vice Manning)
Mr. Hume's Firm Junior Registrar	Mr. M. M. Whiteley from January 1, 1954 (vice Freeman)
Mr. Hosford's Firm Junior Registrar	Mr. N. A. Green from January 1, 1954 (vice Slack)
Surgical Professorial Unit Junior Registrar	Mr. M. Braimbridge from January 1, 1954 (vice Birnstingl) (Mr. T. Thorlaksen was acting locum tenens until December 31, 1953)

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

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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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ON BEING HIGH POWERED

THERE are those who have a love of small print, and the smaller the print the better. These are the men who collect obscurities, who treasure quaint eponyms. It is, like collecting matchbox tops, a harmless hobby. No one is any the worse for knowing forty-nine causes of haemoptysis, provided he remembers that tuberculosis is one of the more usual reasons for spitting up blood. The damage to a man's education comes when he is so obsessed with the footnotes that he remembers nothing else. It is of this peril that we have been warned in a hundred cautionary tales.

There is the story of the student who gave the blood supply of the sciatic nerve in the upper arm. The Philistine examiner failed him.

Yet most people are well aware that it is essential to learn the essentials, that what is needed in clinical training is a good groundwork, that one must learn to walk before one can run. We are not lacking in good sound solid advice, and that advice is seldom unheeded. The danger is all the other way.

For if there is one quick way to damn a thing, in the eyes of medical students, it is to call it "high-powered." It is high-powered to quote any of the journals in the Library, or to know of anything that has not yet been published in the standard text books. The lecturer suddenly checks his enthusiasm and says, "But I will not bother you with this: all you need to know for the examination is. . . ." Even in those things that have nothing to do with medicine, we must not be high-powered. It is high-powered to say anything about modern art, except that we do not know which way up the picture goes. The Unknown Political Prisoner exhibition was the work of high-powered lunatics.

Rightly, anything new must show that it is worth while before it is accepted, and we are suspicious of cranks and freaks. But it is the exaggeration of this feeling which is harmful. For what is high-powered in our student days may be the common practice of to-morrow. There are still some doctors who regard penicillin as high-powered, and send their patients to the nearest hospital to get injections. If we do not learn to use judgment and discretion when we are students, it will be more difficult to find our way about medicine when we have no medical school to guide us. It is the timidity with which we approach the high-powered that has encouraged over-specialisation, for we need not suppose that the small print is intelligible only to the specialist.

There is, however, no glory in failing one's examinations, in neglecting the syllabus. Yet is the student's time so crowded out working for these difficult examinations that he has no time for anything that asks for more of his thought? No one can give a universal answer to this question: it depends on the individual student, and on the encouragement that the student receives from his teacher. There were many specific suggestions in the Abernethian Society discussion on medical education. It would be useful if a lecturer would occasionally give references to papers and books on his subject. Perhaps, too, the subject of a ward round could sometimes be announced beforehand, and reading suggested in preparation for it. It would soon be possible to tell how many students were able to find time for this reading.

Yet however many specific suggestions are made, the idea that must light it all is that knowledge should not be cut into two parts, divided artificially into the high powered and the stuff we learn.

Tennis Court

The new hard tennis courts behind the hostel are now in full use. It is a great luxury to have tennis courts built in the centre of London on such expensive ground, and the authorities responsible should be thanked for providing such an excellent opportunity for sport and exercise so close to the hospital. The journey to Chislehurst may have deterred some people who wanted exercise from getting any, but these tennis courts are in reach of anyone who can still stagger five yards.

There are only two disadvantages to these courts. One is the dust on them, which is inevitable in this smoke-polluted city. Anyone who plays in whites soon finds himself playing in grey. The other disadvantage is the audience. People passing on the pavement, who would otherwise be watching holes being dug in some neighbouring road, come and watch the game. The line of grimly silent spectators peering through the fencing, waiting glumly for one's mistakes, produces panic in the more sensitive players.

Perhaps it will be possible later on to alter the present rather cumbersome booking arrangements.

Three Hospitals Orchestra

A concert was given by the Three Hospitals Orchestra in the Great Hall, St. Bartholomew's Hospital, on Saturday, 19th December, 1953. The request to write this account of the concert reached the writer some weeks after the performance, so that details were less clearly remembered.

The Hall was extremely well filled by an appreciative and an enthusiastic audience. The acoustics which are for a speaker difficult and even disheartening, were greatly improved for the music by skilful drapings and other arrangements, the result being that the efforts of the orchestra and of the soloist could be well appreciated all over the Hall.

The concert began with a performance of Mozart's Overture to the Magic Flute, which was played at a tempo which enabled the orchestra to give due emphasis to the details of the music without the handicap of undue speed. This was followed by Elgar's concerto in E minor, op. 85, for violin, cello, and strings, in which the soloist was Miss Amaryllis Fleming. Her performance in this work was sure and competent, and sympathetic not only to the music itself but to the associated efforts of the orchestra.

She is to be congratulated on a very fine performance. After the interval, during which some light refreshment was available, the orchestra played Rachmaninov's Symphony No. 2 in E minor, op. 27.

It was rather disappointing to recognise so few Bart's faces among the performers and it is to be hoped that this interesting and delightful concert may stimulate recruits from our Hospital. Thanks are finally due to Mr. Norman Delmar who conducted with sensibility, vigour and success. The availability of a first-class conductor should be a further stimulus to recruitment to the orchestra by its third—and at the moment junior—member. It was a pleasure to welcome members of the medical and nursing staffs of St. Mary's and St. Thomas's Hospitals.

Fencing

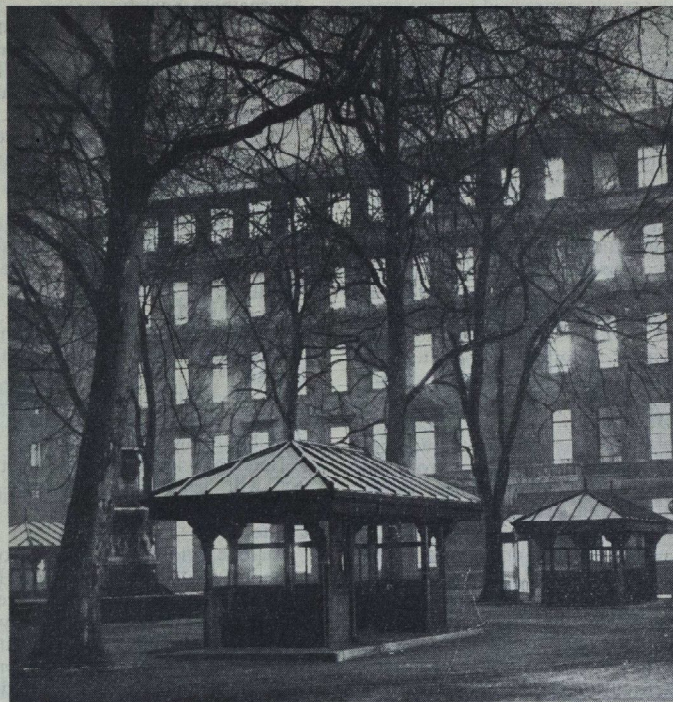
We have received this month a report from the Fencing Club. So much has been said in recent years about the lack of sporting success at Bart's that it is a pleasure to hear of the very creditable performance of the Fencing Club following fast on the victories of the Boat Club.

Airs on a Suture

The show that was put on at the Cripple-gate Theatre this Christmas was a dashing success. On each of the three nights there was the air of a tremendously successful First Night. It was a first-class show.

It is not easy for the producers to take a number of short ward shows, and weld them into a coherent evening's entertainment. Things that go well in the wards do not always go well on the stage, for the audience is different, and the spirit of the occasion is different. The aim at the Cripple-gate is quite clearly to entertain a medical audience that wants to hear topical Bart's jokes, while the most important aim in the hospital should not be to entertain the doctors or the nurses but to put on a show for the patients. And the Pot-Pourri had its topical songs and its topical jokes. Not only was the material good, but it was put over with admiral slickness and glitter.

The humour did not, for the most part, rely on bawdiness. Although the songs were often very funny, there was not much use made of the fact that there was a stage to play with. It was more radio humour than



THE SQUARE, DECEMBER

stage humour. There was little ingenuity in situation. With one or two exceptions all the turns were song and dance. But such was the excellence of the songs and dances that there was no sense of monotony.

One of the problems that the producers have to solve is the difficulty of what to do between acts. For some poor man to have to tell half a dozen funny stories is not the only solution. The people who told the stories told them well, and the stories they told were really funny, but jokes do not make good interval music for jokes.

The Pot-Pourri has to be made out of the ward shows in a very short space of time. The people who do this job deserve praise for having done it well. There is a great deal of organisation to be done, the printing of tickets, the rapid printing of programmes, the transport of props. Bert, who again did the make-up as expertly as he has done for the hospital for the last 30 years, deserves our thanks.

Everyone who saw the Pot-Pourri will agree that Bart's put on, for three nights, the best revue in town.

Christmas Dinners

By now Christmas is a month-old memory, but good food is not easily forgotten. Both in the hostel and in the hospital the kitchen staff produced an excellent Christmas dinner. The meal in the hospital was a particularly colourful affair, as there were present a number of disreputable pirates and assorted cut-throats, all painted ready for the ward shows.

The Christmas dinner in the hostel produced everything except a speech from Dr. Scowen. There were crackers, paper hats, roast turkey, plum pudding, but no speech from Dr. Scowen. At this dinner there arose again one of those unsolved problems of the modern age, what should one do when Dress is optional? Dress should never be

optional. The result is a ragged-looking mixture of Dress and Undress, and everyone's embarrassment. If there is doubt as to whether everyone can produce evening dress, then there should be no question of Dress.

Show Cases

There has recently been a display in the Library of the records and treasures of the Abernethian Society. During its long history the society has accumulated many interesting documents. They were able to display letters bearing the signatures of Osler, of Paget, and of Abernethy himself.

The minute books contain an enormous number of pages, accounts of all lectures given to the society since its foundation. There is much of historical interest in these books and much which now seems quaint prejudice.

Uplift and Downlift

This hospital is remarkable for the number of its lifts. They vary in character from the decrepit to the unserviceable. When people talk of the stress and strain of modern life, it is to these lifts that they are furtively referring. Legs aching, the sad cry "Stop at the fourth floor, please," and the empty lift whistles past, intent on causing the maximum inconvenience to the maximum number of people. That particular lift is a clear case of diabolical possession. It is licenced to carry five passengers, but it creaks and groans in mockery if its load be no more than two nurses, one student, and a Chief, implying to everyone's embarrassment that someone is grossly overweight. Thus must Jonah have glanced at his feet, coughing nervously.

The George V block also has a number of lifts less infamous than that reserved for medical and nursing staff. There is the one reserved for dustbins, and there is the respectable old lift whose heavy dungeon-like doors need a strong man's weight to move them. There is a lift that no longer lifts, but let's let sleeping dogs lie.

The pathology block possesses a machine that was, in 1911, permitted By Order to carry eight people, but which now is only allowed to carry four. This is the famous cage through whose bars Sir Holburt Waring was offered a banana.

Five minutes away, separated by 40 years, is the College Hall. Swift silent lifts with infallible memories, bright lights and gay colours, automatic doors that know to open again if they accidentally crush you, this is Progress.

Abernethian Society

On Tuesday, February 2, students will present a small number of interesting cases and a discussion will follow. This will be held at 5.45 p.m. in M.O.P.s, and a senior registrar will be in the Chair.

On Wednesday, February 10, there will be an afternoon visit to the Spinal Injuries Centre at Stoke Mandeville.

On Thursday, February 18, Dr. James Andrew will talk on his experiences as an M.O. in the Antarctic, and will show a short colour film. This will be in the Recreation Room, College Hall, at 8 p.m.

On Thursday, February 25, Dr. Keith Simpson will speak on "Crime and the Doctor" at 5.30 p.m. in the Clinical Lecture Theatre.

On Thursday, March 11, Dr. Melville Arnott, Professor of Medicine at the University of Birmingham, is making a special visit to London to lecture to the Society. His subject will be "The Aetiology of Cardio-Vascular Disease."

Crime

Anyone who leaves his soap or his toothpaste unguarded in the College Hall will find on his return that he is the owner of significantly less soap and significantly less toothpaste. He will be face to face with the crime wave. It is a major social problem when one has to keep one's toothpaste under lock and key. Are we to booby-trap the bathroom? Why should men, otherwise honest, bath with other men's soap, leaving the door open through sheer bravado? Someone recently went so far as to purloin a razor blade. Good mornings do not begin with a bladeless razor. How much longer will the taps be safe? Oh, you'll take the cold tap and I'll take the hot tap.

Change of Address

The following Bart.'s men have sent us new addresses:

A. Barnsley, Hurstcote, Shere, Guildford, Surrey. Telephone: Shere 238.

W. H. Rowe Jeremy, 6 Elm Grove Road, Exeter. Telephone: Exeter 56108.

Philip Gosse, 15 Grantchester Street, Cambridge.

Sqd./Ldr. J. H. Reading, 19 O.M.Q., R.A.F., Honington, Bury St. Edmunds, Suffolk.

Congratulations

To Ena, wife of Sqd./Ldr. James H. Reading, at the Radcliffe Infirmary, Oxford, a son Anthony Michael.

THE NOTEBOOK OF EDWARD JOHN SPRY

Extracts from the Notebook of Edward John Spry, M.D. Sometime Student of St. Bartholomew's Hospital, Surgeon to the Truro Royal Infirmary and thrice Mayor of Truro, in the County of Cornwall.

(Published by the kindness of Dr. J. C. SPRY, LEVERTON)

Eliz. Williams aet. 41—Gwennap—*Scirrhus Mammac.* Admitted May 27th, 1847. Operated on June 1st. Present Mr. Bruce, Mr. Bassett, Gorringe, Pomeroy, Andrew, R.N., Mr. Martyn of St. Columb, Leverton. Inhaled three drs. aether*—insensible in two minutes—operation performed without any consciousness of pain—shortly able to walk downstairs—passed a good night—the only circumstance which delayed the progress of the case was a marginal slough of the incision—A large scirrhus tumour was removed—no artery required tying—two sutures brought the integuments into apposition—cold water dressing—then isinglass plaister—then simple dressing and adhesive plaister.

July 1st. Almost healed—in excellent health—

Mary Ann Kinsman—Polypus Uteri— Aet. 43. Admitted Jan. 28th, 1847, under the care of Dr. Carlyon. The wife of a mason residing at Redruth—has had nine children—is of middle stature, dark hair, sallow complexion, grey eyes—Her father died of Phthisis her mother died at 82. She states that until two years since she enjoyed good health when she first noticed unusual discharges of blood ex vagina, without pain, but some uneasiness in the back—about nine months since had a violent pain in the abdomen which obliged her to keep to her bed for a long time. Her Surgeon (Mr. Boon) called it "a gathering in the womb"—yellow looking matter was freely discharged per vaginam—every few days since that time she has had a purulent sanguineous discharge—obtained no relief from medicine—discharge latterly has been more bloody occasioning frequent fainting. Tried the following T. Ferri serquichloridi dr. 1. T. Hyos. dr. 2. Mist. Camph. Op. and Mist. Cap Coch. 2 ter die—

Feb. 2nd. Again profuse discharge—pulse 100—very weak. Countenance very pallid—I examined her this morning with Dr. P. Smith's speculum vaginae—A large polypus was found occupying almost the whole of the vagina—attached to the uterus within the cervix—on the left side, about

midway between cervix and fundus—ascertained this and that there was no inversion by passing a small rectum bougie into the uterus which passed to the fundus without any interruption on the right side, and measured the length required to reach it—tried the same on the left side of the uterus, but could not reach the same point with the extremity of the bougie by one and a half inch—

Feb. 12th. At the request of Dr. Buckman applied the ligature to the neck of the tumour with the aid of the double canula—the application gave very little or almost no pain—The haemorrhage, which from the patient's statement was sometimes sufficient to fill an ordinary chamber vessel in 24 hours, ceased from the time of applying the ligature—which I tightened daily and this morning (19th) I found the tumour quite loose in the vagina. It was about the size of a small pear—the lower surface had ulcerated and was hollowed—when suspended in water the edges were flocculent—the tumor was of a firm consistence, but very vascular appearing almost as pervious as a sponge—from which the haemorrhage was at times terrific—the preparation is in my possession marked No. 10. It is a little darker than when it was removed having been left too long before it was put into spirit—

She had some haemorrhagic reaction and suffered from an attack of bronchitis which yielded to the ordinary remedies and she left the infirmary March 12th cured.

—*Couch,* of Ladock, aged 16, discharged per rectum on Friday, March 12th, 1847, two masses of foreign matter the first the size of an egg, the second much larger and longer, much compressed and hardened covered with a thin film or coating of albuminous matter having almost a shining appearance—They were voided with much difficulty and with excessive pain in the presence of her mother who placed them afterwards under the pump and unraveled them with a stick—The mother forwarded the masses thus unfolded to me consisting of hair, dyed wool thread, rags all fitted

* Ether as a surgical anaesthetic was first used in England in Dec. 1846.

together and unchanged in appearance as to colour and tenacity. *March 14th.* Visited her this day. She declared to me in the presence of her father and mother that she had not the slightest recollection of having ever swallowed or attempted to swallow any of the matters ejected—There was a general soreness of the abdomen but she bore the pressure of the hand pretty firmly. Her mother stated that when quite a child and just after she was able to walk she allowed her to amuse herself at the settle, the seat of which turned up in which the rags were deposited until the rag man came round to purchase them—that her children had in succession assisted themselves in walking by holding by the edge of this chest when the cover of it was raised and that she supposes the girl must have swallowed all these matters about that period—

Catamenia appeared slightly two years ago—then ceased—was in a state of chlorosis and anaemia when she first applied to me—has been regular now for the last three periods—

July 3rd. Visited me at Truro—rode in a cart—looks healthy and fresh coloured—has grown considerably. Bowels occasionally painful and digestion languid. Gave her some antacid powders and advised daily exercise on a donkey—

Case of early appearance of the Catamenia—M.A.I. aged not quite nine—Catamenia appeared in Dec., 1846, and continued three days—She complained of a little smarting in making water a few days before the event and was alarmed when she discovered what had taken place—She has continued to do so regularly to this time March, 1847—Her mother commenced at 13. The cousin of this little girl was only a little over nine when it happened and has continued regular ever since—now 17—M.A.I. is rather short for her age, but of a set figure and rather stout.

Case of simple fracture of the astragalus through its neck with portion fractured forwards and outwards. Recovery, with considerable motion of the foot.

Thomas Rogers, a very healthy muscular and robust miner aged 42, was brought to the Infirmary on the 24th of September, 1846, and admitted under the care of Mr. Bull. It appeared from the statement made by the patient that whilst at work in the morning of the preceding day at Poldice Mine in Gwennap he had slipped from the end

of a scaffold about five feet high, and had fallen perpendicularly to the ground, the hollow of his right foot coming in contact with a large projecting stone. On attempting to stand he found that he could place no weight on the limb, that it was very much distorted and that it occasioned excessive pain—The Surgeon of the Mine promptly attending, when an attempt was made to restore the displaced parts, and similar efforts having been made the next morning without success he was sent to the Infirmary in a cart and arrived there about nine in the evening—The limb was then examined by Mr. Bassett and Mr. Gorringe (the Assistant Surgeon) who were induced to try the effect of the pulleys which they did very assiduously, but with no better results than attended the former efforts. The condition of the limb as described to me by Mr. Gorringe on his arrival at the Infirmary was this—The foot was very much swollen, extended, the toes turned inwards, and the outer edge of the foot downwards—and if allowed to reach the ground would have rested on its external plantar margin and metatarsal joint of the little toe. There was considerable swelling of the parts and the inner malleolus was deeply buried in the angle of Adduction, whilst the outer malleolus was remarkably prominent, and just below it and a little in front, was a large immovable projection of bone, covered only by the skin, very tensely stretched. The foot could be brought into a straight line with the tibia and fibula and could be flexed to an angle of 45 degrees with the ankle joint without much effort, but immediately that the hand was removed the parts resumed the same relative positions as before. On carefully rotating the foot when brought into the position described a slight crepitus could be felt—but the patient had no control over the foot and all motion of it occasioned pain—The man passed a tolerable night having slept at intervals—in the morning the limb was not much larger than on the previous evening. On the following morning I was invited to examine the limb in consultation with my colleagues and ascertained the state of the limb to be such as had been already accurately described. I satisfied myself that there existed no fracture of either malleolus, that the displacement was only of some portion of the plantar arch, and not of the entire foot, and that the displaced bone was the astragalus. As the patient was a very

muscular man of florid complexion and still had a strong pulse it was agreed that he should be bled ad deliquium, be placed fully under the action of the Tartarized Antimony for two or three hours, and that the extension should be once more cautiously tried with the pulleys. This was done very perseveringly, and at the same time direct pressure was made on the projecting bone, but it was found to be impossible to move it. The man was extremely faint and in the most favorable state for overcoming mere muscular resistance, but it was not thought expedient to carry the attempts any further—indeed the pressure on the displaced bone had caused the effused fluid about it to disappear so that there remained only the skin covering it and the slightest incision would have sufficed to expose it. It was deemed however more advisable to leave the process to nature's efforts and to watch the result—Warm fomentations were applied to the limb and he had an anodyne.

Sept. 26th. He passed a tolerable night and suffered less than might have been expected—Bowels had been freely acted upon—Pulse 93 and firm—Considerable ecchymosis about the outer ankle—Fomentations continued—The leg placed in a fracture apparatus and raised—the thigh resting on an inclined plane—

Sept. 29th. No greater constitutional disturbance has been excited—Pulse 93—feels easy—swelling gradually subsiding—Vesications found over the displaced bone. From this time (*Oct. 2nd*) the process of sloughing proceeded which extended over the outer malleolus—Pulse 76—The patient's strength was duly supported, and emollient poultices applied to the part. On the 6th the bone was partially uncovered and on the 20th was found so loose, Mr. G. easily removed it by detaching only a little ligamentous tissue—a large cavity was thus exposed in which could be seen the concave articulating surfaces of the tibia—Some haemorrhage followed its removal which was suppressed by applying a pledget of lint and a roller—The portion of bone removed proved to be the large convex articulating surface of the astragalus, that bone having been broken through its neck, just in a line with the margin of its posterior concave surface, carrying with it the internal angle of its tibial articulation.

Oct. 22nd. The finger introduced into the cavity detected the rough surface of the

remainder of the astragalus in situ, which although a little loosened was too firmly attached to be removed—it was also ascertained by the same mode of investigation that the inner malleolus was uninjured—He was allowed O.1. Porter daily and two ozs. Wine.

Oct. 24th. Considerable discharge of pus from the wound—an abscess which had formed over the inner ancle was opened which gave great relief—Strength much reduced—Porter increased to O.2 and wine to 4 ozs. daily, with 6 ozs. brandy.

Oct. 27th. The great discharges have very much reduced his strength and fears were entertained that he might not maintain the struggle, but this morning the circumstances of the case had somewhat improved—very much—there was less discharge and the granulations especially over the outer ancle and lower part of the fibula which had also become exposed were more healthy—There were two openings over the inner ancle from which large quantities of pus are discharged—Sinuses, an inch deep, run in the direction of the joint.

Nov. 5th. At another consultation held this morning it was determined to make a further effort to save the limb.

Nov. 12th. Improvement continues—sinuses filling up—two superficial sinuses were dilated and the cut surfaces granulated favorably—

Nov. 18th. Limb now rests on cushions—in the extended position supported by a splint on the inside—wounds all healing and has recovered so much strength that he can raise his leg a little from the bed.

Dec. 16th. To this date his amendment was gradual. He is now able to get up daily—wounds heal slowly—Heel raised and leg straight—

1847. Jan. 1st. Is now so far restored as to be able to walk tolerably well with the aid of crutches—wounds all healed—the limb is about an inch shorter than the other and still turned pretty much inwards—considerable prominence remaining on the external surface of the foot. Passive motion can be affected to some extent without occasioning pain. Discharged Jan. 2nd, 1847. I saw this man in June, when he was able to walk firmly on the right foot with the help of a stick—He has been at work on the mine about a month—as might be expected the foot is of a very awkward figure, but there is very useful motion in the

ance joint which he thinks is gradually improving. As a proof of the rarity of this accident in Cornwall it may be stated that I had never before met with it and Mr. Bull who has been resident House Surgeon of the Infirmary from its opening in 1798 never recollects the admission of any similar accident. The Surgeons of Gwennap who watch over the casualties to which many thousands of our miners are exposed do not remember to have seen it—and I have obtained similar testimony from other professional friends—I am indebted to the art. in Mr. Bransby Cooper's edition of Sir Astley's valuable work on Dislocations and Fractures of the joints for a very satisfactory account of this

particular variety of dislocation of the Astragalus* and to the publications** of my townsman Mr. Turner of Manchester for much useful practical information on the subject, who appears indeed to have omitted nothing that might serve to make his descriptions of the varied dislocations of the A. minutely complete. Yet the case now described presents some peculiar characteristics although in the main it serves to confirm Mr. Turner's opinion that a dislocation of this bone can never occur without fracture.

* 5th Edition p. 322.

** Transactions of the Prov. Med. and Surgical Association for 1845 Vol. XI—and subseq. in a separate volume.

MÖNCKENBERG

by R. B. P.

Now Mönckeberg's Arteriosclerosis
May sound a most alarming diagnosis,
But through a recent rhyming competition
I have been made aware of this condition,
And in myself have found with consternation
Advanced arterial degeneration.
My arteries, including the aorta,
Have grown a damn sight harder than they oughter—
From overhearing my physicians talk
I'd say they're harder by a good long chalk—
Their middle coats are patched beyond repair,
Their "intima" not really fit to wear,
In short my doctor thinks they're now such wrecks he
Anticipates an early apoplexy!
I'm in distinguished company, it's true,
For many famous men have had it too.
Herr Mönckeberg's confounded monkey tricks
Have played the very deuce with politics!
In England it is generally reckoned
They gave the coup de grace to Charles the Second;
In later years Herr Mönckeberg again
Saw Joseph stricken in his Chamber lain;
Poor Woodrow Wilson in the U.S.A.
Was yet another victim, so they say;
In Russia (which discovered all things first)
Lenin and Stalin both had vessels burst;
In France what finished President Doumerque?
Both rhyme and reason answer—Mönckeberg!

A LITTLE JUDICIOUS LEVITY

by W. R. BETT

Being an address given at the annual dinner of the American Medical Writers Association, at Springfield, Illinois, in September, 1953.

VAGUELY aware of the friendship that once flowered between literature and medicine, physicians continue to describe themselves with, perhaps, undue straining of the phrase as the children of Apollo, who was god of beauty, culture, rhetoric and poetry; leader of the celestial choir on Parnassus; and father of Asclepius, upon whom he bestowed the divine gift of healing. This antonomasia was justified in the days when Sir Thomas Browne, physician of Norwich, could pen such majestic lines as:

'But the iniquity of oblivion blindly scattereth her poppy, and deals with the memory of men without distinction to merit of perpetuity. Who can but pity the founder of the Pyramids? . . . Who knows whether the best of men be known? or whether there be not more remarkable persons forgot, than any that stand remembered in the known account of time? . . . Oblivion is not to be hired: The greater part must be content to be as though they had not been, to be found in the Register of God, not in the record of man.'

What of the present? We belong to a profession which is verbose in unnecessary explanation of the obvious; which delights in the cacophony of technical jargon; which talks of "palms of the hands" and "soles of the feet," yet curiously enough, never of "teeth of the mouth."

It is a mistake and certainly a sin to try to influence an author's style. If all papers were to conform to the same pattern of literary composition, medicine would be not only difficult—it would also be deadly dull. Why are medical writers today so scared of a little humour? Is it too late to be ambitious and emulate such delicious pearls as Osler's charming description of "the area of abdominal romance where the head of the pancreas lies folded in the arms of the duodenum," or Oliver Wendell Holmes's priceless reference to the ischial tuberosities as "those interesting prominences whereon man sits to behold the works of creation," or his inimitable comparison of a sweat gland with a fairy's intestine?

"Nothing like a little judicious levity." The title of this paper is taken from the book

The Wrong Box, written in 1892 by Robert Louis Stevenson and his stepson, Lloyd Osbourne. A little judicious levity! To define one's terms is most urgent and most salutary. According to the Oxford Dictionary, levity is "unseasonable jocularity," but I shall use the meaning which it had for the great Dr. Johnson—"trifling gaiety."

The language of modern medicine is becoming too precise and prosaic, saturated with technical minutiae. Surely the spirit of our time calls for a lighter and crisper touch. I do not suggest for a moment that the *Journal of the American Medical Association* should read like the *New Yorker*, or a textbook of diagnosis like *Tales of Mystery, Detection and Horror*. I do not suggest for a moment that we should resurrect the scurrility and invective beloved of medical journalists a century ago. Those who have been medical students or are teachers of medical students, will appreciate the value of a little judicious levity in the arid atmosphere of the lecture-theatre, with this proviso that it is used to spice teaching, not to dilute it. Hence my insistence on the qualification "judicious." Some subjects, of course, lend themselves much more readily to the humorous touch than others—for example, obstetrics, where, as an anonymous writer in a recent issue of the *British Medical Journal* (August 29, 1953, *ii*, 483) reminds us, "the single-handed problems of birth may be stamped on the student's mind by presenting them in outlandish surroundings, so that he sees himself sharing a rowing-boat with a woman in labour, or galloping by camel to attend a tented delivery in the alarmingly underdoctored stretches of the Sahara."

It may legitimately be argued that this is all very well for the spoken word, but is not medical humour apt to congeal in the coldness of print? Again I underline the word *judicious* in the title of my paper.

That great surgeon and writer, Sir Frederick Treves, for several years lecturer on anatomy at the London Hospital, excelled as a teacher of this subject, for his was a

lucid, nimble style, a genius for the telling, facetious, pungent phrase, which stuck in the student's memory. This was his delightful comment upon the bony deposits on the surface of the skull in hereditary syphilis. (I quote from the sixth edition of his *Surgical Applied Anatomy*, 1911):

'They have been termed "natiform elevations" by M. Parrot from their supposed resemblance, when viewed collectively, to the nates. To the English mind they would rather suggest the outlines of a "hot-cross bun".

Alas! this crack is omitted from the eleventh edition, 1947.

Read, also, a few extracts from "A Study of the Umbilicus," by O. H. Mavor, *alias* "James Bridic" (*British Medical Journal*, 1939, *i*, suppl. 245-8):

'In anatomy . . . it [the umbilicus] is little better than a mere landmark. When we assume the spectacles of the embryologist, however, it takes on great importance. If one may be allowed a poetical image, it is all that remains of the stem that bound us to the parental stalk. It is a reminder that we have been plucked and must sooner or later die. It might be said that when the stem is severed we cease to live in any true sense. We may be ornamental like roses or useful like cabbages, but only for a little. Our dissolution has begun.'

'I wish to draw your attention to the sonority of the word "omphalos," and to regret . . . that Celsus thought fit to change the noble-sounding name of a noble organ to the pedestrian word "umbilicus." We in the profession of medicine are children of Hippocrates the Greek in more than one sense. The magnificence of the Hippocratic language helps to preserve for us what little influence we have in the imaginations of mankind.'

While on the subject of anatomy, it may be appropriate to refer to the "judicious levity" of anatomical mnemonics, pornographic or otherwise, beloved of student and teacher alike, such as "Treves is an excellent surgeon, especially in piles," and "Some inherit money, others inherit syphilis, God is love."

I know some better ones, which I shall judiciously refrain from reciting.

Continuing in this vein of judicious levity, Lord Moynihan, wishing to impress upon his students that in haematemesis the stomach is not always the responsible party, graphically put it thus:

'The stomach is so sensitive an organ that it cannot refrain from weeping when its neighbours are in trouble, and its voice may be so loud and insistent as to drown that of the real sufferer.'

F. G. Crookshank (*Individual Diagnosis*, London: Kegan Paul, Psyche Miniatures, 1930, 66-7), referring to the circulation through the liver and the secretion of bile being affected by chagrin as is the secretion of tears by grief, and to continued emotional stress leading to structural changes in the liver and to the formation of gall-stones, pens this vivid passage:

'The liver has made a series of grimaces, and has been "struck so." So did the grin of the Cheshire Cat remain in Wonderland even when the cat had vanished. So, too, does the fleeting blush of maidenly modesty, if too carelessly evoked, pass into rosaceous grog-blossoms at the climacteric.'

Truly has it been said that, for writing to be really effective, in every sentence should lurk the ambush of the unexpected.

"Nothing like a little judicious levity." I have come to the end of my story. I do not delude myself for a moment that I fit into the thought expressed in Hebrews *xii*, 2: "Be not forgetful to entertain strangers: for thereby some have entertained angels unawares." Let me instead echo Shakespeare's lines:

'Let me play the fool.
With mirth and laughter let old wrinkles come,
And let my liver rather heat with wine
Than my heart cool with mortifying groans.
Why should a man, whose blood is warm within,
Sit like his grandsire cut in alabaster?'

MEDICAL PRACTICE IN THE BRITISH WEST INDIES

by J. E. A. BOUCAUD

THE British West Indian colonies are included in an area between 58°—89° longitude and 1°—20° latitude, and include British Honduras and British Guiana, which are on the mainland of America. All the colonies lie within the tropical belt, and with the exception of British Guiana, which has an Atlantic seaboard, they enclose the Caribbean Sea. The islands include the two large islands of Jamaica and Trinidad and the eastern group of the Antilles, divided into the Leeward Islands and Windward Islands. Barbados and Jamaica have been British since the seventeenth century, but most of the others have had changes of ownership which left traces of their influence as shown by the variety of customs in these "jewels of the west," as the islands are called.

These colonies enjoy great climatic advantages over other tropical parts, as the normal tropical heat is tempered by the prevalent winds and the cooling effect of the sea on small masses of land. Even in British Honduras and British Guiana the temperature is fairly equable. Rainfall is generally abundant, and periods of drought are seldom prolonged sufficiently to affect adversely the health of the people. The islands are really able to boast of natural characteristics and health conditions particularly favourable for countries within the tropics.

Owing to the economic conditions existing in the early days, it was realised that some sort of medical assistance had to be provided for the poor people, and so each colony had to provide a medical service according to its financial position. The aim was to provide free service for the poor and service for others at moderate fees. Necessarily most of the medical officers were Government expatriate officers, and their salaries were supplemented by private practice, which was permissible to all officers except those attached to institutions. There were few private practitioners in colonies where there was East Indian immigration, so provision had to be made for the medical care of the immigrants.

The history of medical practice in the West Indies may be illustrated best by reference to one colony in particular, and I select Trinidad, as it is my homeland and I know much

more about it than any other colony. It was in the year 1814 that a medical board was created in Trinidad to assist the Government in controlling the practice of medicine in the best interests of the community. In 1846, an amending Ordinance was passed authorising the board to control not only the practice of medicine and surgery but also the practice of pharmacy and midwifery. In 1848, a General Board of Health was instituted, and in 1869 this board was reconstituted with the Governor as president, the other members being two members of the Legislative Council, the mayors of Port of Spain and San Fernando, and two members of the Medical Board. The new Ordinance also provided for a medical officer of health and two sanitary inspectors (laymen) for the boroughs. The wardens were *ex officio* sanitary inspectors of the various wards. All medical officers on the fixed establishment, about eight, were responsible solely to the Governor. In 1871 a chief medical officer was appointed and he had to assume control of all medical personnel and medical institutions. The institutions were a leper asylum, opened in 1845, a Port of Spain hospital, transferred to its present site in 1857, a mental asylum opened in 1858, and a San Fernando hospital opened in 1860. A Port of Spain hospital was functioning for some time prior to 1857. When East Indian immigration was introduced in 1845, estates made their own arrangements with private practitioners for the medical care of immigrants. As the result of a protest from the India authorities, the Government decided to assume responsibility for the medical care of immigrants and authorised the chief medical officer to formulate a scheme to meet the existing conditions. After very careful study he formulated his scheme in 1875 and this was accepted. The scheme called for the employment of whole-time medical officers to render medical care to all indentured labour in the various districts, and to all the sick poor, as well as provide medical attendance for all Government institutions, the police and prisoners. It also called for the appointment of medical officers in administrative charge of all institutions. To implement this scheme medical officers had to be recruited from abroad, but the number so recruited

COLLEGE PRIZES

HAYWARD PRIZE

1952 Awarded to C. W. H. Havard

1953 Awarded to A. S. Wint

diminished from year to year. Up to the year 1903, attention was focused on curative medicine, but with the appointment of a sanitary inspector and assistant medical officer of health with a Public Health Diploma, ankylostomiasis got some attention, as well as malaria. An extern maternity department was established in 1918, and a voluntary organisation, a Child Welfare League, was founded in 1918. From then on public health activities were not confined solely to the prevention of infectious disease, as this was taken care of by the 1915 Public Health Ordinance. This provided for the revision of the constitution of the Central Board of Health and the local health authorities in the urban and rural sanitary areas, and also the Port Health Service. The Ordinance provided for a drive on preventive medicine, which proved of immeasurable benefit to the colony and this drive continues to-day. From 1919 onwards, both curative and preventive medicine received the attention of the authorities, but the progress in surgery, where the standard was high, was much greater than the progress in medicine. The training of nurses was arranged for at the two main hospitals in the colony on lines similar to the training in the United Kingdom, but for quite a long time girls were not attracted to it. The general scheme formulated in 1875 continued in force up to 1934, the year of publication of the report of a committee appointed to consider re-organisation of the service. The recommendations of this committee were far reaching, but implementation slow. The venereal diseases scheme, organised in 1937, was stepped up in 1943; the maternity and child welfare scheme for the colony was initiated in 1942, and arrangements were in progress for a tuberculosis survey in the colonies.

Although in 1938 a five-year development programme was drawn up in Trinidad and provision made for a good start in the development of the health service, it was not surprising that the Russell Committee appointed in 1943 were able to record that little progress was made from 1939 to 1943. The committee stated that while on the public health side are to be found the usual activities associated with a colony of this size and that in this respect the health department worked on approved lines, there was no definite stated health policy. It must be noted that these colonies are not able to bear at all times the cost involved in implementing recommenda-

tions of committees, but what was always lacking, until more recently, were stated policies, although there was the guidance of a Colonial Medical Advisory Council composed of senior officers, all of whom had been at one time in active service in the colonies. The Russell Committee, among other things, recommended:

1. Improved administration of the service.
2. Enlargement and modernisation of the general hospitals.
3. Appointments of lay secretaries to hospitals, almoner, dietitian and specialists.
4. The erection of a sanatorium.
5. Increases in medical and nursing staffs.
6. Improved district services.

As all these committees are of interest to all colonies, the reports are carefully studied with a view to improving conditions all round, and so the colonies were generally prepared for the findings of the Moyne Commission.

The Moyne Commission, appointed in August, 1938, conducted investigations in the colonies in 1938 and 1939, covering a wide field. The report of the Commission was presented to Parliament in June, 1945. The chief recommendations affecting health departments were: the appointment of a medical adviser to the Controller of the West Indies Welfare Fund, to formulate health programmes for the West Indies and the creation of at least one school of hygiene in the West Indies. The Commission urged the formulation of long-term policies, stressing the importance of preventive medicine in the West Indies and urged immediate progress with housing, general sanitation, and the control of malaria and venereal diseases. The Commission recommended unification of the medical services in the West Indies and re-organisation of the services with provision for a relative increase in well-trained auxiliary staff, the centralisation of medical institutions, and provision of better facilities for treatment in rural areas and certain sections of the urban population. The organisation of maternity and child welfare schemes, school medical services, and health education schemes were also recommended. The Commission stated that the aim should be to secure greater efficiency and economy in the treatment of the sick, and render possible better training facilities in curative medicine, for all medical personnel.

In 1947, the future of the West Indian medical services was considered at a conference of directors and senior medical

officers at Barbados under the chairmanship of the medical adviser to the Controller of the West Indies Welfare Fund. At this conference certain principles were laid down, and a scheme submitted for the guidance of the colonies. It was felt that the administration of the health services in the different colonies should be established on similar lines, and that there should be an attempt at unification and at centralisation of institutions.

It is impossible to make the best use of the well-trained, efficient and keen professional men in these colonies, for the good of all communities. Each colony has its own medical service, its own system of registering practitioners and its own general hospitals. Each hospital has at least one surgeon, and he may be required to do other duties besides that of a surgeon. The larger colonies have some special hospitals, and their general hospitals have the various departments associated with general hospitals in the United Kingdom. The facilities offered in these general hospitals are good, and the material available excellent, but work is handicapped for lack of personnel. So much is demanded of these officers that there is very little opportunity for research in spite of the wonderful material available. With the introduction of more auxiliary staff, the position is better, but with populations of these colonies continually on the rise, it is difficult to notice much change. There are opportunities for specialising in some branches, but the specialist cannot give his service, wherever needed, due to lack of adequate communication between all the different colonies. It is difficult to recruit the personnel required, but with the University College of the West Indies available to supply recently qualified men, and the facilities offered by Government to enable young men to obtain qualifications for the higher posts, the position should improve. It must be remembered, however, that practitioners are not needed only for the service. There are estates, oilfields and other industrial concerns that can absorb many practitioners, and there is private practice, the standard of which is high, for the physician, the surgeon and the specialist, who may have the use of nursing homes in the larger colonies. There are, therefore, varied opportunities for enthusiastic practitioners, but as the tendency is to enlarge the services and grant greater facilities than formerly, a career in the services should prove more attractive.

At the present time the colonies can boast of:—

1. Large modern general hospitals, with facilities for the physician, surgeon and specialist, and modern laboratories attached.
2. Special hospitals for mental diseases.
3. Special hospitals for the aged.
4. Special hospitals for tuberculosis.
5. Special hospitals for leprosy.
6. District hospitals in rural areas.
7. Chest clinics and health centres.

It must be admitted that the hospital accommodation available is not adequate for the population of the West Indies, but this fact has been noted by the planners who aim at providing more beds.

Great progress has been made in preventive medicine, with the result that the working capacity of the inhabitants has improved considerably and with this the economy of the colonies, especially the more prosperous where living conditions are better. The good results of the health education drive are now visible and the interest of the inhabitants in protection against disease, in good nutrition, good housing, and generally good living conditions, is very encouraging, not to mention the great concern of the poor to-day for the welfare of their children, and their eagerness to co-operate in efforts made to help them by the various social services existing as well as by the health department.

The colonies can look back with satisfaction on the results of the D.D.T. campaign against malaria, the intensive campaigns for the control of ankylostomiasis, the widespread fight against venereal diseases, the re-organisation of the Port Health Services, the tightening up of the quarantine regulations and the recent B.C.G. campaign. The efforts made to maintain a high standard of sanitation in these colonies have not been made in vain. Though it is not possible to say when all the recommendations of the Moyne Commission will be implemented it can truly be said that the present interest of the people in these areas in preventive medicine is due to the enlightenment of the people by the Moyne Commission which revealed the necessity for the health education and generally improved sanitation, as also for the unification of the medical services in the West Indies. This should render more easily available to all communities the specialists and modern institutions to be found in the larger colonies. These colonies can look forward with confidence to steady progress in both curative and preventive medicine.

WILFRED SHAW

by JOHN BEATTIE

Wilfred Shaw has been taken from us at an early age and at the height of his powers. He was not yet 56 years old and suffered a very long illness before he died. His scholastic career was exceptional from the beginning; from King Edward's School at Birmingham he went to St. John's College, Cambridge, with a Foundation Scholarship and Exhibition and he won the Wrights Prize. He obtained a first-class Honours in the Natural Science Tripos, and then came up to St. Bartholomew's. He had a brilliant career at the hospital both as a student and afterwards, and won the Shuter Scholarship and the Matthews Duncan Prize and Gold Medal.

He qualified in 1921 and was house surgeon to Sir Charles Gordan Watson when he began to show great promise in surgery. He became a F.R.C.S. (Eng.) in 1923 and took his M.D. at Cambridge in 1928 and was elected F.R.C.O.G. in 1932 and was a foundation member when the College was first named. The Royal College of Obstetricians and Gynaecologists recognised his outstanding knowledge of gynaecological pathology by making him a member of the Museum Committee.

He was a one-time examiner at the Universities of Oxford, Cambridge and London, also for the Conjoint Board and for the M.R.C.O.G. degree.

After doing his house appointments, Wilfred Shaw began to study gynaecology and obstetrics in Vienna, Berlin, Graz and Munich. He established an association between the Frauen Kliniks in Vienna and this hospital which has lasted until the present time. Two young gynaecologists of First Assistant status have visited this hospital this year and one of our Registrars has just returned from Vienna.

Shaw was the first to hold the post of Resident Physician Accoucheur and resided for four years in a flat in Surgery House. During the whole of this time he devoted his great energies to the study of ovarian and uterine physiology and pathology. He began to publish a long series of papers on the following subjects: metropathia haemorrhagica, the histological changes in the uterine wall associated with multiparity, ovarian tumours,

the Shaw-Dastur cells of the ovary, the anatomy of the pelvic floor, a new operation for stress incontinence and a new method of repairing pelvic floor prolapse. The Williamson Laboratory, which is endowed and forms part of the Gynaecological and Obstetrical Department, was organised and raised to a high state of efficiency by Wilfred Shaw. The department owes him a very great debt for his brilliant work, his great example, and the guidance of his junior colleagues ever since he took charge of the laboratory.

Shaw won at Cambridge, in 1929, the Raymond Horton Smith Hartley Prize for the best M.D. thesis of the year and previously he obtained the Lawrence Research Scholarship and Gold Medal and the Cattlin Research Scholarship at the hospital.

He was elected Assistant Physician Accoucheur in 1930, and after Dr. Barris died and Dr. Donaldson retired he became Surgeon-in-Charge of the department. Even when his private practice occupied his time outside the hospital he continued to do research work on various problems, for he was a relentless worker. He was really at his happiest while doing practical work in the laboratory and each of his published papers had the stamp of individuality and originality. His two textbooks, on gynaecology and on obstetrics, were an immediate success, the one on gynaecology having already reached its fifth edition. These books have a wide circulation and have reached many countries. More recently he wrote a large textbook for nurses, which has also gained a well-deserved popularity. Shaw's international reputation produced a wide correspondence and he had many visitors from abroad, particularly from Europe, America, Canada and India.

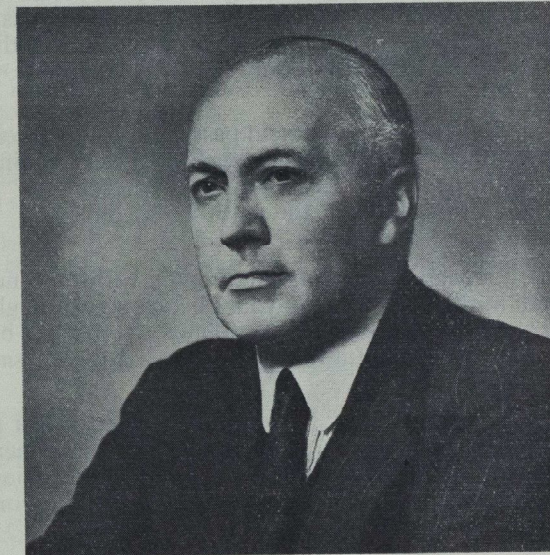
During the 1914-18 war, Wilfred Shaw saw active service as a surgeon-probationer and had a good deal of experience in a destroyer. When the 1939-45 war broke out he did not join the E.M.S. but was asked to take control of a Maternity Unit in Bradford on Avon, where he did most excellent work. The long series of cases which he had under his own care proved conclusively that the doctrine of non-intervention in obstetrics, of which he was such a protagonist, is the safer course to adopt. He was also obstetrical and gynaeco-

logical adviser to a wide area around his hospital and his work was greatly appreciated by many doctors in the neighbourhood.

Shaw's brilliant brain was not satisfied to concentrate only on his professional work. He took a great interest in astro-physics, English history and the history of St. Bartholomew's. His students always had the benefit of his acute observation. His method of teaching was very individual and discussion was apt to range wide and far to include any subject under the sun. His memory was prodigious for he never forgot a face, either of his students or patients. He could relate the minute detail of past history in both

But although he was so happy when working at his chosen subject, Wilfred Shaw was never happier than when at home with his family around him. In later years he became fascinated with horticulture and did a great deal of fruit tree grafting, which was his special interest. It was typical of the man that he was very critical of a belt of pine trees near his garden in Essex because he thought they must be hosts to many a virus which attacked his fruit! He quickly attained specialised knowledge about plant hormoneology and biology which his restless brain applied to his hobby.

His friends will like to remember Wilfred



student and patient many years after his first contact with them, which the qualified Bart.'s man found disconcerting on occasions!

Thousands of Bart.'s men will continue to remember Shaw as "Wilfred," for he was always referred to by his Christian name. Many legendary stories are associated with him, for his quick wit and repartee were famous.

His technical ability as a surgeon was very high indeed and his original mind was always searching for a new technique. Many came to watch him operate and his boldness under difficult circumstances was the envy of all his juniors.

Shaw remaining true to his ideals even during his recent illness which lasted for two years. During this time, and indeed quite recently, he insisted on continuing to write and correct the proofs of his new book on operative gynaecology, which is now in the press. This book should be a memorial to Wilfred Shaw, and for those who knew him intimately it will be something else as well—it will be in memory of a man whose original thought, whose publications, whose tenacity of purpose and clear thinking have left their mark not only on those here but also upon many hundreds of Bart.'s men who since 1923 have been taught and guided by him.

THE PSYCHIATRIST

by M. I. HORTON

"I fear," he sigh'd, "you've moths in what you're pleased to term a 'brain';"

"But dry that tear! Some insulin will put you right again."
Yet insulin is little use, as every dormouse knows,
To one whose disposition's predispos'dly comatose.

"Bear up!" he cried, "some ECT may work your preservation
(If I'm not foil'd by some untimely power cut from the station)."
But I'd been in a Home for months, and after shocks like these
A thousand volts of ECT could only make me sneeze!

"Tut! Tut!" said he, "some horrid past befouls your mental drain;
Some truth-compelling pentothal must flush it clear again."
But when, 'neath pentothal, I cast politeness on the shelf
The only truth I told him was the truth about himself!

"Enough!" he roared, "my constitution will withstand no more,
And though it hurts me more than you, I'll kick you through the door.
You ought to know that honesty confounds the learned brain;
Stop treating me with painful facts before you drive me sane!"

But next time he commands, "Now tell me in the briefest manner
The symptoms you imagine," I shall seize a heavy spanner;
And, wasting no more time in pleas, or vain expostulation,
I'll yell, "I'm homicidal, sir!"—and give a demonstration!"

JOURNAL APPOINTMENTS

The posts of Assistant Editor and Assistant Business Manager are both vacant.
These positions are best filled by Students in their first Clinical Year.

PSEUDO-CHOLINESTERASE

by H. LEHMANN

1. The two cholinesterases of human blood :—
(a) True cholinesterase.
(b) Pseudo-cholinesterase.
2. Differences between true and pseudo-cholinesterase.
3. Determination of pseudo-cholinesterase, normal values.
4. Determination of pseudo-cholinesterase as a liver function test.
5. Specificity of the test for liver function.
6. Pseudo-cholinesterase determination in myasthenia gravis.
7. Pseudo-cholinesterase and anaesthetics.
8. Possible physiological function of pseudo-cholinesterase.

The cholinesterases of human blood

Acetylcholine is an ester which is hydrolysed by enzymes to acetic acid and choline.

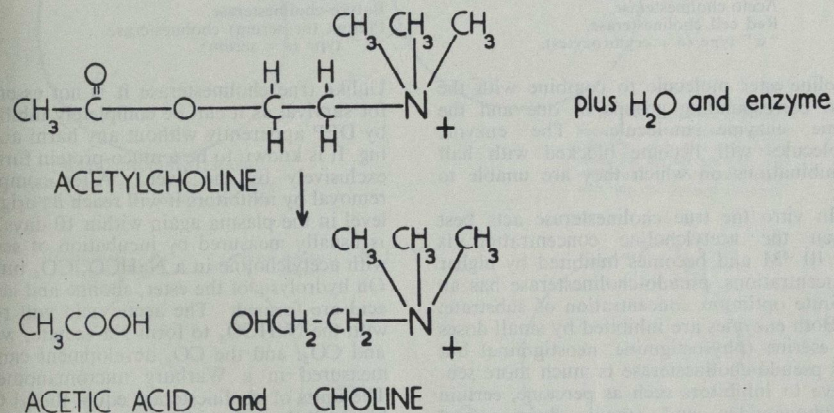
True cholinesterase

Human blood contains two enzymes which are capable of splitting this compound. One is found in the red cells and is identical with the cholinesterase of the neuronal surfaces which is particularly concentrated in synaptic regions and at neuromuscular junctions.

acetylcholine are directly connected. What purpose the "true cholinesterase" of the red cells fulfils is unknown, but as its concentration in the blood rises and falls with that in the nervous system, measurement of the true cholinesterase of the red cells will give an indication of the cholinesterase activity of the nervous system.

Pseudo-cholinesterase

The second cholinesterase is in the plasma



There the enzyme plays an essential part in the transmission of nerve impulses with which the release and the removal of

and is called "pseudo-cholinesterase" because it has only little effect on acetylcholine at physiological concentrations, and is

therefore not involved in the transmission of nervous impulses. Unlike the true cholinesterase it hydrolyses not only choline-esters but also shows considerable activity against non-choline compounds such as tributyrin or ethyl acetate. (The plasma also contains an enzyme which can attack aliphatic esters only, and no choline-esters at all—the "ali-esterase".)

Differences between true and pseudo-cholinesterase

The true and the pseudo enzyme differ in their attachment to the substrate. Both have an active grouping which combines with the ester linkage of the substrate. The true cholinesterase however has also a negatively charged grouping which must combine with the positively charged group of the choline-ester before the enzyme can act. Hence the true cholinesterase will not attack non-choline compounds. If the substrate concentration becomes too high true cholinesterase—but not pseudo-cholinesterase—becomes inhibited. If too many choline-ester molecules compete for the two active groups of the true cholinesterase molecule there is less chance for both active groups of one

DIFFERENT NAMES OF THE TWO HUMAN BLOOD CHOLINESTERASES

TRUE CHOLINESTERASE.
Specific cholinesterase.
Acetylcholine esterase.
Aceto-cholinesterase.
Red cell cholinesterase.
"e" type (e = erythrocytes).

choline-ester molecule to combine with the two corresponding groups of one and the same enzyme molecule. The enzyme molecules will become blocked with half combinations on which they are unable to act.

In vitro the true cholinesterase acts best when the acetylcholine concentration is $3 \times 10^{-3}M$ and becomes inhibited by higher concentrations, pseudo-cholinesterase has an infinite optimum concentration of substrate.

Both enzymes are inhibited by small doses of eserine (physostigmine, neostigmine) but the pseudo-cholinesterase is much more sensitive to inhibitors such as percarine, certain sulphonamides, and organic fluorine and phosphorous compounds such as DFP, TEPP and Parathion, some of which are used as insecticides, or tri-ortho-cresyl phosphate which has an industrial use as a plasticiser. DFP (di-iso-propyl-fluorophosphate) can be injected at a dosage sufficient for complete

suppression of pseudo-cholinesterase activity, yet no ill effect or any symptoms of acetylcholine accumulation will be noted, because the inhibitory level for true cholinesterase has not been reached.

Lastly, there are differences also in the activity of the enzymes against different choline-esters. Only true cholinesterase can hydrolyse acetyl-beta-methylcholine, and only pseudo-cholinesterase can act on benzoylcholine. The pseudo-cholinesterase is therefore characterised and differentiated from the true cholinesterase by:—

1. Ability to act both on choline-esters and on certain aliphatic esters.
2. Absence of the self-inhibitory effect of high substrate concentration.
3. Greater sensitivity to the organic phosphate anti-cholinesterases DFP, TEPP, Parathion, tri-ortho-cresyl phosphate.
4. Inability to hydrolyse acetyl-beta-methylcholine and by its hydrolysis of benzoylcholine.

Determination of pseudo-cholinesterase, normal values

The role of plasma-cholinesterase in human metabolism is not fully understood.

PSEUDO-CHOLINESTERASE.
Non-specific cholinesterase.
Cholinesterase.
Butyro-cholinesterase.
Plasma (or serum) cholinesterase.
"s" type (s = serum).

Unlike true cholinesterase it is not essential for survival as it can be completely inhibited by DFP apparently without any harm accruing. It is known to be a muco-protein formed exclusively by the liver. After complete removal by inhibitors it will reach its original level in the plasma again within 10 days. It is usually measured by incubation of serum with acetylcholine in a $NaHCO_3/CO_2$ buffer. On hydrolysis of the ester, choline and acetic acid are formed. The acetic acid will react with the $NaHCO_3$ to form Na-acetate, water and CO_2 , and the CO_2 development can be measured in a Warburg micromanometer. The units of cholinesterase equal the $\mu l CO_2$ liberated by one ml. plasma or serum in 1 min. at $37.5^\circ C$. The measurement by the Warburg technique is cumbersome and a number of alternative methods have been described; none of them has as yet been found to be as reliable and accurate. The normal level in human adults varies between

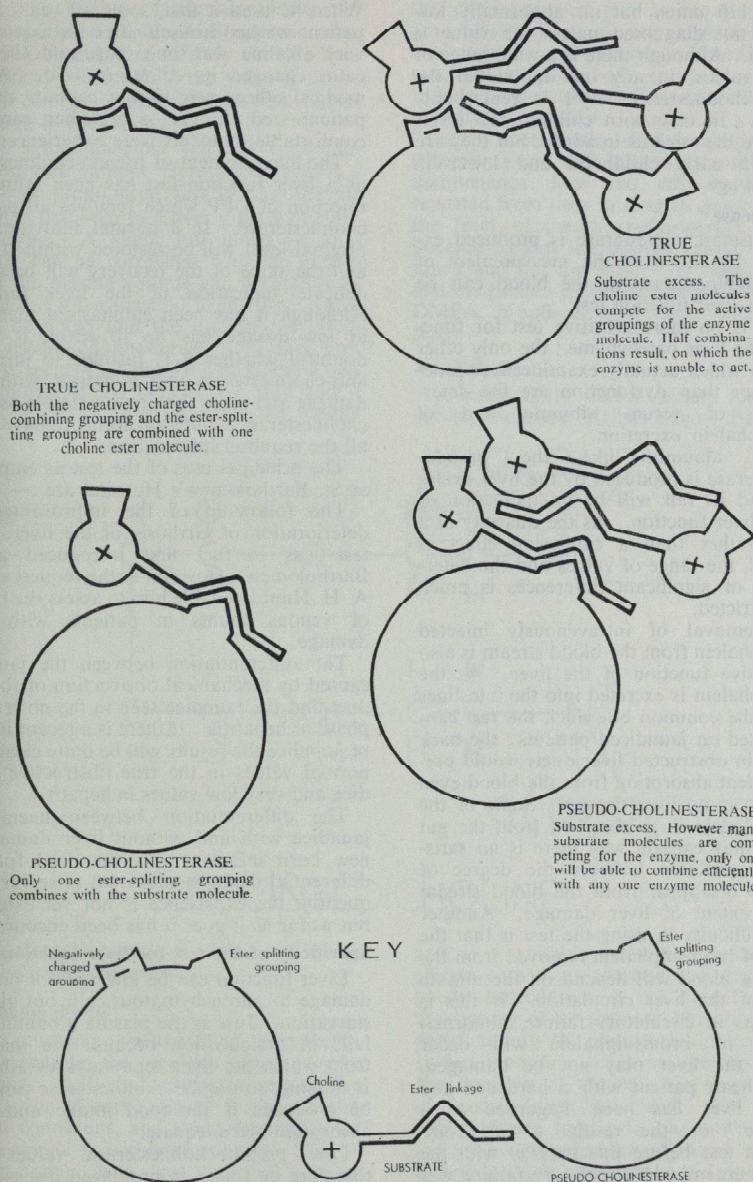


Fig. 1. Combination of true and pseudo-cholinesterase with substrate-inhibition of true cholinesterase by high substrate concentration.

65 and 110 units, but an abnormally low level is not diagnosed unless the value is below 55. Although there is a wide range of normal values, in any one individual the plasma cholinesterase level is remarkably constant. In new born children the levels found are the same as in adults, but they are higher in early childhood and lower in advanced age.

Liver disease

As plasma-cholinesterase is produced exclusively by the liver the measurement of pseudo-cholinesterase in the blood can be used as a liver function test.

There is no more sensitive test for function of the liver parenchyme; the only other two tests which actually examine liver function rather than dysfunction are the determination of serum albumin and of bromsulphalein excretion.

Serum albumin like the pseudo-cholinesterase is produced by the liver exclusively and its fall will be an indication of lowered liver function. As the quantity of a protein rather than a catalysing effect is measured, the range of values and the determination of significant differences is much more restricted.

The removal of intravenously injected bromsulphalein from the blood stream is also an exclusive function of the liver. As the bromsulphalein is excreted into the intestines through the common bile duct, the test cannot be used on jaundiced patients; the back pressure in obstructed liver ducts would prevent efficient absorption from the blood even if there was no liver damage. Some of the bromsulphalein is re-absorbed from the gut and this may explain why there is no satisfactory correlation between the degree of failure to disappear from the blood stream and the extent of liver damage. Another serious difficulty in using the test is that the amount of bromsulphalein removed from the circulating blood will depend on the minute volume of the liver circulation. If this is lowered as in circulatory failure, abnormal retention of bromsulphalein will occur although the liver may not be damaged. Many a heart patient with a hardened and enlarged liver has been diagnosed as a "cirrhotic" on the results of a bromsulphalein test before this parallel with the pre-renal uraemia in circulatory failure was appreciated.

The writer has to admit that he is somewhat prejudiced against bromsulphalein.

When he used it first, some 10 years ago, a patient washed himself after the test with a very alkaline war-time soap, and the indicator changed its colour *in vivo*. As the medical officer was then a captain and the patient—red all over—a brigadier, some uncomfortable moments were experienced.

The measurement of pseudo-cholinesterase as a liver function test has been refined by injection of DFP which removes all pseudo-cholinesterase. In a normal individual the original level will be restored within 10 days and the slope of the recovery will be a very delicate indication of the liver function. Although it has been emphasised that DFP at low dosage has no ill effect, it seems doubtful whether it is justified to inject an anti-cholinesterase into a patient with liver damage and up to the present simple pseudo-cholinesterase estimation seems to have given all the required information.

The principal uses of the test as employed at St. Bartholomew's Hospital are:—

The follow-up of the improvement or deterioration of cirrhosis of the liver. The test was in fact first introduced at St. Bartholomew's Hospital at the request of Mr. A. H. Hunt to enable him to assess the results of venous shunts in patients with liver damage.

The differentiation between the jaundice caused by mechanical obstruction of the bile duct and the jaundice seen in the obstructive phase of hepatitis. If there is a recent history of jaundice the results will be quite clear cut: normal values in the true obstructive jaundice and very low values in hepatitis.

The differentiation between haemolytic jaundice with and without liver damage in new born infants. As the need for this differential diagnosis does not arise very frequently, the experience is not yet extensive but as far as it goes it has been encouraging.

Specificity of the test for liver function

Liver function can be lowered not only by damage to parenchymatous cells but also by starvation. Just as the plasma albumin level falls in malnutrition because the material from which the liver manufactures albumin is missing, so pseudo-cholinesterase can only be produced if the food intake and food absorption are adequate.

Low pseudo-cholinesterase values will therefore be found in prolonged disease, but unless there is gross starvation the values will only be slightly below normal. Thus if in a jaundiced patient with carcinomatosis

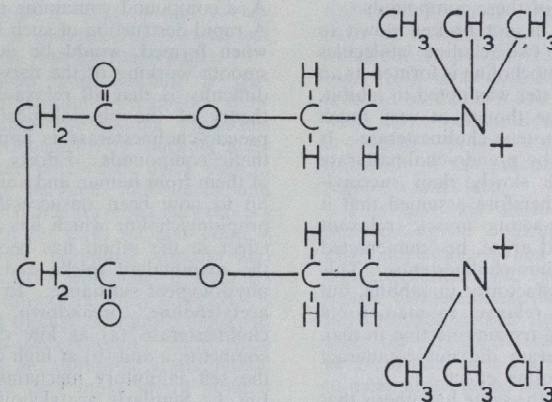
and with a history of chronic illness and under nutrition a pseudo-cholinesterase value of 40-55 is found, it is unlikely that the liver is specifically affected, if the value is 30 or below it can be assumed with great likelihood that there is liver damage.

Very severe anaemia can lower pseudo-cholinesterase values. Here again there is a much less pronounced fall of the enzyme level than that seen in a liver disease of similar gravity. A slight fall noted in mild anaemia can be correlated with the expansion of the plasma volume and if corrections are applied for a lowered haematocrit value it will be noted that the quantity of circulating pseudo-cholinesterase is in fact normal. It seems that the liver produces a certain amount of the enzyme per day and if the blood cell volume falls and the plasma

the cholinesterases but in the body it is gradually transformed into a powerful anti-cholinesterase which by a stoichiometric reaction removes both the true and the pseudo-cholinesterase. The gradual *in vivo* hydrolysis of OMPA makes it a suitable "depot" therapeutic. Pseudo-cholinesterase determinations will help in establishing the maintenance dose and will have to be repeated from time to time to check whether the level of pseudo-cholinesterase remains lowered to just the desired extent, not too much and not too little. As both the true and the pseudo-cholinesterase are affected by OMPA, it suffices to estimate only one of them.

Anaesthetics

A particularly useful muscle relaxant is succinylcholine. It has a short-lived effect.



SUCCINYLDICHOINE

volume rises the pseudo-cholinesterase circulates at a lower concentration.

Myasthenia gravis

The muscular weakness of myasthenia gravis resembles the paralysis seen in curare poisoning. Anti-cholinesterases restore the transmission of nerve stimuli to the muscles in both conditions, and the compound used in myasthenia gravis is neostigmin. This is a short-acting drug and recently another "anti-cholinesterase" OMPA (octamethyl pyrophosphoramidate) has been recommended. OMPA by itself has no inhibitory effect on

and is a suitable relaxant for intubation, electro convulsion therapy and short orthopaedic procedures. It has been found that the brevity of its action is due to its rapid destruction by the pseudo-cholinesterase, and in fact there is a direct relationship between the duration of the effect of a given dose of succinylcholine and the pseudo-cholinesterase level. In patients with very low pseudo-cholinesterase level succinylcholine produces a prolonged apnoea and injection of the enzyme can counteract this.

Research in the effect of pseudo-cholinesterase on succinylcholine has had

some interesting results. It was found that succinylcholine inhibited the true cholinesterase and it was suggested that its action was due to this chemical inhibition as well as due to its well-known physical effect of depolarising the nerve end plates. This unorthodox view was supported by findings in dogs where succinylcholine is a much more powerful relaxant than in man. It was found that the only difference between the enzymes of the blood of man and dog was a much lower level of true cholinesterase in dog, and the most likely explanation was that in fact the chemical inhibition of true cholinesterase was an essential part of the relaxant action of succinylcholine. Since then this chemical effect of muscle relaxants has been fully elaborated as a fact by pharmacological experiments elsewhere, and is now considered to be as essential as the depolarising action of these compounds.

Succinylcholine is not broken down to succinic acid and two choline molecules directly, succinylmonocholine is formed as an intermediate. This ester was noted to inhibit, like succinylcholine though at very much higher concentration, true cholinesterase. It was also destroyed by pseudo-cholinesterase though much more slowly than succinylcholine. It was therefore assumed that it might be a longer-acting muscle relaxant which could, if need arose, be counteracted by injection of pseudo-cholinesterase. This scheme worked satisfactorily in rabbits, but although a suitable relaxant in man, for a hitherto unexplained reason injection in man of pseudo-cholinesterase did not counteract the succinylmonocholine effect.

Working still with the same hypothesis that a choline-ester was a relaxant if it inhibited true cholinesterase, and that the duration of its effect was dependant on the speed of its destruction by pseudo-cholinesterase, benzoylcholine was used on rabbits. Benzoylcholine is an inhibitor of true cholinesterase and is destroyed at least as rapidly as succinylcholine by pseudo-cholinesterase. It was found that in fact benzoylcholine was a short-term muscle relaxant of equal efficiency as succinylcholine. Unfortunately, benzoylcholine raises the blood pressure in rabbits and although it seems to be free from some undesirable side effects of succinylcholine, great care will have to be exercised if its application in anaesthetics of humans should be considered.

The author wishes to thank Mr. N. K. Harrison for preparing the diagrams in this article.

Possible physiological function of pseudo-cholinesterase

From the experiences with succinylcholine and succinylmonocholine which inhibit the true cholinesterase and are in turn destroyed by the pseudo-cholinesterase, we suggested that the physiological function of pseudo-cholinesterase might be that of a protecting enzyme. Pseudo-cholinesterase is always found in close neighbourhood to the true cholinesterase; in the brain it is mostly in the white matter close to the true cholinesterase in the grey matter; in the intestines, the heart, the muscles, everywhere both enzymes are closely associated. It is most likely that succinylcholines and similar esters are formed *in vivo* by enzymes esterifying aliphatic acids. These enzymes are well known to occur in liver and brain, where their action is catalysed by coenzyme A, a compound containing pantothenic acid. A rapid destruction of such inhibitory esters, when formed, would be necessary for the smooth working of the nervous system. The difficulty is that all relaxants to which this theory of the physiological significance of pseudo-cholinesterase is applicable are synthetic compounds. Efforts at isolating any of them from human and animal tissues have up to now been unsuccessful. However, propionylcholine which has a slight relaxant effect in the rabbit has been isolated from the mammalian spleen and is thus a truly physiological substance. *In vitro* it inhibits acetylcholine breakdown by the true cholinesterase (a) at low concentration by competition and (b) at high concentration by the self inhibitory mechanism described in Fig. 1. Similarly acetylcholine, were it ever allowed to reach a high concentration, would of course inhibit the true cholinesterase, and it would then have to be removed by the pseudo-cholinesterase. While there is still much work to be done to explore the theory of the possible protective function of pseudo-cholinesterase we know already at least two physiological compounds: acetylcholine (at high concentration) and propionylcholine (at low and high concentration) which are capable of inhibiting the true cholinesterase and which when formed in excess could produce symptoms of acetylcholine poisoning. The removal of these two esters by an enzyme such as pseudo-cholinesterase would be essential for the orderly progress of nervous transmission.

WOODLICE? SO WHAT!

by THOMAS HUXLEY

THE daily round of many men brings them at intervals, when a natural function forces them to pause, face to face with a wall upon whose plastered, plastic or papered surface they must inevitably gaze. Not many men are fortunate enough to be able to carry out the research of their choice at the tax-payer's expense. Fewer still are able to carry out their researches at these moments. Yet I am one. The intense satisfaction that I receive and, surely, the tax-payer also were he to know, in being able thus to fill this unfor-giving minute with a hundred and twenty seconds' worth of distance run, has at last found its outlet in your journal's pages.

The wall under consideration is permanently damp. Minute organisms grow upon it, and upon the minute organisms browses *Porcellio scaber*. By marking these animals with little patches of black paint I may distinguish between individuals and thereby record distance travelled between my visitations. Then for days on end none is seen, until a new individual appears and moves slowly up the wall until it becomes lost from view among plumber's tubing. It would be wrong to cast premature judgment on these mural observations. Here, they merely serve as an admirable introduction, considered alone they must surely point a moral.

When a book-lover looks at a book he might be interested in that book from a number of different points of view. For instance, the binding and the man who bound it, the printer and the different type he used, the kind of paper it was printed upon, or the publishers. Eventually he might think about the author, the edition or the price. Were he also in an expansive mood, he would undoubtedly surprise most of us with the multitude of interesting considerations (quite apart from the *contents*), attending that which lay in and between the covers of a book.

Trusting in your common sense to prevent me from seeming guilty of being described as an *Oniscophile*, I will here note down some thoughts that occur to me when I look upon a specimen of *P. scaber*.

First, I know it to be a woodlouse because it possesses the l.c.d. of all British woodlice, namely, an approximately oval outline with a pair of fairly distinct antennae the tips of which may be delicately touching the substratum, because its back view presents a head apparently hunched up into the shoulders of the segment immediately behind it, because the remaining obvious segments number more than seven, because it is living out of water in the British Isles, and finally because, if I pick it up and look on its underside, I can see that it possesses seven pairs of walking legs. That it is a species called *Porcellio scaber* I may be fairly certain, even from a distance, because of its size (about a centimetre), and its dull grey colour; while closer examination shows that its back is covered with tiny tubercles. Detailed confirmation of the identification would only require a hand lens.

This leads me on to be thankful that I am working on a group of animals whose gross appearance when seen in the field is highly characteristic and almost entirely unique to themselves, not only to the adults, but throughout their lives. Further to this, there are only 38 different kinds of woodlice in the British Isles and of these I am likely to meet, at the most, less than a dozen. Compare this to a man studying a group of beetles. He begins with over three-and-a-half thousand different kinds in the British Isles alone, and he will almost certainly have to make, at least initially, quite an effort before he becomes familiar with the taxonomy of even a small group.

And why is the woodlouse so easy to recognise? Answer, by analogy: for the same reason that a wing commander is easy to distinguish when messing in Aldershot. The woodlouse and the wing commander are both out of the element of their close relations.

Woodlice in fact are Crustacea, the majority of whom are aquatic. Woodlice even smell of crab when they die. Often called terrestrial Isopods, they are one of the few Crustacean minority groups that have ventured on land. Crustacea in the sea,

insects on land. Place a Porcellionid among its aquatic Isopod cousins in a museum cabinet and it will look much like all the rest. Among its ecological neighbours it appears distinct. Biology is full of exceptions, but the exception here possibly proves the rule, for a few millipedes, which may be considered as intermediates between Crustacea and insects, look much like woodlice.

The basic requirements for life on land are clearly different, even, one might add, more rigorous than in an aquatic environment. The study of the respiration, excretion and reproduction in woodlice, therefore, must be of interest in demonstrating how a minority group may overcome the difficulties inherent in breaking away from the conservatism of their ancestors. By and large woodlice have done so, it would seem, only by subterfuge, by varying the minutiae of their ancestral characteristics. More than 50 per cent. of nitrogenous wastes are still excreted in the form of ammonia, while nitrogen metabolism as a whole seems to be low. Respiration is still largely carried out by external gills involving the retention of a thin surface film of water over a broad external surface which, along with the poor impermeability of the rest of their cuticle, necessitates that they live in microclimates with high humidities. Some adaptations to terrestrial life have, of course, occurred. A number of species have developed short internal "pseudo-trachea" analogous to those of insects, a few have considerably lowered the permeability of their cuticle as well, and two or three are able to assume a spherical shape at rest, thereby temporarily possessing minimal surface-area/volume ratio, all possible aids to water conservation and survival in a wider range of saturation deficits. Water conservation for the newly hatched, delicate larva, is entirely obviated by retaining the young in a brood-pouch filled with fluid, a brood-pouch which is present in aquatic forms, possibly mainly related there to parental care and protection from predators.

Thinking of the young, I am reminded that when they are first liberated from the maternal brood-pouch, only six of the seven pairs of walking legs are fully developed. And this recalls a famous embryologist's reference to this fact, in support of his belief in the theory that phylogeny (the history of a group) is recapitulated in ontogeny (the development of the individual). His reference, in its turn, led Walter Garstang to write his

delightful little verse, *Isopod Phylogeny*,* the last stanza of which runs:

"Macbride was in his garden settling pedigrees,
There came a baby woodlouse and climbed upon his knees,
And said: "Sir, if our six legs have such an ancient air,
Shall we be less ancestral when we've our mother's pair?"

Then suddenly one becomes conscious of the debt that nearly all these thoughts owe to Charles Darwin, whose impressive presentation before the public eye of the plausibility of organic evolution hastened the revelation of a logical skeleton in biology upon which to fasten the flesh of fact.

But are not woodlice too trivial to merit attention? Who can tell? One can only agree that "the doing what little one can to increase the general stock of knowledge is as respectable an object in life as one can in any likelihood pursue." There may even be more to it for, if carefully chosen, each investigation may help to elucidate a wider field. As the above-mentioned studies on certain aspects of the physiology of woodlice are of interest when considering the physiological and morphological changes involved in a major change of habitat, so the nocturnal periods of activity in woodlice, which have been studied in the last few years, have a bearing on the "mechanism" underlying all rhythms in animals. Next door to me woodlice are being used as material for population experiments, in the hope that they may cast light on the relative importance of intra- or inter-specific competition in the control of animal numbers. My own research is concerned with the "what" and "how much" of woodlice food when considering them as members of the diverse fauna of the soil, grass-roots and woodland leaf mould.

So these are some of the questions with which woodlice workers are at present concerned. Doubtless there are a score more yet to be answered. Only note that hardly any of this work is directly related to the importance of woodlice in respect of our human, economy. Of the above-mentioned researches, that one which has the possibility of direct application is, perhaps, my own work which may have a bearing on forestry

* "Larval Forms and Other Verses," by Walter Garstang, edited by A. C. Hardy. Basil Blackwell, 1951.

management. But one cannot tell when, say, the work on the control of woodlice populations, which in itself is discovering interesting data related to other aspects of woodlice biology, might not be of interest were woodlice to become pests in this country, as they are alleged to have done in the tiny island of Tristan da Cunha. But, just as there is more to a book than its *contents*, so, one should appreciate, there is more to woodlice than their economic importance.

Of course, one cannot foretell the future. One does know, however, that in the past woodlice have impinged directly on man. *Armadillidium vulgare*, which rolls itself into a ball, is still commonly called the pill-louse, while Thomas Penny, the botanist who died in 1588, suffered from asthma and is reported by his friend Mouffet to have treated himself

with woodlice crushed in wine. Here we have woodlice playing the medical role: in culinary art they have also found their place. As late as 1885, Mr. V. M. Holt recommended "fried soles with woodlice sauce" for the second course in a menu fit for a gentleman's dining table.

Finally, if you would ask: Why the name woodlouse? (it neither is louse nor always eats wood) one can only reply: Nor does the *Hippocampus Major* look like Epsom Downs. Old names are seldom wholly consistent with the black-and-white of truth, yet they are often apt. Terrestrial Isopods have been referred to as hog-slaters, sow-bugs, and monkey-peas. There must be many more names, for woodlice are conspicuous and common. They may even be seen on a damp wall.

LETTERS TO THE EDITOR

NOT YET DIAGNOSED

Dear Sir,

Further to Dr. Prewer's article "Not Yet Diagnosed," I think your readers may be interested to hear of a similar experience that happened to me last year.

A clergyman friend of mine dining with me one evening mentioned that he was puzzled by certain unusual happenings in his vicarage which had been extending over a period of several years. He told me of various occurrences with much diffidence in case (as he put it) I should think he was "balmy." The man in question was a solid and unimaginative bachelor, approaching middle age, and with cast-iron nerves. Knowing him as I did, I felt that there must be something in it, although I was somewhat sceptical. I accordingly arranged with him to bring a representative "committee of investigation" chosen by myself, and to see if we could "lay the ghost."

On the night of July 18-19, 1952, at 11 p.m., the following came to the vicarage, and I think you will agree this committee was both varied and representative: My wife and myself, two daughters (one a teacher and the other a law student), my anaesthetist, a member of the Stock Exchange, a wine merchant, a Church Army sister, a bishop and a curate! The first thing we did was to make a tour together of the whole of the vicarage, shutting all doors and windows, and then to wait in the lounge. We did not have long to wait, for the "fireworks" started at 11.35 p.m. when the following phenomena occurred (I kept a written record with times carefully noted):

11.35 and 11.42—Doors slammed very loudly twice,

11.43—Noise of falling metal. We went to the back stairs and found scattered there six stair-carpet clips. These had come from a drawer in one of the bedrooms and when we investigated we found the drawer and the room door wide open (both were shut at 11 p.m.).

11.47—Very loud and somewhat uncanny owl-like howl. Doors slammed and more metal fell. (We found that a saucepan lid had removed itself from the kitchen and was lying on the floor on an upper landing.)

11.53—Loud whistle and door banged.

11.59—Loud howl. Faint scream and door banged.

12.15—Lavatory cistern pulled itself! We rushed up, arriving within seconds of the sound of flushing and found the chain swinging violently.

Abnormal phenomena continued to occur at very frequent intervals until 1.9 a.m., when there concluded a most interesting and totally inexplicable evening.

All the committee agreed that these phenomena were not caused by any human agency nor by anything else physical that we could account for. It was certainly not imagination. For my own part, I am no longer a sceptic and I am fully prepared now to believe anyone who tells me that he has seen a "ghost," for after all we all heard things inexplicable to us, can we reasonably doubt that some people may see odd things?

May I suggest a Christian explanation? There is no doubt that in Bible days people believed in evil spirits. In heathen countries to-day missionaries see such phenomena far too often to have any doubts as to their origin. Why not

accept the Bible at its face value and assume that such things occur? Surely this is reasonable in the absence of any evidence to the contrary. In support of this Bible view the following is the sequel to this most interesting evening:

Before we left I had a frank chat with my vicar friend and I told him that I thought whether the ultimate cause of the trouble was evil spirits or not, it was something very unpleasant and it was hindering the good work in his parish, inasmuch as it was preventing him sleeping, etc. We agreed with one or two other members of the committee that we would daily pray that God would cast out the spirit or cause the phenomena to cease. Now, although these happenings had been going on for several years *nothing further has happened except on one solitary occasion since we pledged ourselves to pray in this way*. After all, is this not merely what was frequently done in the early church known as exorcism?

If anyone can give any other explanation of all this I shall be most interested to hear it.

Yours faithfully,

C. MARTIN-DOYLE,

Mowbray House,
Great Malvern.

ADDED SOUNDS

Dear Sir,

Only after much thought am I able to bring myself to criticise the excellent article upon "Added Words for Added Sounds," by J. L. Struthers (November, 1953). He states that rhonchi are snores, rales are rattles and crepitations are crackles and, with the authority of Laennec and Samuel Gee behind them, these terms have always been good enough for me. I see no difficulty in using them in a strictly etymological sense, in that rhonchi are sustained notes and the others are not, rales being louder than crepitations because rattles are louder than crackles. He further states that "On sibili and sonori there is no disagreement." Having never been able to fathom the difference between sibili and sonori, I hope he means that we all agree that they are superfluous terms. If sub-divisions of rhonchi and rales are desirable, then they may be classified as loud, medium and soft: crepitations are always soft and so need no further designation.

My main criticism of Struthers's paper is that he has seen fit to tabulate terms used by various distinguished physicians under the headings of "dry" and "moist" sounds. Surely this confuses the question immeasurably, since all added sounds are associated with moisture, whether they arise from the bronchi, alveoli or pleura. Indeed, no part of the lung ever is dry, so far as I know.

I'm all in favour of rhonchi, rales and crepitations, and leaving it at that.

Yours faithfully,

NEVILLE OSWALD,

70, Harley Street,
London, W.1.

PS. Just off for a good stiff drink of dry water.

MUSIC OF ST. BART'S THE GREAT

Sir,

May I thank you and, through you, Dr. Steinitz for the fascinating article in the December issue on music at our famous priory church.

Dr. Steinitz has unfolded an inspiring story, and it would certainly be wonderful if, as he con-

cludes, it may be possible to hold an annual London festival of church music in the church. The setting is magnificent in the extreme, and the acoustics are perfect. It is always a deeply moving experience to be present at one of the Sunday services, impeccably sung by Dr. Steinitz's choir and at one of his London Bach choir recitals. The recent concert in October this year was a rare musical treat in every way.

Our own hospital has had association with church music of no mean order. In the last century Dr. Henry Gauntlett was organist of St. Bartholomew the Less. Among Bart's alumni can be counted the former Poet Laureate, Dr. Robert Bridges, and a one-time physician-accoucheur, Sir Francis Champneys. Both these were church musicians of the front rank, and some of Sir Francis Champneys's beautiful tunes are in Hymns Ancient and Modern, and his chants are still sung.

As an old Bart's man, I should like to state I am a Fellow for the Council of the Incorporated Guild of Church Musicians, an Anglican order founded in 1888, which confers its own diploma of associate, licentiate and fellowship, and has an annual service at Holy Trinity, Kingsway. Next year it will be on the Wednesday in Easter week.

I would be very happy to welcome any old Bart's man who is an Anglican communicant as a member of the guild and to give information regard to its various diplomas and other activities. The guild seeks to maintain the highest standard of church music in the parish churches of England, where it is very largely inspired by the incomparable cathedral tradition. The music of our beautiful priory church epitomises the splendour of the Anglican liturgy at its best.

Thanking you for printing the article.

I am, Sir,

Yours, etc.,

I. B. GROMEY SMITH,

6, Furzedown Road,
Sutton.

IF THE CAP FITS, WEAR IT

Sir,

The cult of games and societies was invented by schoolmasters to keep boys clean in thought and deed. However, a recent correspondent wishes to provide sex-appeal in the Bart's clubs to stimulate enthusiasm and to increase membership. He considers that only those who actively embrace the opportunities to be offered them are worthy to become doctors. The cure for cancer is to be found only on the playing fields of Chislehurst.

Those with sufficient initiative and imagination to amuse themselves without the aid of the Secretarial herd move that self-appointed crowd of busybodies to the depths of frustration displayed in the letter from your recent correspondent. Lots of lovely clubs, a fine body of club officers, members! Alas, for the spirit of the Upper Vith Students who stay away from the Bart's clubs at Mr. Butlin's camps have indeed some quaint ideas about the priorities of life: for many, apparently, the sole use of the hospital is as a warehouse of medical knowledge! Poor boobs, they do not realise that their first duty is to give themselves as fodder to the ego of the Secretaries.

But we who cherish freedom must not emulate the intolerance of the Secretaries and such: we must not chuck them in the fountain. I for one believe that we can co-exist. I would even venture

to suggest that they perform a useful function. But we must see them as they cannot see themselves—in perspective.

Sir, what do first-year students do after 5 p.m.? Perhaps in a crowded train they progress to a snack at Lyons and a cheerless bed-sitting room at Earl's Court, where boredom is alleviated by a study of the comparatively thrilling lives of Taenia and the fern. Meanwhile, the squash and tennis courts and the well-equipped recreation rooms are available at Charterhouse; but who will stay to play draughts on an empty stomach? Could not the College Hall make available its excellent cuisine to non-resident students and their guests? An à la carte menu from 6 p.m. to 8.30 p.m. might be ideal: not everyone can afford 3s. for dinner and a shorter mealtime might cause a crush. Then the poor could dine with their guests before going to the theatre, and the indigent could eat a bellyful and watch the television.

Would it not be possible to arrange this for a trial period of three months? If such an experiment were successful, perhaps those planning the new medical college buildings at the hospital might consider providing similar facilities there.

Yours sincerely,

J. M. BARNES.

Abernethian Room.

A BART'S REGISTER

Dear Sir,

In general practice I am often being asked by patients who are moving to another district if I can recommend a local doctor to them. My instinct is always to try to find another Bart's man for them, but this entails a very tedious bit of research into the medical directory and there is no reference there to the doctor's type of practice. (I once referred a patient to the senior M.O. of a mental hospital—at his private address.)

Is it economically or otherwise impossible to publish an up-to-date or annual district list of Bart's men with an indication such as G.P., specialist, etc., after their name. I for one would willingly become a subscriber.

Yours sincerely,

ROBERT HUNT COOKE.

20, Brampton Grove,
Hendon, N.W.4.

RALPH CROWLEY

Sir,

It was delightful to see Penry Rowland's tribute to Ralph Crowley in your last issue. We were privileged to have Dr. Crowley as a resident for years in this town and have the benefit of his wisdom, enormous energy and great personality. I well remember one of his colleagues in the Board of Education describe him as the "wandering sun-beam of the Board," a description which gave great delight to his friends. Up to the end he was much the same as Rowland describes, and it is an inspiring thought of the influence all

through life he shed abroad quite apart from the great work he did for the school life of the nation's children.

Sincerely yours,

NORMAN MACFADYEN.

Lunderston, Letchworth,
Hertfordshire.

BRUCE CLARK

Sir,

Chrichton Starkey's retrospect of Bruce Clark gives a very true picture of the man. I should like to record a vivid impression of a disarticulation at the hip joint that I saw him perform forty years ago.

A dresser compressed the external iliac artery at the groin, whilst another held the limb. "The Bruiser" inserted a very long amputation knife with a nine-inch blade obliquely inwards from the outer side of the limb directly into the rim of the acetabulum. With one continuous movement the knife encircled the limb. Towards the end of the sweep the femoral vessels were divided, and were grasped in the fingers of his left hand. The whole procedure was completed in less than half a minute.

I do not suppose any living surgeon could insert a knife directly into the acetabulum at the first attempt, let alone divide all the structures in this manner. The vessels were next sutured with Spencer Wells forceps and ligatured, and the flaps sutured. Current practice, of course, produces a much better looking and fashioned stump, but speed was then considered a very important factor in reducing shock.

BASIL HUME.

61, Harley Street.

AN APPEAL

Dear Sir,

Many of your older readers will remember the late Dr. John Hunter who was for some years Senior Resident Anaesthetist at Bart's during which time he was easily the most popular member of the Resident Staff. In his later years he specialised in anaesthesia for plastic surgery at The Queen Victoria Hospital, East Grinstead, and was possibly the greatest exponent of the art in young children. Owing to his long terminal illness and other causes, his widow has been left in very reduced circumstances. In view of the fact that she is in poor health and was a Bart's nurse, I feel sure that many would like to contribute to a fund which has been started by Sir Archibald McIndoe in order to help her.

I should be most grateful if any readers would send donations, however small, to Sir Archibald at 149 Harley Street, London, W.1.

Yours faithfully,

C. LANGTON HEWER

33, Stormont Road,
Highgate, N.6.

OBITUARY

We announce with regret the death, on December 26th, 1953, of Edward Hamilton Bruce Fox, in his eighty-second year. Dr. Fox qualified in 1896,

HOUSE APPOINTMENTS

January 1st, 1954, to June 30th, 1954

Dr. G. Bourne	M. J. Hodgson	Skin & V.D. Depts.	
Dr. Bodley Scott	M. Evans (until 31/3/54)	Dr. MacKenna, Dr. Nicol	P. J. Barber
	G. H. Bush (from 1/4/54)	Eye Dept.	
Dr. E. R. Cullinan	L. Langdon	Mr. Phillips, Mr. Stallard	M. S. Wilson
Dr. K. O. Black	A. S. Wint (until 31/3/54)	Gynae. and Obs. Depts.	
	D. M. Shaw (from 1/4/54)	Mr. Beattie	
Dr. A. W. Spence	J. H. Fairley	Mr. Fraser, Mr. Howkins	
Dr. N. C. Oswald	R. J. Blow (until 31/3/54)	K. R. Hughes, D. B. L. Skeggs (Intern)	
	I. G. Tait (from 1/4/54)	J. S. Hopkins (Junior H/S)	
Dr. E. F. Scowen	M. V. J. Fitzgerald	Anaesthetists	
Dr. W. E. Gibb	R. J. Knight (until 31/3/54)	J. R. W. McIntyre (S.R.A.)	
	A. H. M. Rimmer (from 1/4/54)	W. R. Daniel	
Prof. R. V. Christie	P. Sleight	C. J. R. Elliott	
Dr. G. W. Hayward	J. E. Cairns (until 31/3/54)	Dental Dept.	
	B. S. Jones (from 1/4/54)	R. T. Pattinson	
Mr. J. B. Hume	C. J. Porteous	Orthopaedic Dept.	
Mr. A. H. Hunt	G. H. Bush (until 31/3/54)	(Accident Service)	B. D. Hick
	M. Evans (from 1/4/54)	Casualty H.P.	
Mr. R. S. Corbett	M. A. Pugh	E. F. Brooks	
Mr. A. W. Badenoch	A. H. M. Rimmer (until 31/1/54)		
	R. J. Knight (from 1/4/54)		
Mr. J. P. Hosford	P. Knipe		
Mr. E. G. Tuckwell	D. M. Shaw (until 31/3/54)		
	A. S. Wint (from 1/4/54)		
Prof. Sir J. P. Ross	M. L. Crossfill		
Mr. J. B. Kinmonth	B. S. Jones (until 31/3/54)		
	J. E. Cairns (from 1/4/54)		
Mr. C. Naunton Morgan			
Mr. D. F. E. Nash	I. G. Tait (until 31/3/54)		
J. G. Ross	R. J. Blow (from 1/4/54)		
Children's Dept.			
Dr. C. F. Harris	R. A. Roxburgh		
Dr. A. W. Franklin	Mrs. M. R. Cudowicz		
E.N.T. Dept.			
Mr. Capps, Mr. Jory	J. P. N. Hicks		
Mr. Hogg, Mr. Cope	R. G. D. Newill		

BOOK REVIEWS

BASIC BACTERIOLOGY, by Lamanna and Mallette. Baillière, Tindall & Cox, pp. 678, illustrated. 76s. 6d.

Bacteriology as usually taught in medical schools is an applied science in which bacteria are studied in conjunction with the diseases they produce, and for the medical student a range of textbooks is available which includes practical manuals of laboratory work, and weighty volumes for reference. Students of bacteriology as a separate science, and biochemists wishing to use bacteria in their researches are perhaps less fortunate. This book, from the Departments of Bacteriology and Biochemistry of the Johns Hopkins University School of Hygiene and Public Health, is an attempt to bridge the gap between elementary textbooks and specialised monographs, and to provide the graduate science student with a guide to the basic behaviour of bacteria. The preface claims that "this book is intended to present the nature of the cytological, morphological, taxonomic, physiological and biochemical problems which confront the bacteriologist," and these aspects have been discussed at considerable length. Some fifty-

six pages are, for instance, devoted to the principle underlying the use of dyes and staining reactions and a consideration of the Gram reaction occupies eleven pages. Among subjects dealt with in other chapters are the structure of bacteria, surface properties, growth, physical factors affecting bacteria, bacterial genetics and bacterial nutrition and metabolism. A final chapter discusses theoretical aspects of chemical disinfection, short sections being devoted to penicillin and streptomycin.

For those whose main interests lie in clinical pathology this book is one for reference and one in which bacteria may be seen displayed in surprising isolation. For those for whom it is intended, it should provide a most valuable guide, although the price may deter some prospective purchasers.

R. A. SHOOTER.

A HANDBOOK OF RADIOTHERAPY FOR SENIOR AND POST-GRADUATE STUDENTS, by W. M. Levitt. Harvey & Blythe, pp. 232. 30s.

Very frequently nowadays it is necessary to choose between surgery and radiotherapy in the treatment of a patient's condition. Most students

could give an outline of the course of the surgical treatment, but very few could say what is going to happen to the patient in the radiotherapy department. No physician or general practitioner is fitted to advise a patient as to the possible alternatives of treatment unless he knows the principles and scope of irradiation treatment.

This book is very well produced and illustrated, and is of a reasonable size. The author includes a chapter which might have been entitled "Physics without tears," for he says: "It has been my experience that a great many medical men are not only not interested in this subject [physics]—but find it positively repellent." There follows an excellent chapter on the general effects of radiations on cells, tissues and organs. He then goes on to describe the application of radiotherapy to the various organs and systems of the body, including the relative sensitivity of different structures or tumours to radiation.

This is a very readable account of the subject. It is well balanced and not only is the scope of radiotherapy outlined but also its limitations, where these occur, are also described.

ADVICE TO THE EXPECTANT MOTHER ON THE CARE OF HER HEALTH AND THAT OF HER CHILD, by F. J. Browne. (Tenth Edition). E. and S. Livingstone Ltd. 1s.

It is not easy to write a booklet for pregnant women that is neither sentimental nor too technical, but Professor Browne may be congratulated on having succeeded. Plenty of factual information is given lucidly yet fully. Although written primarily for young mothers, the nurse in training who was familiar with its contents would have a sound knowledge of the physiology and elementary pathology of pregnancy and the puerperium.

FURNEAUX'S HUMAN PHYSIOLOGY, by William A. M. Smart. Longmans, Green & Co. 10s. 6d.

Furneaux's book is an old friend, and the new edition has preserved enough of the diagrams and format to induce nostalgia. As it is only a book on physiology, a student nurse would need a separate one on anatomy, but it is the candidate for the Diploma of Nursing or Sister Tutor Certificate who will find it of most value. For 10s. 6d. it supplies a full measure of information in a direct and lucid style, well illustrated. One minor error of fact is on page 188. A Rh. positive man's children need not be 100 per cent Rh. positive unless he is homozygous.

PUBLIC HEALTH FOR THE NURSING STUDENT, by P. J. Cunningham and H. M. Cousens. Faber & Faber. 6s.

Social Aspects of Disease appear for the first time in the revised syllabus of the General Nursing Council, and this book is designed to meet the demand for a book on the subject for nurse students. It contains a good amount of factual information, lightened by anecdotes and conversations with patients. There is a useful bibliography.

DUKES' BACTERIA IN RELATION TO NURSING, 2nd Edition revised by Stanley Marshall. H. K. Lewis & Co. Ltd., pp. 204, illustrated. 17s. 6d.

Dr. Dukes' book has been used for years by candidates for Sister Tutor certificates, and the Diploma of Nursing of some universities. It con-

tains an excellent account of the use of the microscope in bacteriology, and of culture and identification of organisms. The collection and examination of a great variety of specimens is described, all common pathogens are discussed; the section on immunity is good, while the chapter on antibiotics fills an important gap in the old edition. There is a brief chapter on cross infection, mostly on dressing technique, and this is one that might be enlarged to show understanding of the bacteriological problems, prosaic but very important, of the ward nurse. Nurses who take post-graduate certificates are likely to help in the teaching of bacteriology, and if there were a closer inspection in this book of the everyday bedside questions of hygiene and technique, it would be as useful to the teacher who had her Diploma as it is now to the candidate working for it.

ANATOMY, PHYSIOLOGY & HYGIENE, by A. Millicent Ashdown and E. Bleazby. (New Revised Ed.), pp. 337, illus. J. M. Dent & Sons Ltd. 10/6d.

A nurse's text book on Anatomy, Physiology and Hygiene is principally written for students taking Part I of the Preliminary State Examination. These will find that this book covers the present syllabus at a reasonable cost. The anatomical section is complete and fully illustrated. It would be improved if there were a method of indicating to the junior nurse which were the essential facts to be acquired early.

The Hygiene portion needs modernisation. Sassafras is still given as the treatment for pediculosis; rayon and nylon deserve mention as material for clothing; the flash process of pasteurisation could be described. The article on transfusions is good, though it is a little difficult to see why it was thought necessary here.

The sections on the vitamins and Rhesus groups are very good, but for tutors not student nurses.

DISEASES OF THE EYE, by Eugene Wolff. 4th Edition. With 150 text illustrations and 6 colour plates, pp. 224. 30s.

The examination candidate is more or less committed to learning his ophthalmology from a textbook, for although the subject closely borders on the territories of medicine and surgery, all too often it is dismissed to the esoteric limbo of the special department, where personal experience is confined to a few weekly sessions. Mr. Wolff's book, while in no way pretending to be a substitute for clinical observation, will at any rate meet the demand for theoretical knowledge fully and readably. A few minor points may be mentioned: it is a pity there is no preliminary chapter on the anatomy of the eye and orbit, and that operative details are not included with the descriptions of the separate conditions instead of being relegated to the end of the book. Again, the differences between the retinal changes in hypertension and arterio-sclerosis are not adequately enough stressed, and one would have liked a mention of the stages in which they are classically grouped. However, the book is well printed and very adequately illustrated, and should be deservedly popular with final year students.

S.P.L.

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DEBT AND OTHERWISE

MR. SOMERSET MAUGHAM is eighty years old. In a broadcast some weeks ago, he talked, among other things, of the time that he spent as a medical student at St. Thomas's. Speaking of those years, he said: "They taught me pretty well all I know about human nature, for in a hospital you see it in the raw."

Few writers know more of human nature than Mr. Maugham. His stories, his novels, and his plays are all studies of human nature. With a careful clinical understanding, so passionless as not even to seem cynical, he writes his superbly well told tales of cowardice, treachery, lust and simple hearted kindness. By acknowledging a clinical training as the source of his understanding, he has saved the critics of the future a lot of trouble.

Other men, too, have left Medicine for Literature. In this number of the *Journal*, we publish an essay on Robert Bridges, sometime Casualty Physician to this hospital, and Poet Laureate. His debt to Medicine is not so clear. He was a poet who wrote of butterflies in the air, of snow lazily and incessantly floating down and down, a man who saw the white clouds build and build in the June sky. There is sensitivity here, but where is the influence of the wards? Bridges was not an analyst; he was the very opposite of Mr. Maugham. Things, for Bridges, were what they seemed.

Bridges was a Bart.'s man, Mr. Maugham went to Thomas's, and Keats was a dresser under Mr. Lucas at Guy's. Keats was, for a short time, a surgeon. He hated the work. Perhaps it was in part his medical education that encouraged the introspection that made him a great poet and an unhappy man. The last operation he ever performed was the opening of a temporal artery. He wrote of

this: "I did it with the utmost nicety, but reflecting on what passed through my mind at the time, my dexterity seemed a miracle, and I never took up the lancet again."

The more you look at the doctors who have become writers, the greater is the diversity that you find. There is Rabelais, who made the change the other way round, jesting with licentious humour, taking up the study of medicine at the age of forty-seven. There is Oliver Wendell Holmes, a Professor of Anatomy and Physiology at Harvard, a man who wrote gentle and whimsical essays. So little have all these men in common that they might have been chosen with a pin.

As well as the famous, there are the less well known who have written perhaps only one book, and even that has gone down to posterity in the reduced-to-sixpence book-stall, or in the more honoured obscurity of the British Museum. John Esquemeling was a surgeon and a buccaneer, and when he retired from this mixed practice he wrote a book about it.

Does this all show that an acquaintance with "human nature in the raw" is a good training for a writer? Freud knew much of the anatomy of human behaviour, but no one has ever supposed that he would have made a great novelist. To look at a man with his clothes off, or to look at nature in the raw, cannot give the whole understanding of civilised man. In hospital we see only the grosser manifestations of disease, and we see there also only human nature in colours that are splashed and daubed, obscuring the details and complexities of normality.

Keats, Bridges, Maugham, and you can easily make the list longer and even more varied. But what is the use of making a list? Some few men who have written well have

been doctors, but what is to be implied from that? It cannot be claimed that Medicine makes poets or novelists, for the genius of a great writer is a gift that may be trained or neglected, and it is not something that is made by a degree course in medicine, or even by twenty years spent as a tramp. The list

would show only this, that a few of those writers whose greatness has been their knowledge of the varieties and vagaries of mankind, whose great interest has been in human nature, served an apprenticeship in the wards, and we are proud that they were once members of our profession.

Zermatt, 1954

P.V.R. writes:

The Ski Club holiday was an unqualified success from the outset, thanks largely to the efficiency and grand teamwork of Geoffrey Dawrant (secretary), Priscilla Foulds (committee) and Richard Beard (treasurer) in arranging travel and hotel bookings. The journey both ways passed uneventfully.

Zermatt was bathed in sunshine when we arrived and, with the exception of two half-days, remained so until we left twelve days later. Recent snowfalls made the vital initial ski conditions good and in a day or so the Bart's onslaught was in full swing over the "nursery" slopes.

As it was an off-season period we were rapidly adopted by the Swiss Ski School, S.C.G.B., and village folk alike, and welcomed openly wherever we went. In particular, I should like to thank Miss Farquharson (S.C.G.B.), Mrs. Fairclough (Continental Secretary), Gottlieb Perren (Ski School Director), Hans Furrer (Chief Instructor) and the President of the Commune of Zermatt for their kindness and great help in matters social and economic.

After "Thé Dansant" over hot chocolate and meringues we would usually plan an evening dancing in one of our favourite haunts. The Walliserhof, besides being the ski instructors "Hand and Shears," was always good for an eightsome reel or music from "The King and I," in contrast to Swiss or Continental dance bands elsewhere. Whenever we went to the Zermatterhof (Zermatt's Savoy) we always contrived to win at least half a bottle of wine on dance competitions, making the visit well worth while!

We stayed very comfortably at the Hotel Dorn, which provided sunny balconies facing the Matterhorn, and food which was most excellent. Again, Herr and Frau Lauber were kindness itself.

Outstanding impressions of the holiday: the president complete with bobble cap and pipe negotiating the "National"; one gentleman brewing tea over a "meth" stove in the Swiss train; Hans Furrer and the Matterhorn, the two great "characters" of Zermatt; ham and eggs at Riffelberg in blazing sunshine; sleigh bells and NO motor cars!

Despite icy conditions after sundown—for we had only just enough snow in the latter part of the holiday—we are pleased to record no serious injuries, and all twenty-seven of us live to ski again next year!

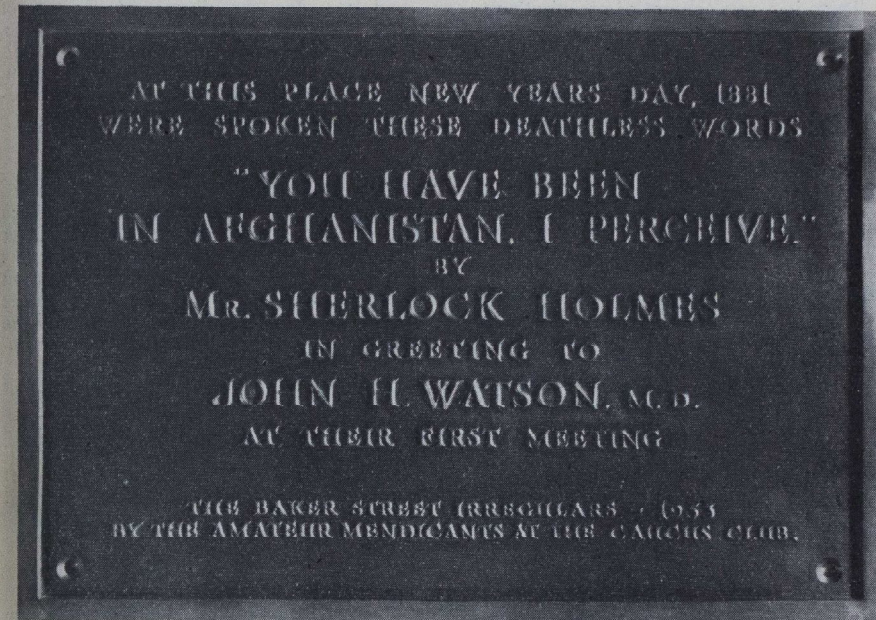
We left, having made many friends in Zermatt whom we look forward to seeing again; meanwhile we invite all Ski Club members, and anyone else interested, to a "Reunion" on Wednesday, March 10th, when snaps taken out there will be on view and the movies will be shown.

Abernethian Societv

Dr. Melville Arnott, Professor of Medicine at the University of Birmingham, is making a special visit to London to address the Society on "The Aetiology of Cardiovascular Disease."

This lecture will take place at 4.30 p.m. in the Clinical Lecture Theatre on Thursday, March 18, and *not* as announced in the Society's programme.

It is hoped that as many members as possible will attend.



THE BRONZE PLAQUE

The Case of the Bronze Plaque

There were a number of clues. Those who, on the morning of January 22nd, read the paper after breakfast must have been surprised to see that a little unceiling had been going on in Bart's. Accounts differed, the clues were confusing. In one paper there was a paragraph headed "Plaques Galore," which gave the impression that there had been a bored and casual party in which someone had nailed up yet one more plaque. Another paper reported the happenings with the polite good humour that might be used to greet a bishop's sporting reminiscences. An evening paper had announced, in heavy type, "Sherlock Spoke—to Dr. Watson."

The party certainly resulted in a bronze plaque, for the photograph above has not been faked. But what sort of a party was it? We visited the room. We had forgotten our magnifying glass, but there were no blood stains visible to the naked eye. There was a smell of fresh paint.

View Day Ball

The Students' Union is holding its annual ball at the Royal Festival Hall on Wednesday, May 12th. It will be called the View Day Ball, and it is being held on that day so that old Bart's men who are revisiting the hospital on View Day will be able to round off their visit with a dance.

Last year the Coronation Ball was a very great success. The View Day Ball is going to be run on the same lines and it, too, will be open to all members of the hospital staff. Dancing will be from 11 p.m. to 5 a.m., to the Curzon Orchestra. For those who have been practising their Scotch Hopping, there will be a piper. There will be a running buffet and breakfast.

Double tickets are 50s. and they may be obtained from Miss Wynn (Charterhouse), Bert Cambridge, G. Harris, E. Clissold, L. Pringle and Miss L. Fletcher (hospital), or by posting off the special form to be found in this issue of the *Journal*.

There is a vast amount of organisation to be done and it would greatly help the Committee if those who are coming to the dance would buy their tickets early.

Last year's ball provoked someone to exclaim, in lyrical verse, "Was it a dream?" To dream again. . . .

Musical Therapy

The Hungarian News and Information Service has sent us a circular on the cure of mental cases through music. This Information Service often sends us its bulletins, detailing the achievements of Medicine in Communist Hungary. This is the sort of propaganda that Bernard Shaw advocated, and presumably the British Council does much the same kind of work. Whether this propaganda is pernicious, or alternatively whether it helps towards the true understanding of nations, might well be the subject of an impassioned debate.

The latest circular that we have received tells of a project, based on Pavlov's theory of conditioned reflexes, in which a team, aided by an artist from the Budapest Opera House, is experimenting with musical therapy. It has been noticed that a particular song not only cheers patients up, but calls forth memories with an adjusting effect. Deranged people who had previously been quite unmoved by normal vocal approaches were seen to develop a rapt expression, even animation, at operatic concerts. It is supposed that the "musical centre" in the brain is a more ancient thing than the centres of speech and hearing. It is not clear whether the Pavlovian theory was used for prediction, or only for explanation.

History

Medical men have a great and proper regard for the history of their profession. Everything is more interesting when its beginning is known. Inevitably, the names of Hippocrates, Galen and Osler are sometimes used more as spells and incantations than as true marks of deep learning.

A recent publication sent to the *Journal* shows that in the United States the study of medical history is prodigious. There are five Departments of the History of Medicine on a full-time university basis. They are at Johns Hopkins, Yale, Chicago, Wisconsin and Illinois. These departments examine

candidates for the degree of Doctor of Philosophy in the History of Medicine. Perhaps the English view is more that medical history should be a spare-time occupation. So Osler thought, and I cannot find a relevant reference to Hippocrates.

A Visiting Lecturer

In January, Dr. Crile, who was over here on a visit from America, gave a 12 o'clock morning lecture to the Medical College. His subject was the surgery of peptic ulceration and of ulcerative colitis. There was a large audience to hear him and the applause at the end would have satisfied the vainest of matinée heroes.

The teaching was different from that usually heard at Bart's, particularly the advocacy of vagotomy as an adjunct to a partial gastrectomy. The lecture was beautifully argued and presented with that rare gift that makes one forget that it is a lecture, and think of it just as a man talking.

Student Papers

In the days of its zenith, the Abernethian Society used often to have papers read to it by its own members. This excellent idea has now been revived; perhaps the fortunes of the Society are climbing towards a new zenith.

At a recent evening meeting in College Hall, Mr. Anthony Thould read a paper on Polycythaemia. Mr. Graham Harris read one on Rectal Examination, and Mr. John Copplestone gave a paper on Peripheral Vascular Discases. It requires courage to stand up and deliver a paper at a meeting where everyone is wondering whether the evening is going to be a success or a notable failure. The evening was a success.

No doubt, despite the strain of the actual performance, those who read the papers enjoyed the work that they did in preparing them. The audience certainly enjoyed hearing them, and there was a pleasant air of mellow enthusiasm about it all, which was much helped by Dr. Balme's chairmanship.

Change of Address

Dr. Douglas Stathers, to Annandale Haverstone Valley Road, Caterham, Surrey Telephone: Caterham 2734.

PARTY IN PRAIA

by W. R. P. BOURNE

It is six o'clock in the morning of September 18, 1951, and I am awakened by one of the young ladies who come to use our showers. I am sleeping on my stomach because the hard floor gives me backache. I turn over and, while I collect my thoughts for the day, I watch the kites and vultures fly up and down outside the window. The visitor, who learnt her English manners when the sailors of the Vanguard had shore leave here a year or two ago, says hopefully "You like me?" but I scowl at her, so she gives me up as a bad job and goes through to wash. It is my last day in the islands, in all probability, so I decide I will spend it around Praia checking up on the local birds, rather than go inland among the mountains and coffee plantations. Also, it is necessary to organise the party we shall have to-night, though I can leave that until later. I get up and put shorts, bush-jacket, and sandals on, and go out, leaving Diva still asleep.

Diva is an Indian from Goa, a young enthusiastic schoolmaster trained in Calcutta, who was so unwise as to engage in certain dubious political activities which resulted in his summary deportation when he returned to his home town. He is now living in the Cape Verde islands on a small allowance granted him by the government, and I have been living with him during the majority of my two months in the islands, for company and economy. He speaks little Portuguese, while I am unable to find anyone able to maintain an intelligent argument in English, so we get on very well together. We live in the smaller half of a little four-roomed, one storey, white house overlooking the battlements of the old town; we have a single room and outhouse, the former furnished with an iron bedstead and suitcase belonging to Diva, and my rucksack, sleeping bag, and mattress; and the latter with the cold shower that makes life tolerable in the middle of the day; and we are very happy here. We are supplied with the best cooking on the island by the local hotel for twenty escudos, which is five shillings, per day, and given any other necessities of life by our landlord, a small, round, merry metropolitan Portuguese

who lives next door. For company, we have the intellectual clique of the younger members of the administration, who are all busily learning a sort of English from Diva, and for entertainment we have the view over the harbour from our window and the best Scotch whisky at ten shillings a bottle. We read the Bible, the Oxford Book of English Verse (thin paper edition) and a textbook of Pharmacology, brought by myself, and we also read a number of blue philosophical Pelicans and several years' accumulation of the *Saturday Evening Post* lent to Diva by sundry administrators; and every Thursday night we go to see some American film at the open-air cinema down the street.

When I go out, the street outside is still cool and shady, while the low brown hills of the desert surrounding the town and the green cultivated slopes of the mountains beyond them have not as yet begun to dance in the mirage, as they will in an hour or so. It is a clear still morning, with little tufts of cloud along the crest of the main ridge of extinct volcanoes inland, and through my field glasses I can see people hoeing among the young green maize of the fields on the upper slopes. Nearer still the lower foothills, which have received much less rain, are still bare and dusty, while little flocks of wandering goats, each in the charge of a small boy, are searching for the wisps of dry grass which were left behind at the end of the last rains, when the grass dried to hay as it stood.

I know I shall have about two hours before it becomes unbearably hot out in the open desert, so I go out on to the old airport behind the town to watch larks. The airport is unused now; it was built before the war by a small French firm, but when France fell in 1940, the Portuguese decided to make use of their opportunity and requisitioned it. It has been lying derelict ever since, an open expanse of desert swept clear of stones, and it is one of the only two places in the islands where I have succeeded in finding the local race of sand-larks. I find a little flock of larks there now; it consists mainly of big, heavy black and white finch larks, but accompanying them are a

pair of sand-larks, smaller, slighter, much more active, and red like the soil they feed on. It is interesting that the two species feed together; the heavier finch-larks stick to the dry seeds that lie waiting for rain in the dust, while the others dash round them catching the flies they disturb. I know that both species must have nests now, because the majority of the female finch larks have disappeared over the last ten days, and the sand-larks are carrying straw; but I fail to find any nests in the two hours I have allowed, and it is then so hot that I am glad to give up and go in under the trees. As far as I know, nobody has ever described the sand-larks' nests in the islands; perhaps one day I shall be able to do so, but not, it would seem, on this visit.

After leaving the airport I walk down the gully to the east of the town until I come to the beach. It supports nothing but a selection of palms, whose long roots can reach the water beneath the surface. On other islands I have seen windmills used to irrigate such places, but here the population is either too poor or too idle to install them, and the old fields, having dried up, are used by small boys as a football pitch.

There is a crowd of small boys playing now, and I watch them for a while, not because I am in the slightest interested in football, but because the inhabitants of the islands are a phenomenally interesting racial mixture. The basis of the whole is West African Negro, because the group was apparently largely settled by slaves imported from West Africa when it was a great transshipping centre for the trade in the eighteenth century. Since then the mixture has been very largely diluted by the addition of Portuguese settlers, and the activities of the sailors of all nations who have had leave at one time or another in the port of St. Vincent. As a result of this combination, there is a complete range of colour—from the pure Portuguese to pure Negro—with a considerable incidence of blonde hair, blue eyes and freckles. There is, perhaps, an unusual incidence of displastic individuals of a peculiarly vicious appearance in the population; their presence is counterbalanced by the presence of an equal number of particularly handsome people who are very often their brothers or sisters. It is interesting that in this mixed community there is no serious colour bar, in marked contrast to the situation I knew in a British colony, Bermuda. On the other

hand, there is a marked social distinction between the metropolitan from Portugal and the native of the islands, a distinction that was absent from Bermuda.

I leave the football match after ten minutes' philosophising and ten minutes' conversation with one of the local youths who is attempting to learn English. He has just bought a bicycle and is having trouble with the back brakes, which we discuss in detail. Then, leaving him, I climb a narrow path up the side of the old fortifications which will bring me home; on the way I disturb the town's company of vultures from their mid-day roost, where they are comfortably digesting their morning meal of garbage and human excrement. There are thirteen: twelve are beautiful black and white adults, marred only in their appearance by evil yellow faces; the thirteenth is a filthy, scruffy, brown juvenile. It will take this urchin three years to grow up: it is an interesting reflection that if it takes twelve vultures to produce one youngster every three years (this ratio is general), presumably it must take some thirty-nine years for the vulture population to replace itself. This suggests a vulture must live some two score years; almost a record among birds, and not bad for a man in some parts of the world. At the same time, vultures have almost disappeared from those parts of the archipelago where the sanitation has been improved, so that it seems likely that, assuming conditions improve in Praia as they are doing elsewhere, this little flock will be starved out long before it can replace itself at all. Even now they look hungry, but then, that is the nature of vultures.

Since it is now past nine, I return home and wake Diva. So far he has slept stolidly through the comings and goings of that large and extremely disreputable portion of the population whom out of a disinterested love of general hygiene we allow to use our shower; now, however, he gets up and begins to sing what he assures me is the "Internationale" while he cleans his teeth. We both have showers, do our hair and walk through the middle of the town to breakfast, watched with envy by the working population who have all been labouring since dawn.

During breakfast, which consists of bacon omelette, bread, butter and the local coffee (which is claimed, with some justice, to be the best in the world), we debate the journey of a German refugee to South America in



Cabo Verde. Midello from Monte Verde

a rowing boat, and wonder, without conviction, whether Diva could do the same. We eventually resolve that he would be far too seasick.

After breakfast, we spend the rest of the morning wandering round the old town, working up an appetite for lunch, and then we go to call on Tedo to discuss our farewell party.

Tedo is the son of a large Cabo-Verdian landowner in another island, and works in the accounts department of the administration. He is tall, dark, cadaverous, and twenty-two: he is busy learning English, since he hopes to go to the United States to learn farming. His office is a room in one of the old forts near the main gate of the town, overlooking the whole town and most of the island beyond it, and since this room has a perfectly panoramic view and he keeps

us waiting, I photograph the town from his window. We then decide how we think the town should be planned, if someone would only provide a few million dollars. I am just taking the fifth shot of my panorama when Tedo arrives, and he immediately has to see and discuss my camera, which he thinks a poor one. When, in ten minutes or so, we have finished that, we next inspect and admire the month's pay of the entire administration he has just made out and is about to deliver. It immediately becomes abundantly clear to us that the administrators whom we have regarded with awe, must live lives of the strictest economy: we all wonder somewhat cynically how they meet their expenses. Then, finally, we get round to the party, and resolve to have a special conference to discuss it at Manuel's house before lunch. Tedo then goes away to deliver the salaries to the impatient civil service.

Manuel is a small, round, freckled person of very high spirits who is sadly oppressed in his home life by a number of extremely pretty sisters of a religious cast of mind. They have made home so uncomfortable for him that he has migrated down the garden to a room in the stables, and when we eventually finish our second session in the square with the lemonade and run him to earth there we find him sitting disconsolately in his room between two half empty bottles of wine, listening to South American dance music on the radio and contemplating a wall completely covered with a series of extremely daring pin-ups. He explains that he has got the *saudade* (a word meaning regretful longing, which everybody tells me they are unable to translate into English because the English never get it). Apparently his latest girl has been sent back to Brava by her parents, who distrust his influence. He feels very black: but five minutes of our society, two large whiskeys, and the recollection that another old flame is due to return from St. Vincent on the boat that will take me away, restores his spirits, and he is ready to discuss parties by the time Tedo and Arturo arrive.

It is supposed to be our party, but Arturo is the real organiser, as he is general organiser to every party on the island. He is a small, lightly built man with a little black moustache, the son of one of the largest merchants in the town, and he is supposed to assist in running his father's business. Actually, this means that he spends the day driving furiously up and down the island in the firm's Austin, the evening singing for Radio Praia, and the night providing life and soul for, usually, some two or three parties at once. In Praia the work of the day is done during the morning: this time Arturo spends in bed. We arrange to provide a bottle of whisky and some ten litres of assorted red and white wine: Tedo agrees to obtain glasses and china; Manuel says he will prevail upon his sisters to cook the chickens we shall provide for the meal, and some nuts; and Arturo agrees to arrange the band. After further discussion concerning Manuel's affairs of the heart we finally part for lunch, having resolved to start the party immediately after Arturo's evening broadcast, at seven o'clock.

We have lunch at the hotel; to-day it starts with vegetable soup, continues with fish steaks and veal curry, both accompanied

by seasoned rice and sweet potatoes, and concludes with Guayavas and Paw-Paws, which I detest. During lunch, we discuss the iniquities of the Portuguese electoral system and the proper treatment for jiggers in the feet; after lunch, with the rest of the population, we go home to sleep, admiring Arturo's car on the way. Diva sleeps happily for two hours: I read "Adventures of Ideas" for an hour, until it is cool enough to go out, and then decide to spend the afternoon chasing Cane Warblers in the nearest plantation.

The plantation and the attached village lie in a ravine some two miles west of the town. As the shadows begin to lengthen at three o'clock I have a shower, collect my field glasses, and set out along the west coast road. This leaves the plateau holding the citadel by a narrow arch and a steep track: then it turns west straight into the sun, and after running through a loose cluster of outlying hovels, sets out straight across the open desert. I detest the march to the ravine, but luckily as I leave the last mud hut I come up with a group of villagers returning from the market in Praia, where they have been selling fruit, and one is an old sailor who accosts me in English, and I go on with him until we come to the village. We discuss different ports, the habits of sailors, the iniquity of the act restricting immigration into the United States, and the vernacular names of the local birds. When I get to the village he asks me to have a drink, and out of politeness I accept, though my time for the plantation is already running short.

I am given aguadente: raw spirit distilled directly from fermented sugar cane, the staple anaesthetic of the islands. It burns the back of the throat horribly, and I immediately wish that it is one of the more palatable orange brandies made by a second distillation over orange peel. I look at my host's hut: he has spent all his wages abroad, and is, like the other villagers, now miserably poor. The walls are made of loose stones, the roof of palm leaves, and the floor is bare earth. There is an old board door, and one rough iron bedstead which apparently serves for my host, his young wife and their innumerable pot-bellied children. Their few worldly goods are stored in a couple of old boxes on which we sit. They are dressed in the last tattered shreds of second-hand

clothing imported from America; and there is no shoe in the whole village. Their chickens and dog share the hut with them. Their standard of living is appallingly low by the very worst European standards; but they live in a warm, dry climate where the necessities of our civilisation are no more than luxuries, and they are continually occupied, and, never having heard of either ambition or politics, perfectly happy.

I play tarzan among the sailor's orange-trees for an hour, but fail completely to find one of the cane warbler's nests, though I can hear the birds chuckling and singing all around. I find three blackcap nests and flush an owl and two monkeys that are raiding the plantation, and have to be satisfied with that when it is time to go home. I say good-bye to the villagers, who give me as many mangoes as I can get into my pockets, glasses case and hat, and, in addition, two green coconuts for good measure.

It is five-twenty when I leave the village; the desert all round me is brown, yellow, and grey, with a green sheen where rain has fallen on the higher hills. Within the next ten minutes clouds begin to form on the higher mountain tops, and then, very suddenly, the sun begins to set behind the great ten thousand foot cone of the volcanic island of Fogo, forty miles away behind me. The clouds on the hills suddenly turn scarlet, and the red volcanic rock faces and pinnacles of the ranges inland light up as if they were incandescent, while further out the bare brown slopes become a mass of purple shadows broken by red, yellow and green bars where the edges of the ravines catch the light. A brilliant livid landscape stands out against a sky of rose, primrose and pale green for ten minutes; then, slowly, the greens, the yellows, and finally the reds fade as the sun disappears. Within the next five minutes the visibility falls from thirty miles to five hundred yards, and I find myself walking into Praia in the dusk among a cloud of busy white moths attended by an assortment of bats of different sizes. The last thing I hear as I enter the town is a terrific shrieking, as the Guinea fowl flocks that have been hiding out in the desert all day come down into the trees to roost.

I get back to the central square of Praia at half past six, in time to see the evening promenade, and join Diva, Tedo, and Manuel at a little table by the central kiosk. We each have a whisky, as a preliminary preparation for the party, and then sit and watch the show.

All the towns of the islands have a central cobbled square, holding a kiosk selling drinks, a bandstand equipped with a loud-speaker which relays Radio Praia, and several miserable mimosas which provide a certain amount of shade for the seats beneath them in the middle of the day. During the day the square is deserted except for loafers and small boys; but at dusk all the inhabitants put their best clothes on and parade *en famille* for half an hour before dinner. In twenty minutes, therefore, we are able to review the entire society of the town. Since in a society of a few hundred people such as this one everybody knows everybody else, I am soon informed of the few pieces of local scandal which have escaped me whilst I have been away over the last week.

By the time we have been sitting half an hour in the square most people have gone home to dinner, and we decide it is time to collect Arturo and the band. Praia has the inestimable advantage that its broadcasting house is easily accessible and unguarded in the middle of town, and we stroll across the square and catch Arturo in the middle of the song which is making night hideous around the loudspeaker outside, and cut it short. He has a few quick words with the announcer, who is heartily glad to be rid of him; and then, preceded by the band, who stop at intervals to serenade any likely windows on the route, we roll across the square and down to Diva's room. I hide my field glasses, which are breakable, and the band tune their guitars; Diva sets the glasses out, and Manuel goes to supervise the task force that will bring dinner when it is ready. Arturo puts my towel round his waist in preparation for his celebrated imitation of the wife of the chief of police trying to catch a turtle, and a crowd of small boys begins to collect around the window.

The party to end all parties is about to begin.

A FASHIONABLE FUNERAL

by M. VERONICA STOKES

AT THE first glance, the contents of the dusty bundle, labelled "Extracts from Wills," appeared dull and unexciting. Most of the papers contained a brief note of the benefactor's name and the amount of the legacy to this hospital, but one folded sheet had written across it "Undertakers Bill." Anticipating something unusual, I opened it and found that it was headed "The Funerall of Mr. Edward Coalston at Ealen by Thomas Wilde of Mount Street. August 16th, 1763." All the expenses had been set down in detail, from the coffin to the drink provided for the underbearers, the total coming to the considerable sum of £60 13s.

The Edward Coalston or Colson¹, who was buried with such fine trappings in 1763, had been a Governor of St. Bartholomew's Hospital, and had appointed the President, the Treasurer and the Governors as the executors of his will. They were responsible for paying out the various legacies, settling any debts and any expenses arising out of the administration of his estate. All the documents connected with these matters had been carefully kept separate from the other papers in the bundle and tied together. It is difficult to find information about Edward Colson. He lived in Park Street, Grosvenor Square, and was unmarried; in one document it is mentioned that he belonged to the second troop of the Horse Guards. He was wealthy, leaving considerable legacies to friends and to distant relations, most of whom lived at Lincoln, perhaps his original home. Though he was generous in his will to this Hospital, he was not the benefactor after whom Colston Ward was named. The ward had been given the name, in 1752, of another Edward, a wealthy Bristol merchant and a Governor, who had died in 1721 at Mortlake and was buried in All Saints' Church, Bristol. He was childless and from the documents in the hospital's possession it is impossible to say whether or not there was any connection between the two men.

However, though the figure of Edward Colson is faint and shadowy, every detail of his fashionable funeral stands out clearly.

The first entry, in a small neat hand, reads "To an Inside Ellm Coffin and Ruffled with superfine crape and a Quilted Mattrass at the Bottom . . . £1 15s." The outside lead coffin cost £5 10s. and six men were needed to carry it to Park Street, getting 9s. for this and for "putting in the Corps." They were also rewarded with a shilling's worth of drink. The "Superfine Shrowd, Sheet, pillow and Dress" cost as much as £2 2s., but the task of "making up the Corps and Attending the Plumbers when² Solderd Down" involved only 3s. 6d. There was also "a large outside Ellm case Covered with fine Black Cloath and set round with Double rows of the Best Brass Naitles drove close, 4 pairs of large Contrast Handles and wrote plaites and Gripes, and Adorned with 8 Doz of gilt Drops and a Double plate of Inscription all Gilt": all this came to six guineas. The six men were paid 9s. again with drink for carrying in this case and putting the lead coffin in it. Over it went the "Best Velvet Pall" hired at 10s. 6d., and a lid of the Best Black Feathers, one guinea. Then comes "To a hearse and four and Coach and Four . . . £3.", followed by "a Set of the Best Funerall Feathers for Hearse and Horses at £2 10s."

There seems to have been nearly a dozen people who accompanied the hearse as mourners or coachmen or pages, and all were provided with mourning. Two gentlemen had cloaks, 2s., silk hat bands and gloves, £1 1s., and Paduasway³ scarves £3 3s. The two women mourners had "Scarf and Hoods made up, £3 18s." with lace looped kid gloves, 12s. "Two Porters of Horseback" attending the funeral had to have "silk Dresses" and crepe hatbands and gloves, an expense of £1 15s. Mourning cloaks, hatbands and gloves were provided for the coachmen. The two coach pages and six hearse pages did not have cloaks but the latter had "Favours, Truncheons and Gloves." This item cost 15s. and their wages

¹ Another form is "Colston."

² . . . the Lead Coffin was . . .

³ A strong corded or grosgrain silk fabric.

*The Funerall of Mr. Edward Coalston
at Ealen
By Thomas Wilde of Mount Street.*

To an Inside Ellm Coffin and Ruffled with superfine crape and quilted Mattrass at the Bottom . . .	1 15 0
To a shrowd, sheet, pillow and Dress . . .	2 2 0
To a strong out side lead Coffin, solderd Down . . .	5 10 0
To a lead plate of Inscription & Lid for Coffin . . .	0 5 0
To 6 Men to carry in the Lead Coffin and putting in the Corps . . .	0 9 0
To Drink to the Men . . .	0 1 0
To making up the Corps and Attending the Plumbers when solderd Down . . .	0 3 6
To a large outside Ellm case covered with fine Black Cloath and set round with Double rows of the Best Brass Naitles drove close, 4 pairs of large Contrast Handles and wrote plaites and Gripes, & Adorned with 8 Doz of gilt Drops and a Double plate of Inscription all gilt . . .	6 6 0
To 6 Men to carry in the Case and put in the Lead . . .	0 9 0

Part of Edward Coalston's Will

were 3s. each. Drink to the men in town cost 2s. 6d. The Minister and Parish Clerk were not forgotten. The former had a "silk hatband and laced shammy gloves with a large silk scarf" for £2 5s., but the clerk only cost 13s. 6d. with his "plain shammy gloves and silk hatband." Then came the six underbearers in the country and their drink, 17s. They also had to have silk hatbands and gloves, £1 6s.

The next two items, "To self on horseback to attend the funerall." and Mr. Wilde's mourning, raised the amount by one guinea. Turnpikes on the road cost 2s. and the passing bell, 5s. "Parish dues at Ealin" were high, £10 11s., but the gravedigger only had 2s. The last item of the bill is amusing when one considers the swift journey to Ealing by Underground at the present day: "Dinner and Expences on the road, £2 3s. 6d."

SO TO SPEAK . . .

Conservatism Again

In Bart.'s it is an old custom that the patient does not put his feet on his pillow.
—Skin Department.

Deader and Deader

Without adequate treatment death may result from circulatory failure, leading to renal failure and anuria.
—Davidson.

ROBERT BRIDGES (1844-1930)

Medicine as a Training for Poetry?

by JOHN POTTER

MEDICAL men give various reasons for having taken up their profession, but few can have started as medical students with the programme devised for himself by Robert Bridges, who subsequently became Poet Laureate. His intention was to study and practise medicine for a limited period of about fifteen years only, and then to retire at the age of forty and use, for the purpose of his art, the knowledge of men that he had so acquired. It is interesting to imagine what would be the reactions of a present-day medical school dean when interviewing such a candidate for admission. Bridges was already twenty-five and obviously gifted, so that it is unlikely that a liberal-minded man would refuse him entry, although he might doubt whether it would be so easy to escape from such an all-absorbing profession, even though it were unnecessary for him to earn his own living.

Escape Bridges did, however, and, probably owing to a timely illness, three years ahead of his appointed time. He went to live for the next twenty years at Yattendon on the Berkshire Downs, where he married and settled into the greater achievements of his long life.

Sir Walter Langdon-Brown believed that his ten years in the study and practice of medicine were all-important to him as a poet, and that he would have been unable to have written *The Testament of Beauty* without them. Yet we know that in his later years Bridges scarcely ever referred to his professional life, and hated being called "doctor." There was evidently no overt acknowledgment by him that he attached such great value to his few professional years. This is a point that is worth pondering as we pass briefly through Bridges's career, pausing particularly at the medical signposts which may help to point our way.

Robert Seymour Bridges was a "Man of Kent" and proud of it. He was born at Walmer on October 23, 1844, of stock that had become rather more than yeoman; the "gentleman farmers" of Halsted, the historian of Kent. Those who are familiar with

and love the county of his birth will find his descriptions of downs and orchards nostalgic and enchanting.

At the age of ten, he went to Eton, where he spent nine years. He idealised the school and it was once suggested that Dante and Browning had been omitted from his anthology, *The Spirit of Man*, because they were not Etonians! At school cricket he was described as "chiefly a batsman, of the imperious, aggressive kind," and had the unusual experience of bowling and then catching his victim from the square-leg position. We are told that while at school he studied, read and wrote verses constantly.

In order to orientate ourselves in the world of poetry at that time, we may note that Browning, Tennyson and Matthew Arnold were all active. Tennyson had succeeded Wordsworth as Poet Laureate four years earlier, and was, that year (1854), to read in *The Times* of the battle of Balaclava and write *The Charge of the Light Brigade*. Arnold had, the previous year, published *The Scholar-Gipsy*, of which Bridges was later to say that it and *Thyrsis* were "the only things of Arnold that were any good." The latter poem was written to commemorate Arnold's Oxford friend, Arthur Hugh Clough, who died in 1861. Clough, also, is worthy of brief mention in this digression, both as a relative of Florence Nightingale, whom he helped and for his famous modification of the sixth Commandment, which must have been a great comfort to many doctors during the following years of therapeutic impotence. How much easier it is now officiously to keep patients alive, but how much more difficult it may be for a doctor's conscience!

Sport continued to attract Bridges after he had gone up in 1863 to Oxford, the city which remained for him the "fair lady of learning." He entered Corpus Christi College and stroked the college boat in 1867, when it was second on the river. In Greats he took a Second.

From Oxford, he travelled abroad to Egypt, Syria, Germany, the Netherlands, France and Italy, before and even after

had signed on as a student at St. Bartholomew's Hospital in 1869. Little is known of his early years there, except that a fellow student, with whom he used to walk in Regent's Park, is recorded as saying that he had no idea at that time that Bridges was a poet, and this was true also of his friend and correspondent, Gerard Manley Hopkins. It seems that he kept his poetry much to himself. He graduated M.B. (Oxon.) in 1874. In 1876 he had printed for his friends at Bart.'s a Latin poem which consisted of 556 elegiac lines on the hospital, its history and famous figures and existing staff. At the end there is a description of the poet's own examination for the membership of the Royal College of Physicians, in which he had that same year been successful. Men still discuss their adventures at this examination—but not in Latin!

An anecdote concerning Bridges's "membership" was told by Sir Henry Head to Harvey Cushing. Nowadays, in the examination, there remains a vestigial appendix, the German or French piece for translation. This serves rather to remind those connected with the examination that they are still acquainted with culture and learning, than to intrude as an obstacle to the candidates' success. In Bridges's day there was both a Greek and a Latin passage for translation. Since there were no instructions as to the language into which they were to be translated, he put the Latin one into Greek and *vice versa*.

Also in 1876, while a house physician, he published in the hospital "Reports" a paper entitled "A severe case of rheumatic fever treated successfully with splints." From his own words, we picture a man who, as we shall see later, was always intensely sensitive to suffering, displaying in the presence of pain the shameless compassion that is too commonly transient in the recently qualified doctor. In this case it was a pain that was only really alleviated with the introduction of salicylates a few years later. We must sympathise with him (each of us surely recalling some similar experience) as the dignified prose veils thinly his indignation at what he considered "indolence and spared judgment." His introduction to the paper reads as follows:

The inflammation of joints, which is the characteristic and constant symptom of rheumatic fever, is the cause of such intense suffering to the patient, that even were it possible to believe that this might in all cases be neglected without danger or fear of bad consequences, yet the physician would

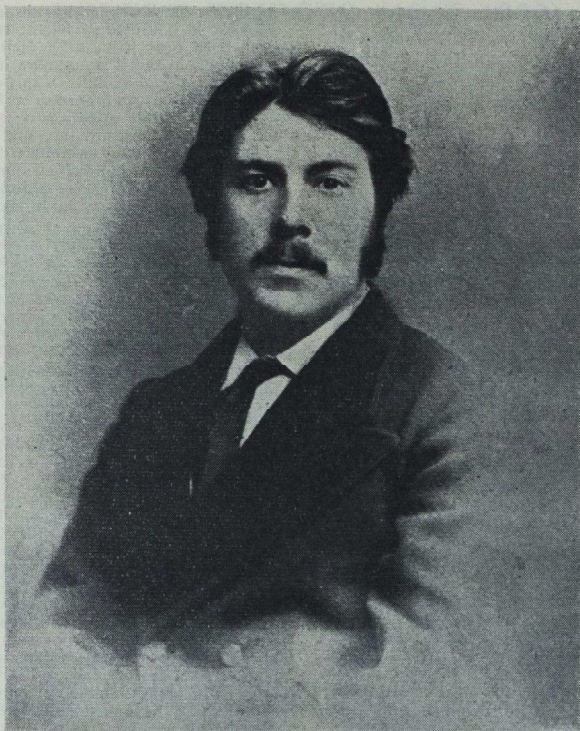
hardly be the less bound to do all in his power to alleviate it. Unfortunately, the remedies that have been tried bear witness by their number to their inefficiency; and it is common in clinical teaching to see the special assaults of this disease considered in themselves as unimportant so long as they spare the viscera, while attention is mainly directed to the heart and pericardium; and the state of the patient in whom these continue sound is held to be so satisfactory that he is merely encouraged to support his agonies, in expectation of a future and uncertain day when they will probably take their leave.

This method of treatment, if treatment it may be called, has found support in the tendency of a therapeutic fashion, that by the watchword of expectancy has not only taught prudence, but has often excused indolence and spared judgment, so that it is not a matter of wonder to the student to see some patients waiting for their pain to pass off as others do for their fever, while the knowledge that inflammation of the heart is more serious than that of the knee is sufficient erudition to divert their attentions and defer their efforts.

Such consideration, coupled with the common agreement of surgeons concerning the treatment of inflamed joints, led me to ask leave to publish in this volume the account of a case of rheumatic fever of unusual severity treated by splints. The method is not a new one, and I shall be able to give some account of its history; but since during five years at our hospital I have never seen it put in practice, nor even heard it mentioned, so it was not until I became responsible for the treatment of a patient who seemed to be dying of sheer pain, that being myself compelled to seek such resort, I had an opportunity of witnessing its effect. I make no apology for having only one case to report; it is more likely to be read, and is, in my opinion, of more value than a table of figures, and whatever experience I have persuades me that it is worth reporting.

We read later that the patient, a "sound, stout, healthy girl, aged 21, light complexioned," after a severe illness, left hospital well but weak on the fifty-fifth day after admission. There was no heart murmur.

In 1877, *The Practitioner* published a brief paper by Bridges entitled "Two cases of violent chorea, illustrating the administration of Chloral Hydrate in large doses." In this he is critical of timorous, ineffective dosage with this drug in so serious a malady and recommends larger doses than were customary at that time. He suggests starting with thirty grains and repeating this or half the dose if sleep should not result. Thereafter, smaller maintenance doses are to be given for as long as sedation is necessary to give rest from the involuntary movements. [It is interesting to note that these adult doses are not large in comparison with those sometimes given, and with impunity, to children nowadays in neuro-surgical practice. All this illustrates both the capricious action of



Robert Bridges, as a Medical Student

chloral and the truth of the aphorism of J. H. Drysdale that 'the proper dose of any drug is enough.']

During the year 1877-78 Bridges was one of the three casualty physicians at Bart.'s whose work was the subject of his most memorable medical publication. It appeared in the "Reports" for 1878 and was reprinted twice elsewhere, last by the O.U.P., in 1936, for members of the Society for Pure English, which was one of Bridges's later Oxford ventures.

"An account of the Casualty Department" should be read by all doctors who to-day consider themselves overworked in clinics and surgeries, with insufficient time to spend on individual patients. It is a skilful and amusing essay, exposing a system which Bridges, at the end of his paper, describes as intolerable. There is too much that would be worth quoting here. It is better read in its

entirety, but a few random extracts will illustrate that Bridges was a thoroughly practical man.

On the four busiest mornings of the week in the casualty department, the junior assistant physician joined the three casualty physicians. "It might perhaps be thought," says Bridges, "that the virtue of a casualty physician was distributive justice. In a better world no doubt it would be; as things are, there are several considerations which override strict justice." The chief consideration was time. The function of a casualty physician was to supervise the "filtering" of the patients that attended the surgery. Bridges confesses that he never quite attained the speed of a "good medical filtrator, working at high pressure," who would pass 100 patients per hour! He calculates that, on the average, he saw 148 patients in a morning, spending 1.28 minutes on each.

On two days in the week he did the men, and on two the women; and he observes tartly:

With the lowest estimate of female garrulity, one must recognise the grandeur of the feat accomplished in giving separate audiences to the troubles of 150 women in three hours and a quarter. Indeed, with all I could do, though their complaints were generally less worthy of attention than those of the men, though I learned to enforce laconicism by making them stand with their tongues out much longer than was necessary for medical diagnosis, I yet find that an average female case lasted one-fiftieth of a minute longer than a male case. The impossibility of listening to long stories with patience, or of acknowledging the receipt of crooked answers soon led me to assume a tyrannous air that forbade them to seek sympathy by plaintive recitals; and by dint of talking very loud, and asking every question three times, I arrived sooner than one would expect at the facts. Since I have tried to make negative physical examination of every one who seemed to me seriously ill, or who had not been benefited by his treatment, it was necessary for such a patient to strip while others were being interviewed; and in the prevalence of sore throats, those who complained of them were set on one side till a long enough row of them had been collected to justify my rising from my seat to visit them all at once with the spatula.

In the year, Bridges estimated that he saw 30,000 patients, and reckons that a similar number in that period each carried off a pint of quassia and iron mixture at a total cost to the hospital of only £135—"a fact which reflects great credit on the economy of our system." Magnesium sulphate for a similar population cost only £9 10s. He then goes on to consider the cost of his own services, "nor shall I be suspected of any other feeling than that of gratitude [to the munificence of our hospital] in stating that, after deducting income tax, which promises to be a permanent charge, the sum paid to the casualty physician per patient is about seven-tenths of a penny." This incidentally raised the cost of a "quassia and iron patient" from 1.123d. to 1.835d.! He also observes that "it is not everywhere in the country, to be sure, that one can have the opinion of a Fellow of the Royal Society for a halfpenny, and have that sum paid for one by ancient endowments and public subscription." [This is presumably a reference to Dr. Lauder Brunton, F.R.S., who until recently had been junior assistant physician.]

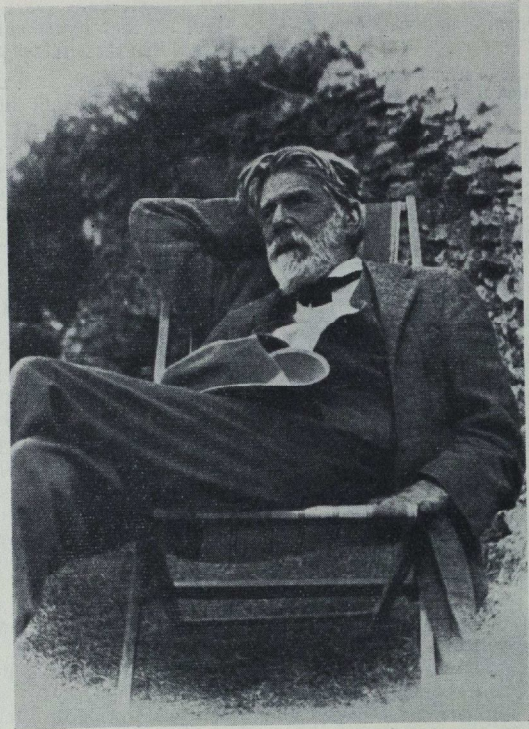
While the quantity of these patients may seem remarkable to us at the present time, to some of Bridges's lay acquaintances later at Oxford his stories of these events were apparently quite unacceptable as truths. One day,

after a great many years of such doubt, was—perhaps slightly uncomfortably—interested to learn that these things were feasible.

Although some notice must have been taken of this elegant tirade, new casualty buildings were not erected until 1906, and then only temporary ones. Sir Walter Langdon-Brown says that it also resulted in Bridges never getting another appointment at Bart.'s, and he warns with solicitude a student audience, "the powers that be do not appreciate irony, and youthful reformers still find it advisable to curb their tongues and pens." But the poet told Dr. (later Sir) Norman Moore, who had been a casualty physician the previous year, that he did not desire further promotion at his Alma Mater in view of the long apprenticeship in the dead-house which was necessary in those days.

Instead he became, in 1878, assistant physician to the Hospital for Sick Children, Great Ormond Street, and physician to the Great (now Royal) Northern Hospital. His life as a consultant was short-lived; for in 1881 he contracted pneumonia and an empyema, the only serious illness of his life, and after convalescence in Italy and Sicily, retired for ever from medicine in the following year. He went to live a life of leisure and happiness at Yattendon, where he married in 1884. His family consisted of two daughters, one of whom died during his lifetime, and one son, the eminent civil servant, Sir Edward Bridges, who survives him. *The Yattendon Hymnal* is a legacy of that period when Bridges, with his deep knowledge and understanding of music, so unusual in a poet, trained the local church choir. In the preface to the enlarged edition of *Songs of Praise* there is grateful acknowledgment of the impetus that he gave to the general improvement in our hymnody. It was said that Bridges's acute musical sense also resulted in his having an enviable reputation among his contemporaries for auscultation; but others will know whether this is a likely possibility.

In 1900, the Royal College of Physicians honoured themselves by electing him a Fellow, and two years later we find a few claudicating verses addressed to its president, Sir Thomas Barlow. The occasion, it seems, was the receipt by Bridges of an autographed reprint of a recent address by Barlow; and the poet, unkindly it may be felt, chaffs him for his optimism regarding medical progress.



Robert Bridges, Poet Laureate, in Old Age

In 1907 he moved to Oxford, where he had built Chilswell House, Boar's Hill; now a nursing home. It is situated right in the countryside so loved by Matthew Arnold, and referred to in his two great elegiac poems. The name is the same as that in *Thyrsis*, "Runs it not here, the track by Childsworth Farm."

In 1895, Bridges had been urged unsuccessfully to be a candidate for the professorship of poetry. When, in 1913, Mr. Asquith offered him the post of Poet Laureate, it was a surprise to the public who would have chosen Kipling, but not for the poets. Edward Thompson talks of Asquith's admiration for fine poetry, but Humbert Wolfe remarks, "by some accident—perhaps because the name began with a B—the choice of the Government was the choice of the poets." The stipend was £75, and £27 "in lieu of a butt of sack." Bridges, "then a young man of

69," accepted on condition that there was "no damn nonsense of knighthoods or anything of that kind." To counteract the reporters who flocked to Boar's Hill, he employed a stone-deaf girl to answer the door, and went away, "That girl soon cured them. Now they leave us alone."

In 1929, the year before his death and during which he was awarded the Order of Merit (evidently not classified as "damn nonsense"), he gave the first National Broadcast Lecture for the B.B.C. For a man who had been born in 1844, the insight that he showed into the potential good of radio is thoroughly to be admired. He hoped that it would flood the primary schools with spiritual teaching, and warned the B.B.C. in its capacity as a teacher, not to give the young the common stuff that is so readily available to them anyway. It may be hoped that someone has given the same warning about television.

Robert Bridges died on April 21, 1930. What sort of a man was he? Physically, he was of striking appearance, and there are many independent testimonies as to the beauty of his face, even in old age. His youthful figure, athletic build and robustness remained with him, and when over eighty he refused even a local anaesthetic for a tooth extraction. Sir Henry Newbolt described his "great stature and fine proportions, a leonine head, deep eyes, expressive lips and a full-toned voice, made more effective by a slight occasional hesitation in his speech."

In contrast to this attitude of toughness, he was profoundly sensitive to the thought of pain. It is said that he shuddered as he passed the site of the Martyrs' stake in Oxford, and we have already read of his distress at a patient in pain. It has been said that his *Shorter Poems* "knew hardly anything of sorrow" and that "passion hardly entered his world and the grievous things were rarely close at hand; they were by report if at all." Even were this latter statement to be applied to the poems alone, and not used for generalisation, it is difficult to surpass the passion, the sense of grievous things that occurs in one of his best-known poems in this series, "On a Dead Child," published while he was still active at Great Ormond Street. It was objected also that these poems "know little of a world where penury and helplessness drag out their days"; a strange comment on the work of one who had seen 30,000 of London's sick poor in the course of a single year. Personal grief of great intensity occurred in 1866 when a younger and favourite brother died, and is well recorded in a poem in this series on the death of his brother-in-law, Maurice Waterhouse. Much later on, that also of his daughter, Margaret, gives rise to some haunting lines in *The Testament of Beauty*.

The surprising success of this last poem, which was the great and crowning work of his life (he started it in 1926 at the age of eighty-two) was gratifying to him. He had never sought popular acclamation and had steadfastly refused to compose to order. For this latter trait he was teased and abused, as it was considered by many to be part of the duty of the Poet Laureate to write verses for national occasions. Horatio Bottomley, in the House of Commons, asked if he were earning his salary; and during Bridges's visit to Michigan in 1924, a frustrated American

reporter caused the appearance of the notorious headline, "King's canary refuses to chirp."

He was asked to compose a poem for the octocentenary celebrations at his old hospital in 1923, but declined. From the same place, a students' society asked him to address them, but he answered that he had nothing to offer which was worthy of their acceptance!

Bridges was, however, a sincere man; "even his affectations were honest and lovable." He would, like Dr. Johnson, speak freely as the thought came to him, and he was "opinionated but willing to be corrected and almost certain to listen closely to your reason for disagreement." He was "immune to theological dogmas" and was on the whole a reserved man who kept his own personal secrets; he destroyed just before his death all that shed more light on him than he wished.

One or two other characteristics are worth recording. He prided himself in having what he believed to be a knack of knowing in advance what books were no use to him. Singled out for such inattention was poor Dryden, "a poet with whose works I am by choice unfamiliar." [One cannot help reflecting what a blessing such an attribute would be to many a doctor to-day; so much there is now of medical literature with which it would be a pleasure to be unfamiliar.]

Reference has already been made to his musical accomplishments. He was also a keen naturalist and was particularly fond of wild flowers and knew them well. He loved the birds and maintained in a delightful passage in *The Testament of Beauty*, and again in his broadcast lecture, that of all animals they are the nearest to men, "gracefully schooling leisure to enliven life." There is also an amusing comparison in his poem *Flycatchers*.

On Bridges's poetry, I comment only as one who has found pleasure in it, believing that there is plenty there for most people to enjoy. To many, the pleasure is that in his earlier works at any rate his grass is always green and not emerald or flashing; his skies blue and not turquoise, azure or sapphire; all this being one critic's very objection to his poetry when he was made Poet Laureate! Much of his verse is the "pure poetry" of George Moore—technical and experimental; a reference book for poets, with much original work. However, among all his erudition

there is plenty for those of us who are less sophisticated and who enjoy simple beauty in simple words, and we can ignore, if we like, his odd and inconsistent spelling, although there is something to be said for such words as "liv" and "thatt" as he used them, and the reform of spelling is a fashionable subject again. Many, after reading *The Testament of Beauty*, will agree with Sir Walter Langdon-Brown's description of Bridges as "the poet of evolution." That great physician said, "he wished his poetry to express the philosophy of life he acquired from natural science in general and from medicine in particular." While the "Testament" shows evidence of wide learning and reading, and of knowledge which he was ever ready to seek from experts in their particular fields, it is easy for a medical admirer to emphasise the part played by the brief medical interlude that was a bare tenth of his long life. It was, moreover, apparently the one tenth that he was prepared to forget. Sickness and a dying man are sympathetically portrayed in "Winter Nightfall," but many a lay poet has had insight equal to that shown in this description by one who happened once to have been a physician. Perhaps we some-

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CORRESPONDENCE

FROM THE SHERLOCK HOLMES SOCIETY OF LONDON

Dear Sir,

The Sherlock Holmes Society of London would not like the occasion of January 21 to pass without expressing their appreciation. They are delighted that the amateur mendicants of Detroit chose such an attractive tablet and such wise wording to commemorate the historic meeting of Holmes and Watson in the Bart's laboratories. They congratulate the authorities of St. Bartholomew's Hospital on the choice of a site in such conformity with the Canon and with such an historic view of the tower of St. Bartholomew the Less. Finally, they are most grateful to Sir George Aylwen and to Bart's for inviting some of their number to see the plaque and for entertaining them so royally.

January 1, 1881! Watson must have moved quickly after the battle of Maiwand, which was fought on July 27, 1880. Perhaps he and his "great train of wounded sufferers" got away before the British troops were besieged in Kandahar and had to wait three weeks for their relief by Lord Roberts after his famous march from Kabul. Perhaps he recovered quickly from his wounds. Perhaps the months he was laid up with typhoid were poetic licence. It would seem a shorter way to Karachi and so home via Quetta

times over-estimate the spiritual basis of what we loosely term "our calling." That Bridges saw through a lot of the humbug that existed in Victorian medicine, then as now, is amply shown in the "Casualty" account. We should not flatter ourselves by trying to make him "one of us" but remember that he said:

I will be what God made me nor protest
Against the bent of genius in my time,
That science of my friends robs all the best,
While I love beauty, and was born to rhyme.

Let us rather be content to honour a learned and versatile man who has bequeathed great beauty to us.

Acknowledgments

I have quoted from *Robert Bridges*, by Edward Thompson (a friend and neighbour of the poet), and from other Bridges publications of the Oxford University Press; also from *Thus We are Men*, by Sir Walter Langdon-Brown (Kegan Paul, London; 1938), the *D.N.B.*, *Saint Bartholomew's Hospital Journal and Reports*, and from the *Radio Times*. Mr. John L. Thornton has been most helpful, and Sir Edward Bridges very kindly lent the photographs reproduced here.

than via Peshawar, but perhaps the lines of communication ran north and only turned south after crossing into India: my geographical knowledge of the frontier is not good enough. The problem has been discussed but not decided by Gavin Bred in *From Maiwand to Marylebone*, in the *Sherlock Holmes Journal* (Vol. 1, 1953).

Again with many thanks, from

MAURICE CAMPBELL
(Chairman)

8, Queen Anne Street,
London, W.1.

CAMBRIDGE BART'S GRADUATES CLUB

Sir,

The Cambridge Bart's Graduates Club will hold its Annual Dinner on Friday, April 2, 1954, at 7 for 7.30, at the Royal College of Surgeons. This function continues, by common consent, to be purely for men. Cards will shortly be sent out to members, and we should be grateful if any Bart's Cambridge graduate who fails to receive a card would let us know.

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

St. Bartholomew's Hospital,

FILTER PAPER ELECTROPHORESIS IN MEDICINE

by W. G. DANGERFIELD

THE introduction of filter paper electrophoresis will probably rank as one of the most outstanding advances made in biochemical technique for many years. This simple procedure is already widely used and is being developed to include quantitative methods as well as reactions for detecting glycoproteins, lipoproteins and enzymes. It can also be used for preparative work, but in this case the paper may be replaced by some other medium such as agar or starch.

The principle and technique of paper electrophoresis can only be very briefly outlined here. A small measured quantity of serum is applied in a line across a strip of filter paper which is then wetted with alkaline buffer and its ends connected to a source of direct current at 100-300 volts. At the pH used all the proteins are negatively charged and move towards the positive end of the paper at a rate depending on the size and charge of the particle, the albumin moving fastest. This produces a series of bands of protein in the paper somewhat like a spectrum. After several hours the paper is removed, dried and stained to show the position of the protein bands.

At present the main application of paper electrophoresis to medicine is in the investigation of serum proteins in disease, for this sometimes helps in making the diagnosis or in following the progress of the case. Serum is usually employed in preference to plasma because fibrin precipitates on the paper at the point of application. The pattern given by normal serum on electrophoresis at pH 8.6 is described below, taking the proteins in order of decreasing mobility:—

- (1) The albumin gives much the most intense and the widest band.
- (2) The α_1 -globulin gives the weakest band and is sometimes not visible, being merged with the albumin.
- (3) The α_2 -globulin band is of moderate intensity and width.
- (4) The β -globulin band is usually slightly more intense but narrower than that of the α_2 -globulin.
- (5) The γ -globulin band is about the same intensity as the β -globulin but much wider, almost as wide as the albumin in fact.

The width and intensity of the bands vary slightly with the details of the technique used; occasionally two β -globulin or two γ -globulin bands can be seen. A uniform technique is therefore desirable throughout any investigation.

The changes that occur in the patterns as a result of disease are best considered as changes in the quantity or nature of the individual proteins. There is no special virtue in the concept of the albumin/globulin ratio, and in fact the mechanisms controlling the production of albumin and the globulins are probably quite separate. To consider the proteins in the same order as before the changes are as follows (and see Fig. 1 over):—

- (1) Albumin is decreased as a result of albuminuria, malnutrition and wasting diseases such as carcinomatosis or ulcerative colitis; the lowest values result from prolonged albuminuria.
- (2) α_1 -globulin is often increased in carcinomatosis and ulcerative colitis, but this is not a very useful finding since the quantity of α_1 -globulin is difficult to assess when a normal quantity of albumin is present.
- (3) α_2 -globulin is moderately increased in acute and sub-acute inflammation, and much increased in the nephrotic syndrome.
- (4) β -globulin does not undergo any large or characteristic change in disease.
- (5) γ -globulin, which includes almost all the antibodies, is greatly increased in cirrhosis and Banti's syndrome. It is increased in a variety of chronic conditions such as sarcoidosis, periarteritis nodosa, systemic lupus erythematosus, some cases of rheumatoid arthritis and a number of tropical infections, particularly kala azar. It is decreased in severe type II nephritis, perhaps due to leakage into the urine.

The zinc sulphate turbidity shows a marked correlation with the intensity of the γ -globulin band and may be regarded as a rough measure of the quantity of γ -globulin present.

In multiple myelomatosis, the electrophoresis pattern is very characteristic indeed

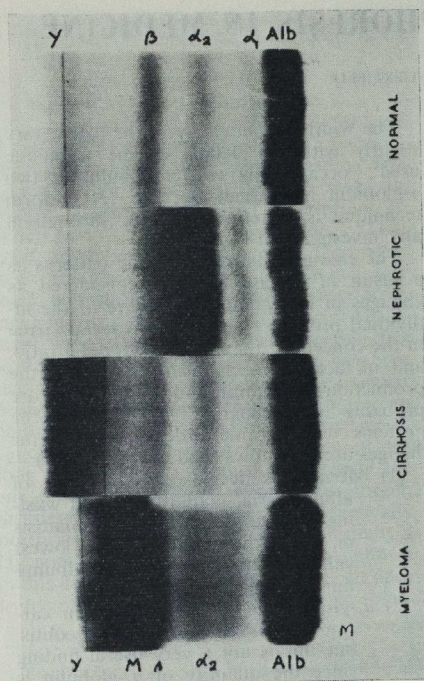


Fig. 1. Protein Patterns

—almost diagnostic in fact. In about 90 per cent. of cases there is a dense band of protein apparently superimposed on the β - or γ -globulin or in between them. In the remaining 10 per cent. of cases the pattern is normal but in these cases there is usually a considerable quantity of Bence Jones protein in the urine to give a chemical indication of the diagnosis.

If the strips are stained for lipid matter instead of protein an entirely different pattern is obtained. Practically all lipids in the serum migrate during electrophoresis and are probably bound to protein. Normal serum gives a pattern consisting essentially of two main bands—the so-called α and β -lipoproteins and a “trailing” zone extending from the origin to the β -lipoprotein band (see Fig. 2 in which the narrow portion of each strip is stained for protein and the wide portion for lipid.)

In some conditions, notably in type II

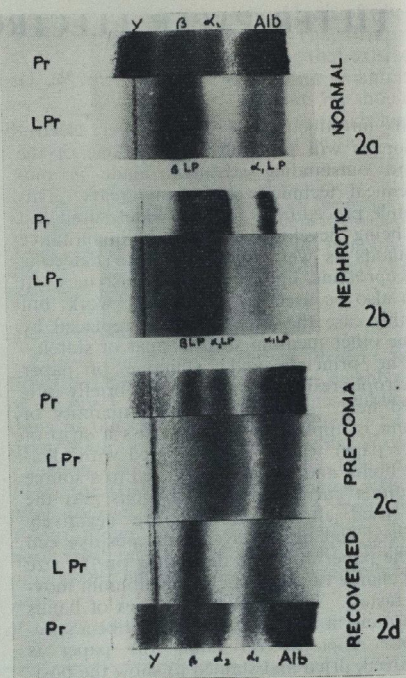


Fig. 2. Lipoprotein Patterns

nephritis and some cases of jaundice, the α -lipoprotein (better called α_1 -lipoprotein) is diminished, in fact hardly discernible. In conditions in which the serum cholesterol is raised the β -lipoprotein band is intensified, and usually there is a zone of staining ahead of the β -lipoprotein-peak which may be designated α_2 -lipoprotein (Fig. 2b).

The upset of fat metabolism in diabetic ketosis is strikingly displayed in the patterns shown in Fig. 2c and 2d; the strip shown in 2c was made from the serum taken when the patient was almost comatose (“pre-coma”) and 2d from the serum taken about 20 hours later when the patient had recovered.

It will be apparent from this brief survey that paper electrophoresis may be of help in diagnosis but it is probable that it will render service of greater value to medicine in the help it affords in solving problems of physiological and pathological research.

THE YELLOW SEA

by SURGEON, R.A.N.

The ship was having a few days' refit in a Japanese harbour. Through the screen-door came a small, harmless-looking matelot with head twisted and bent to one side, neck badly swollen, red and bruised. He complained of pain in the neck, most severe on attempted movement. Examination revealed a very tender neck, with the possibility of fracture or dislocation of vertebrae. On questioning, he stated that he had no recollection of how the injury had been caused—he remembered leaving the ship for a run ashore the previous evening; his next memory was of awakening in the ship that morning. From this story he would not budge. His neck was duly encased in a strong plaster collar, and he returned to duty. Subsequent x-ray, when facilities became available, revealed a healing fracture in an upper cervical vertebra. Eventually the story of that lost evening was discovered: The victim had gone for a quiet run ashore. He visited several bars, and eventually found himself seated, beer at elbow, next to an enormous Canadian soldier. This latter was on a few days rest and recreation leave from Korea, and in anticipation of his return to his unit, had bought a live rabbit which he intended to fatten up and eventually dine off with his friends; it was at present lodged inside his tunic. The matelot glanced at his neighbour at the bar, and to his horror saw a face with long ears appear from the tunic, and as quickly disappear. He rubbed his eyes, unable to believe his senses, looked again to ascertain nothing was there, and ordered another beer. Then once more the head popped out and in, then out again. This was too much—he couldn't possibly have the horrors—so just to convince himself, he stretched out an arm, grabbed the rabbit, and twisted its neck. The Canuck was speechless with fury and surprise, but thought “If the basket thinks he can screw my rabbit's neck, I'll screw his.” And thereupon did.

One summer's day saw “Tribal” assisting a landing on to an enemy island. No medical parties went ashore with the invaders, and casualties were dealt with in a sick bay which had overflowed into the captain's cabin. All the usual hazards of surgery at sea were there

—an ungentle rocking motion, an insecure table, and an “anaesthetist” who fainted at the first knife stroke. Only one virtue outshone all other theatres—the light. This had been rigged by an enthusiastic electrical party, and would no doubt have been effective for signalling from Earth to Mars. However, one new and novel problem arose. Finding it somewhat difficult for one to operate, anaesthetise, assist, attend to drip, and obtain blood at the same time, a signal was sent into the ether for assistance from another surgeon. In response to the call, an American small ship arrived, and deposited a surgeon—from Texas. We got about as far as introducing ourselves as being respectively from University of Texas and Bart's (“Bath, yeah, ah h'd cous'n there'n '44”) and then discovered that we had no common language. Conversation lapsed into isolated words, and the respective replies of “Pardon me. Say again,” and “Sorry, old boy. Didn't quite catch that.” However, in the U.N. spirit, the surgical team mastered the difficulties and settled to the task of removing bullets from Korean abdomens. The biggest surprise came at the end of the day when we seemed to be getting to know one another. To the invitation “Say, Yank, come, drink a rye!” came the reply “No thanks, old man, never touch the stuff!”

A report was received that the inhabitants of a small island, including thousands of refugees, were starving. The ship's company of three hundred odd wanted to help, so all gash food was loaded on to a motor junk; all ranks and ratings emptying their private hoards. This was supplemented by some crates from the supply officer and some Red Cross stores. The surgeon, too, was thrown into the junk with a bagful of medical supplies and told to ensure that all the stuff was fairly distributed. “Tribal” then waved farewell and went over the horizon upon her lawful occasion.

The surgeon was left in the junk with a crew of villainous-looking Korean guerrillas and a radio operator. The latter was there to keep contact with the ship, but contact was lost after 500 yards—the crystal, no-doubt,

having worn out. The WT rating industriously operated the machine for the rest of the day but no contact was made.

The junk was steered between various islands, the only apparent navigational aid being a bamboo pole which was used to judge the proximity of sandbanks. The pile of food supplies was soon observed to be diminishing in size. Careful observation showed that the piratical crew, in addition to banqueting themselves on it, were secreting vast quantities beneath every loose plank, keg, or coil of rope. Angry remonstrances brought a check to this activity. However, the check was probably more due to the fact that some of the pirates had opened tins of "Powder, Water-Sterilising," and wolfed it, assuming it to be some strange Western dish.

Landfall was eventually made, the shore being achieved in an extremely ill-balanced flat-bottomed boat. A trek up a mountain took us to island army headquarters, occupied by an interesting and cultured Korean colonel, his staff, and men under training. Arrangements were made for food distribution, though it seemed unlikely that any starvation would occur, as when put to it, a raid was organised behind enemy lines, when cows and rice were taken off—very reminiscent of Scottish border raids. Refreshment was provided in the form of tea in dainty china cups, saccharine, tinned Nestlé's cream and Scotch shortbreads. No questions were asked about the sources of these items! Innocent looking and very polite South Koreans came and went, many with records

of frequent parachute jumps, throat-cutting expeditions and complete indifference to danger.

With evening coming on, time came to make a rendezvous with "Tribal." Once more into (or onto, as there was but one deck) the junk. This time, in addition to the pirate crew, there was an almost equal number of North Korean prisoners, including some officers with maroon-coloured epaulets and silver badges. We all sat on the deck with no differentiation according to rank or rating, white or yellow, north or south. When we were well at sea in the motor junk, the surgeon amused himself by planning coups by which the northerners could overpower the south. This led on to thoughts of Siberian salt mines, as we were but a few miles from the north Korean coast. We were making poor headway against a strong tide, and further impetus was added to the speculations when the engine expired, and every element seemed combined to take us to the north coast in the least possible time.

The crew formed an admiring open-mouthed group around the engine, and appeared to make no strenuous effort to right the trouble. Never before did a vessel leap towards a shore as did that junk.

At the eleventh hour, to the immense surprise of all concerned, the engine sprang to life. Explain the phenomenon how you will—Yhogi, Transubstantiation, Will-power, or the fervent, effectual prayer of one righteous man (i.e. the surgeon), the motor certainly started, and it was not due to any mechanical genius aboard.

OBITUARY

S. F. H. writes:—

C. H. G. Prance, Bart.'s, 1892-96, died on January 21, 1954, aged 84 years.

He started in general practice in Polyphant, Cornwall, later moved to Plympton, and moved to St. Austell shortly before World War I. He served with the R.A.M.C. at Gallipoli, and was mentioned in dispatches. On his return from the war he settled in Ashstead, Surrey, where he practised for twenty-five years. He served on the welfare committee of the Ashstead branch of the British Legion for many years, and was chairman of the branch in 1936. After his retirement in 1940, he was chairman of an Army Medical Board. In 1945, he went to live in the South of France, and returned to England shortly before his death. In the days when he entered general practice, great demands were made on the family doctor

who, besides filling the rôle of physician, general surgeon and accoucheur, might be called upon to act as dental surgeon, dental mechanic, and veterinary surgeon. C. H. G. Prance, with his resourcefulness and versatility, was equal to anything.

His unbounded energy and his great love and understanding of his fellow men endeared him to all who knew him.

We also announce with regret the death of:—

Bertram Abbott Keats, on September 18. Qualified 1909.

Wilfred George Orchard, on October 4. Qualified 1912.

"BART'S"

by H. S. CRICHTON STARKEY

"WHAT was your hospital?" "Bart's" . . . casual question and simple answer, yet one which however often repeated through the years always causes the same curious thrill. For a brief instant time stands still, and a scarcely formed vision hovers, dream-like, into consciousness, of a Square surrounded with blocks of grey stone buildings, plane trees, and in the centre a fountain.

Really important things in our lives are often symbolised by some little picture; it may be that when, far away, our thoughts turn to England, all we see is a small hillside meadow bounded by woods, just at that perfect moment when the sinking sun casts long shadows across the grass, and rabbits begin to scuttle in and out of the hedgerow. So it is not the well-known view from Smithfield of the Henry VIIIth Gate, or the wards and departments in which we worked that "Bart's" conjures up, but the Square, sun shining through the leaves, convalescents wrapped in scarlet blankets in the shelters, while white-jacketted students sit and chat round the edge of the Fountain; the Square in a November fog, bare trees etched against the sky, sodden plane leaves underfoot, the Fountain desolate and deserted; or perchance a Square silent and still in dark hours after midnight, dim shaded lights gleaming from windows, as we cross, skirting the Fountain, on a belated night round,

or hurry half awake to an emergency call. Always the Square and always in the centre the Fountain, focal point around which every activity of the hospital, social and professional, revolved then as it does to-day and will do to-morrow.

Founded by a great mystic, for centuries the tides and currents of London's history have surged round the old hospital, rebellious, martyrs burning at the stake, royal and civic pageantry, traitors and felons departing on hurdle or cart for their last journey from Newgate, and generations of citizens going about their daily business or visiting the great fair outside the walls . . . while ever through the gates streamed the sick poor, seeking in that peaceful backwater such relief and cure from bodily ills as the medical knowledge of their day afforded.

From the moment of entry as students we became the heirs of a great heritage and tradition of service, privileged men because allowed an opportunity of sharing *our* generation's strivings to maintain the fair name and fame of St. Bartholomew's Hospital.

Romantic poets lament the absence of any object worthy of a lifetime's devotion and affection, but no one ever feels this lack if when asked "What is your hospital?" he can reply "Bart's."

EXAMINATION RESULTS

UNIVERSITY OF OXFORD
SECOND B.M. EXAMINATION
Michaelmas Term, 1953

Bateman, J. G.	Bush, G. H.	Jones, J. M.	Radford, B. L.
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UNIVERSITY OF CAMBRIDGE
FINAL M.B. EXAMINATION
Michaelmas Term, 1953

<i>Part I</i>			
Ainsworth, R. W.	Burrows, P. J.	Garrad, F. E.	Maltby, J. W.
Aldous, I. R.	Dinkel, P. A.	Gawne, E. F. D.	Ogden, W. S.
Brady, J. P.	Evans, J. M.	Gibbs, A. E. R.	Scott-Brown, G. G.
<i>Part II</i>			
Birdwood, G. F. B.	Gibbon, R. H.	Vernon, I. D. S.	Low, F. M.
Buttery, D. J.	Lock, S. P.	Blow, R. J.	Reed, G. A.
Eminson, B. I. F.	Masheter, H. C.	Cozens, F. S.	Tait, I. G.
Gibbs, J. T.	Salmon, J. D.	Knight, R. J.	

UNIVERSITY OF LONDON

FINAL M.B., B.S. EXAMINATION
October, 1953

Pass

Beattie, A. O. C.
Boomla, D. F.
Brown, J. R.
Cairns, J. E.
Cudkowiec, M. R.
Davies, H. F.
Davies, M. B.Evans, M.
Fisher, F. M.
France, G.
Goode, J. H.
Green, A. N.
Haggatt, R.
Hill, E. J.Hyland, R. K.
Iles, D. S.
Keet, S. J.
Livingstone, A. V.
Nicholson, C. G.
Penty, P. R.
Rimmer, A. H. M.
Hill, E. J.Scott, H. G.
Shaw, D. M.
Thomas, G. E.
Thompson, S. G.
Wilkinson, D.
Wint, A. S.

Supplementary Pass List

Part I

Anderson, M. G.
Arnold, D. L.
Bee, D. L.
Blofeld, A.
Britain, E.
Bromwich, L. R.
Clements, R. D.
Cook, W. A.
Coppelstone, J. F.
Cory-Wright, O. M.
Crabtree, A. S.Cree, J. E.
Dowie, L. N.
Ellison, C.
Fielding, M. E.
Forget, Y. N. P.
Foy, B. N.
Gambell, B. I.
Godwin, M. H. G.
Harris, F. A. S.
Hobbs, J. T.
Hooper, M.Landau, N.
Lindop, P. J.
Meredith, H. D.
Murrell, J. S.
Nye, J. F.
Pearce, J. F.
Perkins, M. V.
Pickering-Pick, M. E.
Pippet, D. J.
Poirier, H.
Reid, A. L. A.Reid, K. M.
Reiseger, G. M.
Stevens, J. H.
Thould, A. K.
Voysey, M. M.
Weir, D. A. D.
Willing, R. J.
Wooding, D. F. P.
Young, S. J.

Part II

Adam, R. M.
Andrews, D. A.
Cour-Palais, A. J.Mackay, A.
Morlock, R.
Need, R. E.Rowley, H. E.
Smith, E. P.
Ullman, G. H. A.

Whitting, H. W.

Part III

Arnold, D. L.
Bailey, R. D.
Baker, A. S.Brazenor, E. L. F.
Britain, E.
Martin, R. M.Matheson, P.
Morlock, R.
Prior, J. J.

Rowley, H. E.

Part IV

Adam, R. M.
Andrews, D. A.
Arnold, D. L.Britain, E.
Matheson, P.
Need, R. E.Prior, J. J.
Reid, K. M.
Smith, E. P.

Whitting, H. W.

SPECIAL FIRST EXAMINATION FOR MEDICAL DEGREES
December, 1953

Pass

Dobson, J. L. C.
The following have qualified for exemption:
Cawley, M. I. D.
Davies, D. J. C.O'Keefe, C. J. H.
Marsh, J.
Pilkington, R.Jones, L. C. T.
Price, D. J.
Waters, W. E.

Dymond, G. S.

CONJOINT BOARD

FINAL EXAMINATION
January, 1954Pathology
Pagan, R. T.Baker, A. S.
Goss, G. C. L.Jones, H. D.
Mackay, A.Medicine
Walker, L.

Carrick, D. J. E. L.

Mackay, A.

Surgery

Luke, M. F.

Mears, G. W. E.

Reid, K. M.

Austin, S.
Bloom, M.
Cory-Wright, O. M.
The following have completed the examination for the Diplomas M.R.C.S., L.R.C.P.:
Carrick, D. J. E. L.Gibbs, A. E. R.
Kellert, P.
Lindop, P. J.
Gibbs, A. E. R.Midwifery
Martin, R. M.
Nainby-Luxmoore, R. C.
Winton, F. W.
Walker, L.

Kneebone, J. M.

Luke, M. F.

CONJOINT BOARD

FIRST EXAMINATION
December, 1953

Physiology

Long, J. D. N.

Jones, H. D.
Fletcher, L. O. A.
Luscombe, A. H.Grant, B. G. H.
Fletcher, F. M.
Canning, W. C.

Pharmacology

Burgess, E. H.
Winton, F. W.
Pagan, R. T.

Lloyd, A. G.

SPORT

BOAT CLUB

Club Dinner

This was held in Pim's Restaurant, Old Bailey, on November 18. Mr. O. S. Tubbs was in the Chair and the Club's guests were the Dean (unavoidably absent through illness), Messrs. J. H. M. Ward, P. N. Carpmael, R. P. M. Bell, C. W. Scott and Dr. A. G. S. Bailey. The toast of "The Guests" was proposed by the Secretary and replied to by Dr. ("Joe") Bailey. Mr. Tubbs proposed the toast of "The Club" and this was replied to by the Captain, who presented Mr. ("Ham") Ward with an engraved stopwatch in token of many hours spent coaching Bart's, and in anticipation of many more.

Winter Eight Regatta

Junior Division

Chiswick to Kew. Bart's "B" lost by two lengths to K.C.L. "B."

Senior Division

First Round. Beat St. George's Hospital R.O.
Second Round. Rather a scrappy race, but Bart's finished strongly to beat K.C.L. "A" by one length.

Final v. Birkbeck College. Kew to Mortlake. Bart's obtained an early lead of a canvas, after a false start. Birkbeck stayed close, until, approaching Cubitt's Basin, Bart's began to draw away. By Quintin Boat House some 20 strokes from the finish they were nearly three-quarters of a length in the lead, when the Birkbeck cox realised that in the failing light Bart's had wandered on to their water, and at once turned in and scored a somewhat dubious collision, upon which they were awarded the race some 10 strokes from the finish.

Crews:—

"B": M. Stuart, bow; 2, D. W. P. Thomas; 3, P. Ernst; 4, A. Ellison; 5, D. Pollard; 6, T. W. Bolton; 7, P. J. Fenn; E. J. Rossiter, stroke; W. J. B. Cocker, cox.

"A": J. L. Struthers, bow; 2, P. Ormerod; 3, M. F. Burton; 4, T. A. Evans; 5, G. D. Langham; 6, R. W. Beard; 7, D. A. Chamberlain; B. P. Harrold, stroke; R. L. Rothwell-Jackson, cox.

Christmas Dance

This was held on December 15 in the Recreation Room. Dancing was until midnight to the Derek Pyke Band and E. J. Rossiter on the pipes. Mrs. Spence, the wife of the President, made the Christmas Draw; and the cabaret was given by the "Nightlights" Dick Phelps, the Thames R.C. boatman, was there to welcome guests in his scarlet Doggett's Coat and Badge.

FOOTBALL

During the month of December we have played three games only.

Sat. 5, v. Old Cholemelians 2nd XI (home).

WON 3-1 (King, Pilkington, Dr. Grassby).

The Old Boys opened at a tremendous pace and during the first 15 minutes they nearly ran us off the pitch. Somehow or other, they failed to score when they so clearly had the upper hand, and

when the run of play became more even our own forwards proved more accurate in their shooting.

Sat. 12, v. Old Quintinians (home).

WON 3-2 (Berry, Gould, Pilkington).

This was a particularly interesting game as we were introduced to this team by the Emergency Fixture Bureau, a remarkable organisation run by the A.F.A. to help those whose proper opponents have cancelled at the last minute. The team which arrived more or less out of the blue proved on the whole to be rather too good for us, but they came with only ten men and paid the inevitable price. Even so, we won by the narrowest possible margin.

Sat. 19, v. Normandy Coy., R.M.A., Sandhurst (away).

WON 5-0 (Gould 2, Dr. Duffy 2, Dr. Wills).

To play at Sandhurst is to be too nearly within the grasp of the Army again for most people's peace of mind, and we were more alarmed than otherwise to see our hosts polishing their boots and the buttons on their blazers before venturing out on to the field. The game itself was nothing very dramatic, but we were royally entertained afterwards, and we now have a handsome but formidable old muzzle-loading pistol to add to the other trophies which decorate the bar at Chislehurst.

Wednesday 27th, 2nd Round of U.H. Cup v. Guy's (home)

WON 4-2 (Berry 2, T. Stainton-Ellis, Viner).

On one of the coldest days of the winter, with the temperature well below freezing and a biting easterly wind that seemed to be coming straight from the Russian Steppes, twenty-two shivering players assembled at Chislehurst to decide which hospital should go into the semi-final for the competition for the U.H. Cup. Guy's looked a most workmanlike team in their numbered shirts as they grimly ate glucose before the start, and their legs seemed to have swollen to a most formidable size by reason of the enormous shiu guards they wore beneath their football stockings.

The game itself was fast, and the high-bouncing ball was easy to kick but difficult to control on the rock-hard ground. In the twelfth minute, Guy's scored with a shot that gave Roberts no chance. Almost from the kick-off we took the ball up the field and Viner equalised with a hard shot that skimmed the underside of the bar. A few minutes later the hard-working Berry put us one up, but just before half-time the Guy's left-wing made it 2-2 with a kick that was so good and from such an impossible angle that we were uncharitable enough to think it partly good luck.

In the second half, Guy's pressed strongly at times, but they spoilt good approach work by poor shooting that never looked dangerous and never deceived the watchful Roberts. Berry headed a neat goal for us about half way through, and the *coup de grâce* was administered by T. Stainton-Ellis who collected a long pass from the opposite wing, calmly steadied it and then banged it into the corner of the net.

We meet U.C.H. in the semi-final.

Whether or not medical students take longer to recover from the effects of Christmas than most other people is difficult to say, but we began January by losing two matches.

Saturday 2nd, v. Norsemen (home)
LOST 0—2.

Saturday 16th, v. Economicals (home)
LOST 0—6.

Wednesday 20th, v. St. Mary's (away)
WON 6—2 (Berry 2, Gould 2, Pilkington, Tchamouroff).

Saturday 23rd, v. Queen's College, Cambridge (home)

DRAWN 2—2 (Tchamouroff 2).

FENCING CLUB

The last fencing event for the club in 1953 was the final round of the Inter-Hospitals' Cup. In this we were narrowly defeated by St. Thomas's, 9—7. This match was also memorable for the fact that it was the last in which Dr. Beatley was eligible to fence for us, the last fight of the event occurring between O. E. Reynolds, of St. Thomas's, and our own Beatley, both Olympic fencers. Reynolds primarily a foilist, and Beatley a sabreur, it was much to the latter's credit that he took Reynolds to "four all" before losing the odd hit, all this in what was his opponent's weapon.

We should like to take this opportunity to pay tribute to Beatley's support of the Fencing Club for the past four years. He is undoubtedly the most outstanding fencer ever associated with this college, a distinction which will probably remain true for many years. In recognition of his services to Bart's Fencing Club it was decided by the committee last June to make Dr. Beatley an honorary vice-president. We wish him every success in his future professional and fencing career.

Since the beginning of the 1953-54 season the interest shown in the club has been most gratifying, and the number of regular members well in excess of our wildest hopes. Many of the new members show considerable promise and we should like to re-emphasise here that the road to success in the difficult art of fencing lies largely in the mastery of the first few months' basic tuition.

Of five fixtures, three were unfortunately cancelled for various reasons by our opponents, the remaining two were: versus King's College Hospital (three foil and sabre), an "away" match, lost 14—4; versus London School of Economics (3 foil and sabre), an "away" match, drawn 9—9. So far 11 fixtures have been arranged to take place in the new year.

Fencing Display

The fencing display, organised by the Port of London Authority, in which a Bart's 1 F.E.S. (foil, epee and sabre) team took part, included also a six-man contingent from the Royal Navy and Royal Marines headed by Captain Harry, and including Sgt. Anderson, a National and Services sabre and foil champion.

The proceedings opened with a simple class demonstration by the P.L.A. fencing section, followed by some informal assaults between other guest fencers. The Bart's v. Thomas's match fol-

lowed (a much more cheerful business than the final of the Inter-Hospitals' Cup!) which St. Thomas's "won" 2—1.

The marines' team then demonstrated the teaching methods and basic movements employed in foil, epee and sabre fencing.

The evening concluded with a most entertaining skit on the film duel and its production, by the marines' team. This was cleverly arranged by Sgt. Anderson who has, in fact, "doubled" for the stars in many film fencing sequences, to show how the stand-ins do all the acrobatics, leaping on and off tables, being flung to the ground and generally working pretty hard, while the actors are interpolated in brief close-up views in various stages of the fight. When suitably cut and arranged we are therefore given the impression that Mr. Stewart Flynn and Errol Granger are having the most terrific battle, whereas, in all probability, they are sitting down watching the stand-ins at work and having their wigs artistically ruffled by the make-up experts.

HOCKEY

After a rather disappointing start to the season, the first and second XIs have been meeting with more success recently.

The second XI provided a very satisfactory prelude to the Annual Club Dance on December 2, by defeating the Middlesex Hospital, 4—1, in the first round of the Junior Inter-Hospitals Cup. It is to be hoped that the second XI will have the same success in the second round, and that the first XI will follow their example.

Jan. 16th, Bart's v. Blueharts (home)
LOST 0—4. A very enjoyable game, in which a weakened Bart's team did well to prevent a bigger score by a much superior side.

Jan. 23rd, Bart's v. Rochester & Gillingham (home)
DRAWN 4—4. This was a fast and very exciting game. After being three goals down in the first half, Bart's rallied and scored four goals before the opposition managed to get in an equaliser in the last few minutes.

Jan. 30th, Bart's v. N.P.L. (away)
LOST 0—3. A rather scrappy game, played on a hard, frozen ground, with falling snow.

The Hockey Club would be very grateful if any gentlemen who would be willing to umpire second XI matches, would give their names to either R. White (Pre-Clinical) or C. B. T. Grant (Clinical).

WOMEN'S HOCKEY CLUB

December 2nd, v. The Rugby Club
Lost 5—0.

December 5th, v. The Royal Free Hospital
WON 7—1.

December 12th, v. Guy's Hospital
WON 3—2.

This last match was the second round of the Inter-Hospital Cup. By winning it we now enter the semi-finals. The team was greatly encouraged by the presence of their president, Professor Wormald, whose support was much appreciated.

BOOK REVIEWS

PRACTICAL PROCEDURES IN CLINICAL MEDICINE, 2nd Edition, by R. I. S. Bayliss. Churchill, 1951, pp. 484, illus. Price 32s.

This is a guide to the techniques employed in the investigation and treatment of medical patients. As one can appreciate neither the value nor the limitations of such practical procedures without some knowledge of their scientific basis, sufficient information is given to enable the reader to arrive at their rational interpretation.

There are 15 chapters, each followed by some references as a guide for further reading. The first chapter discusses in 20 pages the taking of blood and giving of injections. The others describe practical procedures relating to alimentary tract, cardiovascular system, disorders of the blood, blood transfusion, parenteral fluid therapy, urine examination, kidney function, liver, respiratory system, central nervous system, endocrine glands, rheumatic disorders, radiology. The chapter at the end is called "miscellanea" and deals, *inter alia*, with biopsies, diets, notification and incubation periods of infectious diseases, post mortem weights, and also gives a posological table and a guide to the choice of antibiotics.

There is a host of valuable information and the book is lavishly equipped with tables and no less than 61 figures in 465 pages of text. It is not intended to be just a textbook, for it also aims at helping at the bedside or in the clinical side room when information may be wanted quickly, and where it may be desirable to survey what has been done, what should be done next, how this should be done and how the result will have to be interpreted. Simple laboratory tests which are part of the routine examination of most patients are given in detail; the more complicated haematological and biochemical procedures are more briefly described, with the exception of a very few which the clinician may wish to perform in an emergency when the laboratory is closed.

It is invidious to single out examples, but the kind of information the reader will find is, for instance, not only a short description of the technique and interpretation of the test for acid serum phosphatase, but also a sentence to warn him that a rise of acid phosphatase level may follow the palpation of a benign prostate "hence after performing a rectal examination a sample of blood should not be taken until 24 hours later."

There is an index of 18 pages.

H. LEHMANN.

CIRCULATION OF THE BLOOD AND OTHER WRITINGS, by William Harvey. Everyman's Library, J. M. Dent & Sons Ltd., pp. 230, 4s. 6d.

It is very good to see another reprint of this work which was first published in the Everyman Library in 1907. With an introduction by E. A. Parkyn and a full index the edition represents first-class value at the price, and should be bought by all Bart's men if it is not on their shelves already.

S.P.L.

ESSENTIAL UROLOGY, 2nd Edition, by Fletcher H. Colby. Baillière, Tindall & Cox, pp. 352, illus. Price 61s. 6d.

This second edition, within a few years, shows that the book has proved most popular in America. Some alterations and additions have been made and it remains a very good production of its kind. It is designed for students, both the undergraduate and the postgraduate, rather than for the practising surgeon. It is profusely illustrated with diagrams and photographs which, with few exceptions, are of a high order from both the instructive and artistic point of view; this is especially so of the histological micro-photographs. There are ample lists of up-to-date references (mostly American) at the end of each chapter. There are, of course, some discrepancies. Much the same space is given to sarcoma of the prostate as to injuries of the male urethra. The pathology of hydronephrosis is dealt with rather inadequately, and bladder neck obstruction is merely mentioned. These are minor criticisms, however; the aim of the book is academic rather than practical, the sections on embryology, anatomy, physiology and pathology are quite comprehensive and form a good introduction to the subject; the book can be strongly recommended.

A. W. BADENOCH.

PHARMACOLOGY, by J. H. Gaddum. 4th Edition. Geoffrey Cumberlege, O.U.P., 1953, pp. 562. Price 35s.

The last edition of this book appeared in 1948. In this new edition there are many alterations and improvements, more on the anterior pituitary, more on the blockade of neuromuscular junctions, more on antibiotics. The book has grown by 60 pages, but its character has not in any way altered.

In the days of snake's hair and unicorn's horn pharmacology was an empirical subject. It still is. Here and there science has entered in, and the subject becomes more scientific every day. The neurohormones and the antibiotics are part of a science. But there are so many odd oils and powders, with strange-sounding names, whose use is still entirely empirical, and it is difficult to write about such things in an interesting way. Parts of this book are dull.

The approach to the subject is, by the writer's intention, scientific. It is not a textbook of therapeutics, but a textbook of pharmacology. This edition "preserves the essentially fundamental character of the approach." The book would be of more interest to most medical students if the "fundamental approach," without being any less fundamental, could have added to it more information clinically useful, for here is a place where integration between clinical and pre-clinical medicine should be easy. However, it is still a book almost without a rival.

Of some drugs the doses are given, of others, they are omitted.

G.E.

CLINICAL CHEMICAL PATHOLOGY, by C. H. Gray. Edward Arnold & Co., 1953, pp. 138. Price 10s. 6d.

This is a much-needed book which, in 120 pages, briefly summarises the chemical pathology of acid-base balance, oedema, salt and water deficiency, the function of the alimentary tract, the kidney and the liver, and the metabolism of sugar, fat and calcium. Chemical tests for endocrine diseases are also surveyed and there are useful paragraphs on the cerebro-spinal fluid, uric acid, cholesterol and nutritional deficiencies.

Whether it was worth while to add in such a slender volume instructions on blood collection and details of routine tests may be doubted. These subjects are fully discussed in other books and could barely be described sufficiently in the additional 14 pages devoted to them. Thus, no mention is made of the salicylic sulphonic acid test for albumin in urine, and the student will not be helped greatly when all the information on chemical routine tests for blood in urine is compressed into a statement that "the only satisfactory test is the microscopical examination of the centrifuged deposit for corpuscles, or in the case of dissolved blood (haemoglobinuria), with the spectroscope." When in the Rothera test an ammonium sulphate-nitroprusside mixture of 20:1 instead of 100:1 is employed, traces of acetone will be recognised only with some experience in view of the dark colour due to nitroprusside.

The author is well known for his contributions to the interpretation of liver function tests, but his view that in haemolytic jaundice urobilinogen and urobilin are not present in the urine in excess, unless there is liver damage, has not been generally accepted. One foresees difficulties both in the clinical side room and in the examination halls if students rely on the statements to that effect on page 55. However, these remarks on relatively minor points should not detract from the fact that this book is a most valuable contribution, and fills an acute need. Among its attractive features belong suggestions for "further reading" at the end of each chapter, a table of "normal values" and a helpful index giving more than 300 references. As the price is only 10s. 6d., one cannot but hope that not only every student but also many a graduate will find it worth while to add "Clinical Chemical Pathology" to his reference shelf.

H. LEHMANN.

FRENCH'S INDEX OF DIFFERENTIAL DIAGNOSIS. 7th Edition. Edited by Arthur H. Douthwaite, John Wright & Sons, pp. 1,058, 731 illus. with 200 in colour. 105s.

This is a reference book, and so it should be judged not only on its contents but also on the ease with which the reader may find in it what he is searching for. There is nothing more frustrating than a badly arranged reference book.

But this book is extremely well arranged. The last edition, the one that came out in 1945, was in places obscure and mazy. In the old edition there was a certain amount of repetition and overlap, but the new one has been set out much more logically. If, in the old edition, one looked up "murmurs," one found that the references jumped from "mucus in the urine" to "nails," with no "murmurs" between. In the 7th Edition "murmurs" are just where one would expect them to

be, and the section that follows on "nails" is illustrated by very fine photographs. Clearly, this new edition is a much more business-like production than its predecessor. There is a 147-page index.

As to the contents, the book has been brought up to date. A section has, for instance, been added on liver function tests. Not only are the tests listed, but their significance and their interpretation have been discussed. Here and there one sees the inevitable time-lag between the writing of the book and its publication.

The original editor, Dr. Herbert French, died in 1951. He produced the first edition in 1912, writing the larger part of it himself. Since then, the book has become less and less the work of one man, more contributors being added to each edition. This time, Sir Adolphe Abrahams is one of the new contributors. There must be a stupendous amount of labour in producing and editing such a work.

G.E.

RECENT ADVANCES IN PATHOLOGY, by various authors, edited by Geoffrey Hadfield. Churchill, 1953, pp. 374, 53 plates. Sixth edition. Price 30s.

Though the latest edition of this invaluable book maintains its format and size, there are a number of important changes since the previous volume of 1947. Chief among these is the absence of Professor Garrod from the editorship, though his former co-editor has remained, and the splitting of the book into contributions from various specialists. This might be thought to make for an absence of the readability for which the work has always been noted: it is a tribute to the present editor that this is not so, and that a polished style is found in every chapter.

It must be admitted that the book is now of more use to the professional pathologist than to the medical student. Several chapters, the contents of which still do not appear in the standard textbooks, have been omitted in the new edition. Thus Goldblatt's experiments on arterial hypertension are not mentioned, nor is there any account of the London Hospital classification of nephritis. On the other hand, some old favourites remain and have been brought up to date, e.g. Professor Hadfield's chapter on the liver, and the account of the aetiology of rheumatic fever. As the author remarks in his preface: "... the authors ... are under no cramping necessity to give a full account of their subject ... (they) write about what has interested them and the reader gets the benefit." The student is advised to dip into this book for interest, e.g. the chapters on experimental cancer research and the ductless glands, but the candidate for honours in the M.B. Path. is still advised to borrow the fifth edition from the library.

S.P.L.

THE BRITISH CONTRIBUTION TO MEDICINE, by Jaime Jaramillo-Arango. Foreword by Sir Arthur Macnalty. E. & S. Livingstone, Edinburgh, London, 1953, pp. 220, illustrated. Price 25s.

Possibly because most writers of books on the history of medicine have hailed from the Continent or from the United States, British contributions to medicine had been somewhat neglected. This omission has been noted by several eminent foreign historians, and Dr. Jaramillo-Arango, former

Colombian Ambassador to this country, decided to remedy the defect. Beginning with a brief general historical survey, he provides chapters on the conquest of typhoid and paratyphoid fevers, penicillin, antibiotics, the conquest of malaria, the vitamins, and the struggle for the conquest of cancer. The author does not devote his chapters entirely to British contributions (in fact a large proportion of his references are to foreign literature), but the subjects are those in which modern British scientists have made major advances.

Despite the footnote references to original papers, the book is not sufficiently well documented for an historical work, and it by no means records the full story of the British contribution to medicine, as the title would suggest. Nevertheless, it presents an interesting picture of our pioneer work in several fields of research, and the well-produced volume is remarkably cheap compared with similar publications.

J. L. THORNTON.

BACTERIOLOGY FOR MEDICAL STUDENTS AND PRACTITIONERS, by A. D. Gardner. 4th Edition, O.U.P. 12s. 6d.

The last edition of Gardner was produced in 1944. Subsequent advances, particularly in virology, have necessitated considerable revision.

The section on general bacteriology is very good. Space is allotted with remarkable fairness according to the importance of the organism considered. Unimportant details of antigenic structure and fermentation reactions are omitted whilst space is devoted to diagnosis. Organisms of the same group are considered together and information about one organism is available under one heading. Actinomyces bovis would perhaps be more at home with the fungi than with the mycobacteria. A table of bacterial classification, based on affinity for Gram stain, would be of considerable help.

The chapter on viruses is also good and gives the medical student enough but not too much. The general properties of viruses are outlined and are discussed in relation to six typical diseases. There is a long chapter on Immunity, Hypersensitiveness and Anaphylaxis. This is rather tedious and the subject seems to have been tackled too fully.

The book is well written and eminently readable. Historical features are included where of interest or important for an understanding of nomenclature. The book is well produced and is a good twelve and sixpenny worth.

In summary—an excellent introductory and revisional manual.

R. H.

SURGICAL INSTRUMENTS AND APPLIANCES USED IN OPERATIONS, by Harold Burrows and Ronald W. Raven. Faber and Faber, 14th edition, pp. 160. Price 8s. 6d. net.

The latest edition of this popular book, intended primarily for theatre sisters and house surgeons, contains some new material, while descriptions of obsolete instruments have been deleted. Particularly valuable is a table with comparative sizes of catheters on the French and English scales: the book would be even more useful, however, if future editions gave the eponym to every instrument possessing one, e.g. Samway, for *anchor tourniquet*.

S.P.L.

A SURGEON'S LIFE, by Ferdinand Sauerbruch. Andre Deutsch, 1953. 296 pp. 15s.

This autobiography of the German surgeon Ferdinand Sauerbruch, a most distinguished pioneer in thoracic surgery, evokes a succession of differing emotions in the reader; for the surgeon, although an egotistical bully, was a colourful personality and not entirely lacking in a sense of humour. Indeed, on rare occasions his humour was liberal enough to permit a laugh at "himself."

His contributions to surgery were many and varied, ranging from the development of thoracic surgery based on a proper understanding of the significance of pressure relationships in the chest, to the ingenious amputation stump which allowed the muscles remaining to impart motive power to artificial hands.

Though one may respect his contributions as a surgeon, there can be little respect for the character of the man, as revealed by this account of his life. Sauerbruch's position brought him into contact with many important figures in political and social circles. His accounts of these meetings have an exhibitionist flavour and the inclusion in the appendix of the book of a disclaimer by the widow of General Ludendorff might be interpreted as lending verisimilitude to the saying "old men forget," and casts some doubt on the accuracy of Sauerbruch's description of many of the incidents mentioned in the book.

Though Sauerbruch denied an interest in politics it seems clear that he was at least a fellow traveller of the Nazis. His subsequent de-nazification would seem to confirm this.

Perhaps the most useful purpose of the book as far as medical students are concerned is to indicate the conditions which obtain in a clinic directed by the Geheimrat type of professor. Fortunately the species, common enough on the Continent, is rarely encountered in this country.

D. J. ROBERTSON.

RAWLINGS'S LANDMARKS AND SURFACE MARKINGS OF THE HUMAN BODY, by J. O. Robinson, 9th Edition. H. K. Lewis, pp. 101, illustrated. 12s. 6d.

It is almost fifty years since the first edition of this little book was published. Now, the ninth edition emerges and as it is edited by a Bart's man, it should promise well for the future. Like its predecessors this volume is compact and inexpensive, two traits so dear to the soul of the medical student when adding to his already large scientific library.

This book deals simply yet competently with the subject of surface anatomy with a style that will appeal to those who tread even the most precarious of anatomical paths. This edition, like the eighth, has been rigorously pruned of eponyms, only the most revered remaining.

It differs from the previous volumes in having some new illustrations and the tables of ossification dates has been extended.

If one criticism could be levelled at such an unpretentious book it would be at the illustrations which are of a uniformly low standard, whilst the diagrams are simple to the point of crudity.

However, this small point should in no way retract from the value of this excellent book to the student of anatomy, whether pure or applied.

M.B.

MEDICINE. ESSENTIALS FOR PRACTITIONERS AND STUDENTS, by G. E. Beaumont. Churchill, pp. 831, 69 illus. Sixth edition. Price 37s. 6d. net.

It is not surprising that there is a steady demand for *Beaumont's Medicine*, for it has many of the virtues of the hypothetical ideal textbook. Thus there is often a discussion of the basic relevant physiology before the description of the disease processes, the accounts themselves are short, lucid and practical, while a mere glance at the index will assure a practising lifeman of enough ammunition for several months. The neurology section is particularly to be recommended, and includes an intelligible summary of the anatomy of the C.N.S. and cranial nerves. It is, of course, possible occasionally to find fault with the author: thus he states the prognosis in essential hypertension to be better in men than in women, with which most authorities would disagree; there is no mention of lymphosarcoma as an entity separate from Hodgkin's disease, and although there is a small section devoted to cortisone and its uses, the drug is not advised in the treatment of acute leukaemia or polyarteritis nodosa in the respective sections devoted to these conditions. These are small criticisms, however, and the book is thoroughly to be recommended as a readable compromise between the enormous tome and the last-minute cram-book. S.P.L.

ELEMENTARY PATHOLOGICAL HISTOLOGY, by Barnard. 3rd Edition. H. K. Lewis & Co., Ltd., 1953. 17s. 6d.

Pathology, like the malignant tumour of which it teaches us so much, is invading every corner of medical knowledge. No desk, department or surgery is complete without its cards for "application for pathological investigation." Soon it may be difficult to remember whether clinical medicine was an entity in itself or merely an old-fashioned name for applied pathology.

Clinicians are not yet front-line pathologists, but they cannot work without them, and still less can they work without a knowledge of disease processes as seen from the viewpoint of the cellular pathologist. The ability to picture the changes that are occurring is the reward received for hours spent staring down a microscope. For some, these hours are not enough to fix the image of those all too similar pictures of fibroblasts and lymphocytes and thank heaven for a giant cell upon the mind. To them, the new edition of Professor Barnard's "Atlas of Elementary Pathological Histology" might be a help. It is an encouragingly slim book, well-illustrated with nearly two hundred photographs and containing notes on the photographs and a short introductory essay on each condition. It is a mobile microscope and slide box that can be used in a tube train or by the fireside. J.A.T.

CURATIVE HYPNOSIS, edited by Raphael H. Rhodes. Elek Books, London, 1953. Price 17s. 6d.

This book is a collection of reprinted articles by a number of psychiatrists and psychologists—most of them American, a few English. One is becoming almost hardened to the shoddy English, shallow thinking and careless methodology displayed in so many books of this kind that

come to us from across the Atlantic; and *Curative Hypnosis* is neither better nor worse in these respects than the general run of them.

Hypnotherapy undoubtedly has a valuable part to play in medical practice; but most of the contributors to this book stake too high claims and write as enthusiasts. Nevertheless, it may be read with profit by all those interested in the subject, provided that the critical faculties are not lulled into hypnotic sleep.

E. B. STRAUSS.

POWELL'S PRACTICAL PREPARATIONS IN COMMON USE, by P. J. Cunningham. Faber, 1953. 86 pp. 4s. 6d.

I cannot think what Sister Hope would have said had she read in a book that still bears her name that a pillowcase should be used to cover the face of the dead. There have disappeared in this edition not only some outdated procedures, but some that are not—giving oxygen and testing urine for instance—as well as the preparation for X-rays and special tests. Such words as "speculae," "phlange," "nappy" and "nasal-gastric" occur, along with proprietary names (that we are asked not to use), of such preparations as procaine.

Among criticisms of technique that could be made are the following: It would be highly dangerous to fill a stomach without apparatus with fluid before passing the tube, especially without a clip (page 72); it is impossible to understand the procedure for a gastrostomy feed (page 44); 1 in 20 carbolic is too strong to be recommended for combing the hair (page 46); requirements for injecting piles appear without comment on a trolley for sigmoidoscopy (page 69); the use of hyalase is universal nowadays in subcutaneous infusion, and it is frequently used for adults (page 73). The book suggests that the author has not had recent practical experience in this field.

If the reader were asked: "What is a Wash Down?"—this being the final procedure—it is exceedingly unlikely that she would know the answer.

TOXAEMIAS OF PREGNANCY, by John Sophian. Butterworth, 25s.

The author has been keenly interested for many years in the aetiology of toxæmia of pregnancy; his book consists of a most erudite account of kidney function and his own theory of origin of pregnancy toxæmia. He postulates that if the ureter can reflexly produce anuria, then the uterus, because it arises from the same soil as the ureter, may possess a similar potential.

The essential thesis is the aetiological association of the tense uterus found in the primigravida, in twins, hydramnios and in cases of concealed accidental haemorrhage, with the renal phenomena characteristic of toxæmia of pregnancy. The author maintains that the signs of toxæmia are caused by a renal dysfunction similar to that first described by Trueta and his colleagues. Sophian and Franklin have experimented on the rabbit, producing paling of the renal cortex when the non-pregnant uterus is distended.

This book will be of great value to the obstetric specialist and to anyone particularly interested in the modern theories of renal function; it is well written and entirely up to date.

J. BEATTIE.

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TALKING OF

THEY finish dinner, and it is a slow and pleasant time of day. There is a case in the wards that no one can diagnose. Functional, says one man. And what does "functional" mean, asks another. Even the clatter of the tin trays seems mellow, and there is a pleasant blur of cigarette smoke. Everyone is relaxed, returned to a golden age of leisure. Someone tells a story about a Famous Mistake. More coffee comes, the cups are muddled but no one worries, the evening unhurried, elbows on the table.

"But," says someone, "but don't let's talk shop."

Everyone jumps, and flushes with guilt. There is a silence, broken only by the harsh rattling of those vile trays. The room is hot and smoky, cigarette ends stubbed out in the saucers. Everyone is uneasy. "No," they say, "no more coffee."

Why are doctors (and all forms of scientists) so ashamed to talk shop, to talk it among themselves and to talk it among laymen? It is in the casual after-dinner conversation, when a man is forced to defend his prejudices before those who have not been trained to respect them, that he suddenly discovers the depth of his own ignorance and the breadth of his own knowledge. It is very refreshing to have to propound neurophysiology to a philosopher, and a man soon discovers what ground he stands on if he expounds enzyme chemistry to a puzzle-loving clergyman who has never contracted any allegiance to the textbooks. It does the chemist good to have a fresh and uninhibited mind slashing at the things that he has taken for granted, and it does the clergyman good to realise what, apart from atom bombs, the twentieth century is coming to.

There is also much to be gained by the scientist talking science to the scientist, or on a less lofty plain, the medical student talking medicine to the medical student. In leisured conversation and in coffee-time debate, ideas grow. This is not to advocate that medical men should talk about medicine and nothing else but medicine. It is not a defence of dull men who quote dull textbooks at breakfast-time. This is only a suggestion that it is a very laudable thing for scientists and medical men to talk about, among other things, science and medicine.

It is nowadays better manners to talk about golf and last year's rainy summer holiday than it is to mention science. There have in other times been other fashions. There were the days when all elegant London would crowd to Faraday's lectures, when a poet would eagerly study electro-magnetism in a search for new images. The wealthy Victorian gentleman collected moths, and knew the archeology of his county. In still more distant days, there was no barrier between the sciences and the arts, and Leonardo was proud to be called an engineer.

It is all a plot on the part of the arts men, this pretending that it's not nice to talk about science, that culture is non-science. The philosopher talks about Ryle, and tells us that all we say is meaningless. We murmur our admiration for his learning. The economist has a few shrewd things to say on convertibility, and we only wish that we could understand. The musician passionately declaims on tone and colour, and the painter shouts about rhythm, and this we tell ourselves, this is real Conversation. Yet they are all talking shop. Why shouldn't they? If the scientist would be more brazen in his shop-talk, his purposes and his responsibilities would not be so superbly misunderstood.

Short White Coats

It has been mooted that clinical students shall again wear short white coats. This was the custom before the war. There is an older generation that is fond of white coats: there is the present generation of students, and this generation dislikes short white coats. For the past months the arguments have been marching backwards and forwards like chess men who are unwilling to leave the board, the outline of each argument as distinct and well known as the profile of a pawn. The final decision on the white coats has now been postponed until May 1st. The general opinion among the students is that short coats, to the eye that has not been brought up to reverence them, look silly. The long white coat, though, is regarded as a well-favoured form of dress. Such a matter is, of course, not simply one of student taste, but very largely a problem for the hospital authorities who bear the costs of the laundering. However, it is strange that in the discussions that took place before the original decision was made, no one seems to have tried to discover the views of those who are to wear the coats.

Madrigals

F. J. C. M. writes:—

The hospital Madrigal Society is not well known, but on Friday, February 12, it gave its first public concert in the Nurses' Home. The programme included part songs and motets as well as madrigals.

In spite of much humorous comment before the performance, every seat in the nurses' large sitting room was occupied; the audience consisted of nearly one hundred nurses, several sisters and one student who survived to tell this tale. The sitting room made an excellent concert hall, unrivalled for comfort and warmth; for not even the Festival Hall can supply arm chairs and settees for the audience. The choir consisted of nine sopranos, four contraltos, two tenors and three basses; they added to the elegance of the occasion by appearing in evening dress.

The concert began with a motet "Jesus the very thought is sweet," a piece of great beauty demanding good breath control and perfect poise, it was, perhaps, a little unwise to choose this piece to open the concert, for the choir had not got over their stage fright. Next, were sung four madrigals. The first madrigal, "Fine Knacks for Ladies," was vivacious and jolly, and well sung; the

second was Orlando Gibbon's famous "Silver Swan," the sopranos came in beautifully, and this song was gracefully and quietly performed. "To-morrow the Fox," an Elizabethan madrigal, was thoroughly enjoyed by both audience and choir. The final madrigal was one which has never been published, called "Thus sung Orpheus," it was written in five parts and was a good test for the choir; they passed with honours.

During the interval, the conductor, Mr. Richard Sinton, entertained the audience with piano pieces by Brahms and Mendelssohn.

After the interval the choir completely lost their initial nerves and really enjoyed themselves. They sang Benjamin Brittain's "Old Abraham Brown," a rollicking thing. The choir ended the concert with two songs which showed the society at its best; the first was a performance of the Irish folk song, "My Love's An Arbutus." This was sung with real sparkle and a fullness of tone for which we had been waiting all evening. The final Bach chorale, "Break In Twain My Heart So Heavy" was perhaps the finest performance of the evening. The singing was reverent, unamplified and well controlled, the result of long practice with a competent conductor.

The society is to be congratulated on its very fine performance; they are now practising a concert of Easter music to be given in St. Bartholomew's the Less, and are also planning a concert of folk songs. Those interested in music are strongly advised to follow the progress of this energetic little society, for they can produce music of the very highest standards. Rehearsals are held in the nurses' home on Monday evenings at 8.45 p.m. Membership is open to nurses and students, the only qualification is the passing of a simple audition by the conductor.

Aids to Bartholomew

The Dean writes:—

"The Vade Mecum recently published and distributed to the students has been compiled for the governors of the hospital by a committee of the Medical Council.

"This committee had the difficult task of collecting information from the various departments of the hospital and editing the vast amount of typescript sent in.

"The result is a pocket-size book which it is thought will be useful to the clinical student, and still more so to the house officers

and registrars; even general practitioners and consultants will find useful information, and the interleaving allows for plenty of personal additions."

The popularity and success of this book will be decided in the months to come, when it is put to the test in the Wards and the Boxes. It certainly made a very favourable first impression, and those who worked so hard in preparing it deserve our very warm thanks. The problem of balancing the contributions from the different departments must have been an unenviable one. The pathology and the dict sections together take up just short of half the book's hundred pages.

The Bart's crest on the front has caused some people to argue that black is white. Far and few are the occasions when this ancient argument has been presented so literally.

A Bart's Register

No register of Bart's men is at present published. Whether a register is brought out must depend on someone being willing to produce it, and on a large number of people being willing to buy it. Two letters have been written to the *Journal* saying that a Bart's Register would be a very welcome thing, and the letter published in this month's *Journal* reminds us that in the past such a directory was issued "from the Journal Office."

There is a copy in the library of the 1923 Students' Union Year Book. It is a limp-covered red pamphlet, of about the same size as the present Bart's Calendar. It contains an alphabetical list of all Bart's men, with their addresses, followed by a directory with names arranged under localities. At the end there is an alphabetical list of students. The year book also contains notes on the Students' Union, and on each of the associated clubs, with a list of that year's officers. Among the societies that have since perished, is the Bart's Jazz Band.

The 1923 directory was prepared by Mr. McAdam Eccles, who was then chairman of the Journal Publication Committee. It obviously involved a great many hours' work. Before anyone were again to contemplate issuing a year book, it would be necessary to have some estimate of the likely demand for it. If any old Bart's men care to write to us on the subject we should be pleased to hear from them.

No hawkers, circulars, flummery

All sorts of doors have all sorts of notices, ranging from the message pinned up for the baker, through a whole variety of Push and Pull and Beware of the Dog, right up to the most polished and sophisticated brass plate that shines in Harley Street. One might think that the world of doors held no surprises, yet the other day there appeared on the door of a Side Room in one of the Wards a quite new sort of notice. It read:—

NOTICE TO VISITORS

The use of the following expressions is strictly forbidden:—

- (1) "I wish I could rest for six weeks."
- (2) "Waited on hand and foot."
- (3) "Well, I expect you will find plenty of material, eh?"
- (4) "Well, you look all right."

This notice had been pinned up by Mr. Paul Jennings, who for some weeks has been a patient at Bart's. Mr. Jennings is known through his articles in *The Observer* as an expert on things that are Oddly. He has very kindly written an article for this number of the *Journal*. We hope that Mr. Jennings will soon be enjoying health as robust as his appearance leads his visitors to expect of him.

The Photographic Department

The photographs of Hogarth's paintings that are published in this month's *Journal* were taken by Mr. N. K. Harrison, of the photographic department of St. Bartholomew's Hospital. These wall paintings are a difficult thing to photograph, for the light on the staircase to the Great Hall is, at most times of day, dim. Mr. Harrison used early-morning light.

We would like to thank Mr. Harrison and his assistants for the help that they have always given to the *Journal*.

Wessex Rahere Club

The Spring Dinner of the above club will take place at the Royal Clarence Hotel, Exeter, on Saturday, April 24.

Mr. H. Jackson Burrows, F.R.C.S., has kindly accepted the invitation to be present as guest of honour.

Membership of the club is open to all Bart's men practising in the West Country. Further details will be circulated to members and to any other Bart's men who are interested and who will get in touch with the

Hon. Secretary. Mr. A. Daunt Bateman, of 11 The Circus, Bath.

Congratulations

To Dr. F. B. Strauss, upon whom the Wolfgang Goethe University of Frankfurt has conferred an honorary doctorate. The citation states:—

"According to the resolution taken in our last meeting, after having carefully scrutinised for more than a month Dr.

E. B. Strauss's merits in the various fields of science and learning, and paying particular attention to the human side of the man, my faculty confers upon him, thereby honouring itself, the title and degree of Honorary Doctor (D.Phil.Nat.Sci.)."

To Mr. and Mrs. R. H. Starte, on the birth of a son, Andrew Harold Roger, on February 11. Mrs. Starte was, before her marriage, Miss S. Young.

CASE BOOK

by PENRY ROWLAND

FLEAS

Two or three miles away from the City of London, one hundred years ago, lay the village of Islington, and theatrical companies used to play first in the Grand Theatre there when starting on a provincial tour.

The village changed and a busy High Street developed between The Angel and Highbury. Two of the old villagers were left in their cottages, with little gardens in the front, and they were content. They grew older and deafer and blinder, and they were alone and friendless. One day the old man said he felt too weak to get up, and his wife sent a neighbour to fetch the parish doctor. When he came, the old wife opened the door and peered at him. She had obviously advanced cataract in both eyes. On entering a terribly dark and musty bedroom, he lit a candle and saw the old man on the bed, gasping for breath and very, very pale. His pulse was scarcely to be felt and he could only whisper. The sheet was black with a myriad bloodstains, and when it was turned down the bed was seen to be alive with fleas—hundreds of them. The old man's body was covered with tiny petechiae from flea bites.

"Do you use Keating's powder for the fleas?" the doctor asked the old woman. "Fleas, sir! I've never seen a flea in the place, sir."

The doctor hurried away to get the old fellow moved, but he died thirty-six hours after.

Diagnosis—Death from anaemia, secondary to haemorrhages following flea bites. In the year of Grace 1900.

THE HOUSEMAID

1899—Queen Victoria still comfortably enthroned. Scene—the grubby old O.P. department of Bart's. People poorly clad and anaemic. Sister Surgery spick and span like an orchid dropped on a dustheap. Usual rumble of Smithfield and of three hundred subdued O.P.s uttering breaths of the type briefly described by Shakespeare in Julius Caesar. Suddenly, the doors are burst open and a fat Victorian cook, escaping the porter, staggers in claspng at knee level, a pale, thin, shrieking housemaid with an eighteen-inch waist (estimated). Junior H.P., objecting to distraction, commands in sergeant-major fierceness: "Put the girl on that couch. Now go until I send for you. No, not a word." Turns to the girl, "Turn on your right side at once and go to sleep." The silent and frightened maid obeys. Routine goes on till lunch time. H.P. gets through his appalling O.P.s and thinks of lunch. Sister approaches and suggests examination of sleeping patient.

"I think I'll leave her till she wakes, Sister."

"Better not, Doctor."

Patient is roused and shrieks again. *Diagnosis*—Perforated gastric ulcer.

Lunch is eaten hurriedly and Mr. Howard Marsh is watched for at the fountain rim. H.P. cogitates on women, waists, diet allowed for thin Victorian housemaids, and on fat cooks.

Diagnosis—Unintentional hypnosis complicating gastric ulcer due to "tight lacing."

WILLIAM HOGARTH

AND THE PICTURES HE PAINTED IN ST. BARTHOLOMEW'S HOSPITAL

by JAMES TAIT

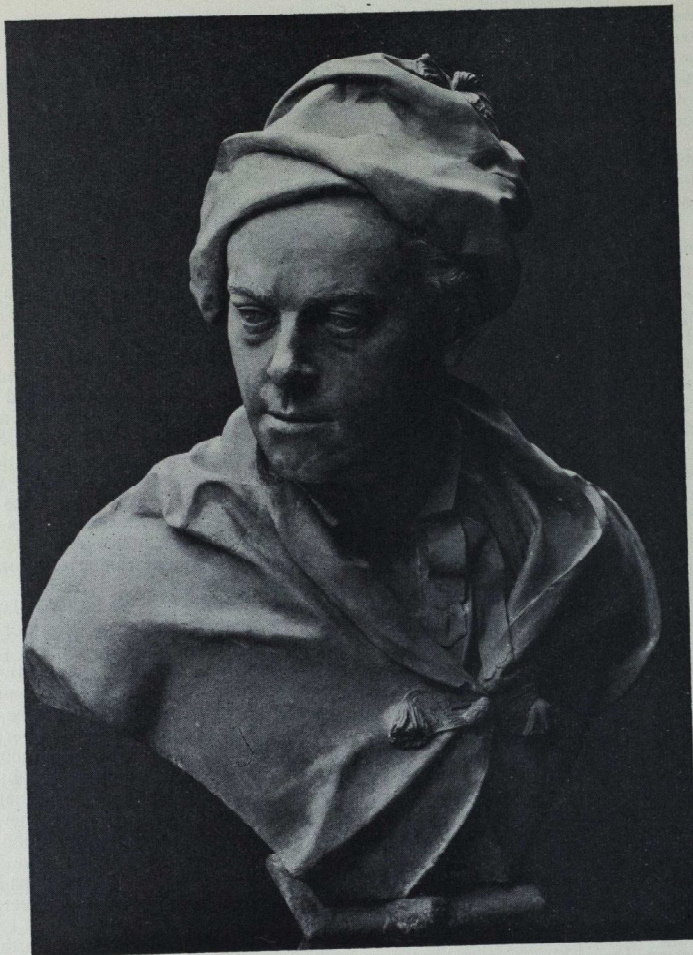
WILLIAM HOGARTH was born in Bartholomew Closte and christened in the church of Saint Bartholomew the Great in 1697. His grandfather had been a yeoman farmer in Westmorland and his father was a rather unsuccessful schoolteacher in the city of London. From earliest times he had a love of drawing and painting and was taken from school to be apprenticed to an engraver of silver. His lack of education did not hamper him in the practice of his art, and after serving his apprenticeship he set up on his own as an engraver. He supplemented his income by designing and engraving plates for book and print-sellers. In 1724 he began to attend Sir James Thornhill's art school, and during the next few years while he continued to engrave for booksellers, he became increasingly aware that there was little money to be made in that field and that he might more easily make his fortune by painting in oils.

From about 1725 onwards, he painted and sold small family groups and conversation pieces. These were not great art, but they were good enough and popular enough to gain him a place amongst the recognised artists of the day. In 1729 he married Jane, the daughter of Sir James Thornhill; this he did against Sir James's wish, and it was some time before his father-in-law became reconciled to the match. It is said that the reconciliation occurred when Sir James discovered that a new series of prints that he admired were by his son-in-law. These prints were the first of the *Modern Moral Subjects* which were to be so popular and to bring Hogarth fame. In this series, which was called *A Harlot's Progress*, Hogarth's unique aim in painting first became apparent. "I have endeavoured," he wrote, "to treat my subjects as a dramatic writer; with my pictures as my stage; and men and women as my players." Hogarth was attempting to fill a gap, for as he says, "I thought both writers and painters had, in the historical style, totally overlooked that intermediate species of subjects which may be placed between the sublime and the grotesque." The human species were the actors, dressed for genteel

comedy or farce, for high life or for low, and by actions and gestures acting a dumb charade. His was the brush that was company for the pen of Swift or Pope or Fielding or Gay. His was an age of satire, and *A Harlot's Progress* or *Marriage à la Mode* or *Gin Lane* or *Beer Street* were weapons as powerful as Swift's ballads or Pope's satires or *The Beggar's Opera* and a good deal easier and quicker to understand.

A Harlot's Progress was an immediate success, and was engraved and had a wide publication. In 1733, Hogarth took a roomy house in Leicester Fields (Leicester Square), which shows that he was beginning to make the money he wanted, but his name was not yet widely known, for when Sir James Thornhill died in 1734, a mention of his son-in-law in the obituary notice read—"admired for his curious miniature conversation paintings," and no more.

In the year in which his father-in-law died, William Hogarth became a governor of the hospital. How he came to fill this position is not known. Perhaps an association with Smithfield in his youth, or an acquaintance between himself and another of the governors, or a friendship with a member of the hospital staff—such as the surgeon Mr. Freke—might have accounted for his election. It might have been a combination of all these factors and of yet another: The desire to indulge in historical painting in the grand manner was very much alive in this painter of "pictur'd morals." Perhaps he had heard from James Gibbs, the architect of the new hospital, that there was a vast expanse of clean wall around the new north wing staircase, but this is in no way established and it is far safer to suppose that he became a governor for the more conventional reason of charity. Soon after he became a governor, he embarked upon the two great paintings that now surround the staircase to the Great Hall. Since there is no record in the hospital archives that Hogarth ever gave the accustomed gift of fifty or a hundred guineas to the hospital on being elected a governor, it is reasonable to think that he gave the pictures in lieu of guineas.



WILLIAM HOGARTH, 1697-1764. A terracotta bust by L. F. Roubiliac.
(Photo copyright National Portrait Gallery.)

Hogarth himself tells us about the paintings in these words—"Before I had done anything of much consequence in this walk (modern moral subjects) I entertained some hope of succeeding in what the puffers in books call the great style of history painting; so that, without having had a stroke of this grand business before, I quitted small por-

traits and familiar conversations, and, with a smile at my own temerity, commenced history painting, and at a staircase at Saint Bartholomew's Hospital painted two scripture stories, *The Pool of Bethesda* and the *Good Samaritan*, with figures seven feet high. These I presented to the charity, and thought that they serve as a specimen to show that

were there an inclination in England for encouraging historical pictures, such a first essay might prove the painting of them the more easily attainable than is generally imagined. 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 expectation of advantages from that source and returned to the pursuit of my former dealings with the public at large."

That public to whom he returned didn't like his staircase venture into the grand manner of painting as much as he would have liked and there was no demand for engraved copies until after his death. A newspaper of July 14, 1737, wrote: "Yesterday the scaffolding was taken down from the picture of *The Good Samaritan* which is esteemed a very curious piece."

A search through the hospital archives discloses an occasional reference to Hogarth, but never anything of great interest. There is an entry for July, 1737, where he receives the official thanks of the other governors for his gift of the pictures. There is another in 1738 to the effect that Gibbs and Hogarth should see that the large eighteenth-century copy of the picture of Henry the Eighth should be properly framed and hung, and to arrange for a bust to be made from the tomb of Rahere in Bartholomew's the Great.

In 1749, there is another entry to the effect that Mr. Hogarth be consulted and asked to give the necessary orders for the cleaning and repairing of his painting.

Hogarth's attendance at the House Committee was never very frequent, and as the years went by it grew even less frequent: Once or twice a year to start with, and then once every year or two, and then he is spared our knowing how little he attended for full lists of attendance were not kept after 1750. His presence or absence in committee will remain a secret, but since the election of a governor was for life, he retained the right to attend until his death.

As a successful painter, Hogarth's life really began after he had painted the hospital staircase. He gave up historical painting and continued to produce the series of moral pictures such as *Marriage à la Mode*, *The Rake's Progress*, *Industry and Idleness*, and many portraits and other satirical and sublime pictures. Amongst the pictures by Hogarth that have any connection with the

hospital, there are two that might be mentioned. He painted a portrait of James Gibbs, and is supposed to have caricatured Dr. Dod, a physician of the hospital who had written an over-solemn pamphlet that had been much ridiculed. This caricature is reported as appearing in a picture called *The Company of Undertakers* or *A Consultation of Physicians*, but if this is so, he has not been recognised from amongst the figures that appear in the picture. Dod's pamphlet was printed in 1746, and Hogarth's picture painted in 1736, which are facts that do not fit easily into any theory that the picture was a result of the pamphlet.

Until his death in 1764, Hogarth went on working at engravings and portraits, but his creations never again crossed the path of hospital history. When he died he was buried at Chiswick, and so even his body remained away from the hospital, and his birthplace in Bartholomew Closte and the church where he was christened. Johnson said that he was a man that saw the manners of men in their faces and that his own portrait is the index of his character. A sturdy, pugnacious, outspoken, honest, obstinate little man, but he was also witty, genial, faithful and generous as we in this hospital have cause to be reminded each time we climb the staircase to the Great Hall.

A little vanity is no sin, and our benefactor possessed this quality. There is a story about Hogarth that tells how one day at dinner he was told that Mr. John Freke, surgeon of Saint Bartholomew's Hospital, had asserted that Greene was as eminent in composition as Handel. "That fellow Freke," replied Hogarth, "is always shooting his bolt absurdly one way or the other! Handel is a giant in music; Greene is only a light florimel kind of composer." "Ay," said his informant, "but at the same time Mr. Freke declared you were as good a portrait painter as Vandyck." "There he was in the right, and so I am," replied Hogarth, "give me my time and let me choose my subject."

This is no place to enlarge upon Hogarth's importance in the history of art, but it is the place to say something more of the two paintings of his that are in the possession of the hospital, and are here illustrated. Paintings such as *The Good Samaritan* and *The Pool of Bethesda* were not in the ordinary run of Hogarth's work. He did on several occasions paint historical subjects in what was more or less the grand manner, but these have



THE POOL OF BETHESDA, by William Hogarth. Painted 1736. 20 ft. 3 in. by 13 ft. 8 in.



THE GOOD SAMARITAN, by William Hogarth. Painted 1736. 16 ft. 9 in. by 13 ft. 8 in.

never been considered amongst his best works.

Horace Walpole, when writing of another artist who died when Hogarth was a boy, said of him that "he is an excellent painter for the sort of subjects for which he is employed, that is without much invention and with less taste; his exuberant pencil is ready in pouring out gods, goddesses, kings, emperors and triumphs over those public surfaces on which the eye never rests long enough to criticise, and where one would be sorry to place the works of a better master, I mean ceilings and staircases." That was a pretty fair description of the degenerate baroque style that was in fashion at the end of the seventeenth century. Hogarth thought no more of the style than did Walpole, and had often been outspoken in his dislike of the sham masterpieces, the Holy Families, Madonnas and other dismal dark subjects which the picture jobbers imported from the Continental high-art factories.

He could dislike the old style, but when it came to his turn to try his hand at historical painting, he was not altogether successful in avoiding that which he decried. Some of the figures in these two pictures are not as surely hogarthian as they ought to be. There is a suspicion of having seen them somewhere before. In the Continental high-art factory perhaps. In *The Pool of Bethesda* the figure of Christ, the reclining nude, the angel, and to a lesser degree, the man with an ulcerating leg and the boy on the left, all appear to have been imported. In the minor figures and more particularly in the group standing behind Christ and the woman holding her child, there is something of the real Hogarth, and here the figures are strong and alive. In the *Good Samaritan*, the Samaritan himself appears as a figure of Hogarth's making, while the reclining naked attenuated figure is a loan from the Continent. The dog (not unlike his own mongrel in his self-portrait) is better drawn than the horse, and the priest who stands on the hill in the background is a figure full of misplaced humour and looks lost in a serious religious historical picture.

In these pictures it is the places where Hogarth brings the characters of ordinary people into being that stand out as having great charm. He understood simple human beings who lived and worked in London in the eighteenth century and his picture is happy where such figures appear. When it

came to portraying well-known religious or historical figures, either he could not forget what he had seen in other people's pictures or else he was incapable of creating such figures.

The figure of Christ in *The Pool of Bethesda* is surprisingly like a mirror image of the central figure in a painting of the same subject by Murillo which is to be seen in the National Gallery. Of some of the other figures it would be possible to say that they were like figures from Titian or Veronese, but it would be a mere academic point as to which old master gave a figure here or which there: It would add little to the enjoyment of looking at the picture.

It has sometimes been said that Hogarth used patients as models for the sick people in these pictures. This could be true, but there is no evidence for such an assumption, and in view of the fact that many of the figures are borrowed whole from elsewhere, and with the knowledge that Hogarth had a great capacity for remembering and drawing all manners of people, it becomes unnecessary to suppose that he did so.

The landscape background and sky were painted not by Hogarth but by John Lambert, and the ornaments, scroll and surround by yet another artist—a Mr. Richards. The pictures are therefore rather uneven in quality, but taken as a whole and in their setting, they are both pleasing and impressive. There are three small studies of the life of Rahere that appear below the main pictures; these are simple and charming.

William Hogarth hated what he called the "dark masters," which were those pictures demanded by the taste of his day that were so darkened by successive layers of varnish and dirt that the pictures beneath were only muddy ghosts of the originals. Probably because of this, he requested that these paintings should never be varnished. His wish was for some time observed, but when they were cleaned in 1934 it was reported that seven coats of varnish were removed.

Engravings of these pictures have been made by Ravenet, in 1748 and in 1772, and by Cook in 1809. Engravings exist in the hospital library and in the small waiting room in the nurses' home; a distribution that is admirably suited to attract the attention of all manners of men which is something that Hogarth would have liked, for it was his aim to paint pictures for the many and not for the few.

VILLAGE PRACTICE ON THE GANGES PLAIN

by JOHN DOSSETOR

ACROSS the north of India lies the thousand-mile-long Ganges plain carrying the holy and reasonably pure snow-water of the Himalayas, albeit with ever-increasing pollution, down to the muddy delta on the Bay of Bengal. The soil is fertile and produces a large proportion of India's food, but it is also one of the most densely populated regions of the world. Unlike areas in Europe of equivalent population density, 90 per cent. of people live in villages or small towns. Until recently the responsibility for administration of the majority of these country areas was in the hands of British or Indian landlords—zamindars—but now the large estates have been broken up. The humble peasant, being quite illiterate, sees little difference between his former semi-feudal serfdom and his present destitute independence. His fate is still controlled, as it always has been, by the merchant, the money-lender and the monsoon (the prosperity of the former two being proportional to their girth at the waist and inversely proportional to that of their peasant clientele).

Hospital amenities are found only in the larger towns where the majority of practitioners have medical degrees. In the smaller towns, qualified and semi-qualified men are quite unsupported by hospital and laboratory facilities. Others, who may be quite unqualified and ignorant, earn a substantial income from the sale of injections (ranging from aureomycin to distilled water) to the even more ignorant patient. Their fees are, however, prohibitive for the villager, whose family income, in actual money, may amount to no more than ten to twenty shillings a month. For the village dweller there are no public services, social security, or medical cover, and his expectancy of life is still only thirty to thirty-five years—and there are upwards of two hundred and fifty million such persons in India. It is not to be wondered, therefore, that Indian patients flocked to the camp hospital at the British Gurkha recruiting depot near the Nepal border as soon as the word was passed that the white "sahibs" medicine was cheaper, and perhaps more efficacious, than that to be obtained in the local

bazaar. They were seen by one of the two R.A.M.C. officers who were stationed there.

Summarised below are the initial diagnoses on one hundred consecutive patients seen in July, 1953. The difference between these and a similar series from the depot soldiers and their families (Gurkha) would show that considerable selection had occurred by the time the Indian patient had arrived at the hospital. Ignorance and superstition would have kept many away, while another factor may have been lack of bullock-cart transport, perhaps. There is an undue proportion of adult male patients to female (three to one), the place of women in this primitive society still being very much in the background, and in the home. During an eighteen-month period, for example, only two women were brought from the villages in obstetrical difficulties. One, included in this series, had had delay in the aftercoming head of a breech delivery and the relatives had pulled the head off the trunk of the foetus, the head remaining in utero. The second was obstructed labour due to partial placenta praevia and an impacted shoulder presentation with exsanguination. Within the camp practice simple conjunctivitis, upper respiratory infections, fungus disease of the skin, three to four-day P.U.O., discharging ears and minor complaints were much more in evidence.

It is stressed that these are only initial, or presumptive, diagnoses. The difficulty in accurate diagnosis, apart from inexperience in tropical disease, and with only one's own laboratory work, was the impossibility of taking an accurate history and the fact that many patients with chronic disorders would not attend regularly—in fact they seemed to believe that one injection would cure all ills. Patients showed reluctance to come in to hospital (as their food had to be brought from their home) and, once admitted, often took their leave with or without warning. History taking had an amusing as well as a frustrating side. A simple question, e.g. "Do you have pain in the chest when you cough?" would be translated from English into Hindi by the orderly and then into the local dialect by the husband or other Hindi-speaking relative. A long argument, excited and gesticulating, would

then take place, the gist of which was then passed back to the orderly who would give the laconic answer, "NO," or "She says that she suffers from terrible headaches." No patient knew his or her own age, or that of

their children, and the most chronic of disorders began "only fifteen days ago, huzoor"! The extent to which pathology could be studied will be seen in the paragraphs which follow the summary below.

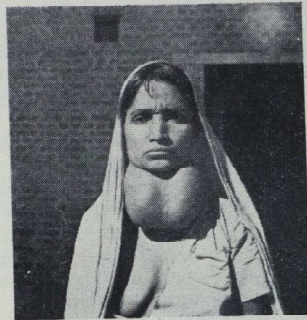
INITIAL DIAGNOSIS IN 100 CASES SEEN IN JULY, 1953

1. ACUTE FEVER.	1	Malarial parasites seen.
Malaria	1	Clinical diagnosis only.
Kala-azar	1	
P.U.O.	4	
2. CHRONIC SPLENOMEGALY	12	Chronic malaria, chronic kala-azar.
HEPATOMEGALY	13	clinically amoebiasis, many with hepatic tenderness.
3. ALIMENTARY SYSTEM...	15	1—acute bacillary dysentery (presumptive).
		1—piles.
4. CHEST DISEASE	11	6—pulmonary tuberculosis (4 AFB pos.).
		1—asthma.
		3—chronic productive cough (? t.b. or bronchiectasis).
		1—pleuritic pain (? cause).
5. VENEREAL DISEASE	8	Gonococcal demonstrable in the majority. One, ulcer on vulva.
		(? aetiology).
6. URINARY SYSTEM	4	Cystitis. One type I nephritis.
7. CARDIOVASCULAR	2	1—? rheumatic fever.
		1—chronic rheumatic valvular disease, dyspnoea.
8. OBSTETRICAL	2	1—foetal head retained in utero.
		1—post-partum urinary incontinence.
9. EYE DISEASE	3	2—conjunctivitis.
		1—abscess on cornea.
10. E.N.T.	6	1—epiphora in an infant.
		1—sinusitis.
		1—acute mastoiditis.
		2—discharging middle ears.
11. SKIN DISEASES	7	1—foreign body in ear.
		1—severe fungus disease of leg.
		1—erysipelas in an infant.
		3—pustular eruption of face and scalp of children.
		2—eczema (? aetiology).
12. LEPROSY	3	
Also:		
Nervous disease	2	2—peripheral neuritis.
Sepsis	3	1—ischio-rectal abscess.
		1—septic palm.
		1—flexor sheath infection of hand.
Dental sepsis	3	2—carious teeth, for extraction.
		1—alveolar abscess.
Trauma	2	1—Colles fracture.
		1—fracture of femur, mid-shaft, in a boy.
Snake bite	1	Patient died, said it was a cobra.
Cancer	1	Epithelioma of jaw.
Unclassified	9	2—headaches, no fever.
		3—vague abdominal pains.
	100	

Dysentery. Amoebic and bacillary dysentery were both common, especially the former and with evidence of hepatitis in many. The villager defaecated in the fields around his village without the least embarrassment, whereas his cattle and his children confined themselves more centrally. The heat of the sun may have some sterilising effect during the dry months but in the

monsoon the paths between the huts (there are no roads in many small villages) resemble a farm midden through which treads man and beast with bare-footed unconcern. Domestic fuel consists of cow-dung, fashioned by hand, and affixed to wall or tree to dry.

Phthisis. This is a scourge—perhaps even more so than in this series as it was



Goitre

becoming known that we were not prepared to treat this disease. Throughout the East, of course, spitting in public is a favoured pastime.

Leprosy. Another common disease, recognised from the pale anaesthetic areas, the thickened peripheral nerves (the visibility of the great auricular nerve being a valuable sign) the involvement of the face and ears and the acid fast bacilli in the nodule 'Juice.'

Venereal Disease. This was mainly gonococcal and identifiable from smears. Primary chancre was seen and occasionally a frank tabetic was recognised. Chancroid did not seem common.

Kala-azar is common in this part of India and was seen in its acute form with splenomegaly, anaemia, two-peaked temp. chart, positive formol-gel test; Leishman Donovan bodies were occasionally seen in marrow smears stained with Giemsa. Several cases of cerebral malaria occurred but not blackwater fever. Periodic acute fever seems to be accepted as part of normal life in the village and this is reflected in the chart above.

Chronic Splenomegaly and hepatomegaly and anaemia. Very large spleens were a daily occurrence and were grouped into those that were i. easily palpable; ii. those that "shook one by the hand" and iii. visible. The differentiation of those due to chronic malaria or chronic kala-azar did not seem easy. (Tropical splenomegaly, not responsive to quinine, was one of the features of the disease now known as kala-azar which was noticed by Manson in 1903.)



Benign Breast Tumour

Ascites with hepatic cirrhosis was presumed to be due to chronic malnutrition, secondary to fatty infiltration, perhaps, when other causes seemed improbable. Hydrocoele was more common than in England and only in a few of these was **filariasis** the apparent cause.

Post **small-pox** scarring (though no acute disease) was often seen. The obvious protection given to a vaccinated community by a single scarification may underlie the faith in the "needle" that was so often present. Other diseases seen were **rheumatic fever**, chronic valvular heart disease (once believed to be uncommon in the tropics), **tetanus**, **poliomyelitis**, oedema and neuritis due to **malnutrition**. **Cholera** occurred spasmodically in the district and the custom was to remove the rope from the well of the affected village—reminiscent of the removal of the handle of the Broad Street pump when cholera broke out in that part of London. **Simple goitre** was common, especially among the Nepalese who came down from the Himalayan foothills and there was good evidence that iodine therapy would cause the diffuse thyroid enlargement in the young adult to disappear completely. **Scorpion sting** was very much more common than **snake bite** and the pain was relieved by procaine injection at the site of sting: it was never fatal.

Among the plethora of clinical material, there were several notable absentees. No case of appendicitis, of angina of effort, or of diabetes was seen during fourteen months, and peptic ulceration was seen only once, a

perforation in a soldier who had spent many years as a quarter-master's clerk. Vague abdominal pain was often given as a symptom, but after vigorous treatment with vermifuges the patients were not often seen again. Visceral carcinomata were uncommon, probably due to the fewer old people treated.

This survey gives some impression of the grosser forms of disease seen in a village community in northern India and of the problems, particularly social and hygienic, which have yet to be faced. Over a year ago, a well-sprung van, supplied by an international health organisation, swept through a few roadside villages in this part of India. Here and there it halted and, after the cloud

of dust had settled, the wondering villagers gathered round. Out stepped three immaculate B.C.G. vaccinators, armed each with a glittering syringe (and the inevitable diaphragm stethoscope). The effect was impressive, and young and old were innoculated. Despite the blarings from the van's loud-speaker few realised for what they had been innoculated or why. The van roared off, never to be seen again. Such puny measures against so vast a problem of overcrowding and unhygienic living (where an anti-spitting campaign would do much more good than buckets of vaccine, for instance) must surely have caused a smirk of complacency to spread across the awesome features of Khali, the Hindu goddess of destruction!

THE BRITISH MEDICAL STUDENTS' ASSOCIATION

The Permanent Secretary of the B.M.S.A. has very kindly sent us the following notes.

History

The BMSA was first mooted in 1940, when, at a conference of delegates of medical schools held at Manchester, it was decided to set up the "British Medical Students' Association" as a Faculty Committee of the National Union of Students. Membership of the Association was open to the representative student bodies of all Medical, Dental and Veterinary Schools, Faculties and Colleges of the British Isles, and to individual students. The first task of the new Association was to prepare a report on students and medical education at the request of the Medical Planning Committee of the British Medical Association.

In 1941 BMSA published a pamphlet entitled "Students and Medical Education—an account of the British Medical Students' Association." This pamphlet concluded as follows:—

"The BMSA can be an organisation of the utmost value to all medical students. Whether or not it will be of such importance, depends on the individual medical student. We have in the past perhaps been too ready to let other people think

for us, and have accepted with too little question all that tradition and authority have placed before us. To-day, the position is clear. If medical students wish to emerge from the part of legitimate but ineffectual grumbling to that of constructive improvements the way lies open before them. Let it be the objective of every student to take an active interest in the work of the BMSA in order to make their organisation a fully representative and effective national body."

A number of medical schools declined to join the Association because of its connection with the NUS and in early 1942 a move was made to set up a national organisation of medical students which would be acceptable to all sections of student opinion. The BMA was asked if it would assist in the running of an independent medical students' body by providing office facilities. This they agreed to do, and under a gentleman's agreement the BMSA undertook to be available to the BMA on all matters of special interest to medical students. The BMA on their part undertook to refer to the BMSA any matters upon which student opinion would be of value and with which they were concerned. There was also the usual proviso that on occasion both parties could agree to differ.

Apparently trouble was experienced from those of the Left who saw in the new proposals an attempt to sabotage the influence of the NUS. It was also criticised by those on the Right who saw it as an attempt by the BMA to increase their membership and so threaten the nice balance of power between the main factions in medical affairs. However, these difficulties were overcome and BMSA, as it is now known, officially came into existence on June 27, 1942, and every medical school except two in London joined.

There is little doubt that the membership of the Association included a number of individuals whose political opinion was strongly directed towards the Left and inevitably some of them came to hold office in the Association. Nevertheless, such political activity has been confined to individuals. The Association, as such, has always rigidly excluded any question of politics from its deliberations. Immediately after the war, when BMSA began to get into its stride, there were unfortunately several instances of medical students closely connected with BMSA using the Association's machinery to further their own political views, particularly in connection with attempts to establish a world student organisation.

The Editorial of the first issue of the BMSJ contained the following paragraph:—

"Since the first plan for this journal was drawn up by A. Malone (London Hospital) and D. Whittingham (Durham) the editors have been pressed to adopt a partisan approach to many of the problems which will have to be discussed in its pages. This influence has been and will be resisted; we shall report the facts and maintain a progressive approach subordinating our freedom only to the wishes of the majority."

But then other organisations, and even countries, suffered in this way in the immediate post-war years. All are now much wiser.

Achievements

In this note only a bare outline of BMSA achievements can be given. Apart from the services which it renders to individual members, such as provision of information on hospital vacation appointments; production of diaries, ties, and scarves; arrangements for foreign travel, film shows, lectures,

clinical conferences, etc.; advice and assistance on personal problems, including grants, the Association has been in constant negotiation with various Ministries on major problems affecting medical students. More recent negotiations have been with the Ministry of Health regarding the position of the provisionally registered houseman.

BMSA has been interested in, and made representations on, the Medical Act, since its first inception, beginning with the setting up of the Goodenough Committee in 1944 to which it gave evidence. Representatives of the Association sat on the BMA Committee responsible for the report on "The Training of a Doctor" published in 1946.

In 1943 a Committee composed of BMSA, National Union of Students, British Dental Students' Association, and Scottish Union of Students, was set up to study problems of Student Health; their final report was published as a pamphlet, "Health and the Student." In 1947, recommendations on Student Health Services were drawn up by BMSA, in co-operation with National Union of Students and Scottish Union of Students, and circulated to all University and College authorities. This was the beginning of the movement which ultimately resulted in the setting up of the British Student Tuberculosis Foundation.

In 1946, BMSA instituted a nation-wide survey of medical student opinion on the proposals for a national health service, which was submitted to the Ministry of Health, the BMA and the Press.

In 1947, at the request of the BMA, the Association put forward its views on compulsory national service.

In more recent years there have been reports, to name a few of them, on compulsory residence, exemption from 1st MB, and payment of national insurance contributions by medical students. In addition, a survey of General Practitioner Schemes in operation in medical schools was drawn up and presented to the First World Conference on Medical Education held in 1953; and facilities for unbiased advice to medical students on insurance matters were arranged with the Medical Insurance Agency.

(Earlier this year, the Student's Union of St Bartholomew's Hospital voted to join the BMSA)

THE INVISIBLE SQUARE

by PAUL JENNINGS

I have never been ill before, unless you count a go of scarlet fever I had in the army, when I passed a curiously dreamlike six weeks in a civilian isolation hospital near Birmingham. It was a great long ward, with four or five children at one end and me at the other. On visiting days parents used to stand on concrete steps outside the windows mopping and mowing, and brandishing toys at their offspring. "Look, Brian, I've brought you a book"; and Brian would scream in rage and frustration at not being able to handle it. They were wonderfully kind Irish nurses, one of them discovered my birthday from my paybook and gave me a pound of strawberries. It was late spring, 1940, and every day the news got more disastrous and dreamlike and incredible. France fell, Italy declared war. And I just lay there having furfuraceous desquamation and picking up tit-bits of information about haemolytic streptococcus or whatever it is.

I said at the start I've never been ill, and it's true, really: I only had scarlet fever, none of these frightful mastoids and rheumatic fever or dementia praecox or leprosy or whatever it is they're afraid you'll have after scarlet fever. But just in case, they kept me there for six weeks, and I just lay there feeling silly, and trying to read *Tristram Shandy* (I still can't, all those dashes and brackets and sly remarks of my Uncle Toby still seem a tremendous bore. But I have discovered George Eliot. I've read *Adam Bede*. It's terrific. However). And it's just the same this time. No pain. No symptoms.

I have something that simply involves staying in bed, being injected once a day with streptomycin, and drinking, five times a day, some concentrated nastiness called PAS (petrol, arsenic and sugar). Here I am in a little room at the end of the ward, the nurses dramatically put on masks and rather splendid pink robes so you would think I was going to have an operation instead of just my bed made again. It's all the more lonely in view of the fact that I am in the SIDNEY COLLINS COT. NAMED BY HIS MANY FRIENDS IN THE WINE AND SPIRIT TRADE. PRESIDENT

OF THE WINE TRADE CLUB, 1939-43. There are times when I think enviously of the Wine Trade Club, I imagine jolly convivial dinners in panelled rooms, jovial fellows offering each other cigars . . . and here I am, in their cot. Here's to you, Wine Trade Club.

This room has the most comprehensive mains I've ever seen. A tap comes out of the wall and if I turn it it *hisses*—it's oxygen. There's a plug for D.C. electricity (I am reminded, for no real reason, of that cartoon in the *New Yorker* showing a condemned man in the electric chair: all is ready, the chaplain is reading the Bible, the warder has his hand on the switch: and the victim is saying, "Is this thing A.C. or D.C.?")

Although I have the faintly spiv-like feeling you get when you are ill without feeling ill, I have nevertheless crossed the invisible but real frontier into the country of proneness and pyjamas—and one of the things that distinguishes this country is the greatly increased rôle of fantasy: indeed, since there is no pain to attract my attention (thank goodness), it's fantasy all the way.

For instance, I have effortlessly built up a picture of life in the Square entirely from the sounds I hear. You people who casually walk across the Square every day, you've no idea how resonant it is, how, up on the third floor, one can hear ordinary conversational witticisms. But it's not so much words as *noises*. Somewhere on the other side of the Square from me there seems to be a women's mental ward, and patients are always escaping from this on to the roof and throwing tiles down. Crash, one hears, then the maniacal female laughter. It is probably someone from this ward, too, who creeps down at 3 a.m. and switches on the fountain (for it must be the fountain: you can't tell me it rains with that persistent Hollywood steadiness every night at 3 a.m.). In any case, only a lunatic would venture at that time of night into a square populated by such cats—I imagine wild, yellow cats two feet long, cats who steal babies and maul lone policemen on dark bomb sites.

Occasionally there's the Revolving Wire-less. In some unimaginable room there is a

wireless with a great horn, like the ones on public address amplifiers; and this revolves slowly, sending out a beam of sound. Just as, watching a lighthouse, one can see the light comfortably ranging over the dark waves and is then suddenly dazzled, so this wireless goes on with a distant babble of crooners and talk till SUDDENLY, FOR ABOUT A MINUTE AND A HALF, EVERY STONE IN THE SQUARE BLAZES WITH WHITE-HOT sound which disappears as suddenly as it came.

There is also the Jungle of Bells. Most of the clocks sound the hour so simultaneously that you can't tell what hour it is—you have to wait till ten minutes later, when a very independent one, perhaps from a church whose crusty vicar took a stand against Day-light Saving years ago, announces all by itself. There is one church that, at some unlikely hour on an obscure weekday night, suddenly bursts into a wild festal peal; and there is

one tremendously deep, solemn bell, that strikes seventeen in an end-of-the-world sort of way at irregular intervals. One imagines an old man, living alone in a tower, cackling as he rings this huge messenger of doom.

In addition to mad bellringers there are mad drivers. There is someone with a lorry who has great difficulty in getting from bottom into second gear, and he has vowed not to go out of the Square in bottom: he just drives round and round trying to change up, *grek-grek-a-grek-GRACH*.

There is somebody who keeps just a self-starter, mounted on a stand, in the Square. Periodically, he goes and plays with it. There is an endless clanking and whirring, but no engine ever starts—and it's always the same clanking and whirring.

I expect when I do get up and have a look at the Square it will seem quite unromantic. But I still want to walk across it—and out of it. That's not a fantasy.

SO TO SPEAK . . .

Mind the Doors!

Patient complaining of loose teeth. History—caught teeth in the door of a tube train.

—Dental Department.

Inner Cleanliness

Patient complaining of having gone clean round the bend. History—swallowed a tin of Harpic.—Source Unraced.

St. Bartholomew's, not St. Trinian's

Q (woman student): Would you like to say a few words on Sudden Death?

A (chief assistant): Means the chap's dead when he hits the deck.

THE PRIEST AND THE PHYSICIAN

by F. GEORGE STEINER

I

IN the dawn of time, priests and physicians were as one. The witch doctor conjured up the healing spirits and cast out the demons of malfeasance. This identity survived into recorded history: witness Esculapus and his daughter Hygieia. Physicians were never far from the temple porch. But with the growth of science, there came a second stage. The priest and the physician turned against each other, and science became the subtlest of heresies. Vesalius purloined the dead from the gibbet and the church sought out materialism with cleansing fire. To anatomise was to doubt.

With modern times and Comte's "positive era" the priest and the physician concluded their truce. Each staked out his vast territories and patrolled his frontiers with mutual politeness. The physician and his top hat came before the priest and his baptismal font; the priest and his extreme unction came after the physician had put away his instruments. Throughout the nineteenth century they glided past one another with a bow.

True, along this frontier and in the neutral zone there were disputed outposts—particularly in Catholic countries. When it came to birth control or such points of anguish as to whether the mother or the child should be saved, the priest reasserted his rights above and beyond the physician. Sometimes the latter fought back. But on the whole, positivism had made the division between body and soul a workable hypothesis and the priest and the physician saw no need to clash. To many great physicians in this era of optimism and apparent progress, their patients' religious life was like a mild attack of influenza or occasional hysterics. The priest, on the other hand, felt more or less certain that medicine, whatever its spectacular advances, would not dare or need venture to the ramparts of the heart and soul.

In the late nineteenth century, the lines became blurred. It turned out that the

"body-soul" disjunction was a surrender to words rather than to facts. Explorers from medicine and literature ventured into the interior. Instead of finding a clearly marked no man's land, they uncovered a vast twilight region in which ancestral voices and mythological imaginings returned to life. Freud watched Charcot at work in the laboratory, and great writers—those odd insects whose antennae seem to reach just over the edge, into the future—created their complex personages. In the world of Dostoyevsky and Strindberg and Chekov (who was both physician and writer) soul and body wrestled in a narrow space. Epilepsy and hysteria and tuberculosis infect the "souls" of the modern literary characters as well as their bodies. Obviously, the great writers had known this to be true throughout all ages and with fine instinct: the "body-soul" division was probably meaningless to Sophocles, Shakespeare, Diderot and Blake. But with modern times it became meaningless to the layman and this meant that the armistice between the priest and the physician was over.

Along the entire frontier between religion and medicine new frictions arose and branches of medicine reached into new territories occupied hitherto by necromancy or faith. Wherever one looks to-day—from the church or the hospital and laboratory—there are outposts under fire, areas where inquiry and dogma are bound to clash. Psychology and psychiatry are probing into the "soul" (by whatever name they seek to master it) and they will obviously meet the priest coming from the other direction. Histology, cytology and biophysics are working nearer and nearer the sources of "life"—and again the real spiritual problems involved are disguised by a neutrality of scientific vocabulary. Pavlov and his famous dogs are obviously related to any doctrine of free will or pre-determination; but how many triumphant agnostics care to remember that Pavlov himself (with the permission of the Soviet

government) worshipped in the Orthodox Church to the end of his days?

The clash between science and religion, moreover, is bound to increase. Certain "semi-sciences" such as parapsychology are dealing overtly with religious problems and the "semi-sciences" of to-day are the acknowledged disciplines of to-morrow. That these conflicts have not blazed into the open is due to three facts: the churches, and the Catholic church in particular, have been careful to avoid them by adjusting old dogmas to new conceptions or by refusing to admit that the old division into "soul" and "body" no longer makes sense. Scientists, on the other hand, have found it respectable either to ignore religious questions as altogether alien to their work, or to observe traditional religious forms with a vague Newtonian assertion that God's glory was further enhanced by their research. Thirdly, both the priest and the physician have developed opaque vocabularies to mask the fact that they are frequently talking about the same thing in contradictory ways. Medicine and biology have succeeded in surrounding words like "life," "death," "body" and "soul" with polysyllabic qualifications. As a result laymen use these words with a feeling of guilt about their ignorance and the scientist need not use them at all.

The average scientist's security and indifference regarding this state of affairs was founded on the assumption that religion was a more or less moribund form of totemism. Many of the great scientists of the late nineteenth century were fairly confident that religious beliefs would become one of those fossils embedded in rational and material progress. In fact, the contrary has happened. Organised religions have acquired a new momentum and threaten to fill the vacuum of disillusion. Those moral dilemmas and anguishing perplexities of feeling which science left in its rear, have been recaptured by religion. The perfectly understandable inability of the scientist to cope with the political and ethical conflicts created or aggravated by his discoveries, has made human beings look back to the church. In Henry Adams's celebrated terms, the dynamo is no longer replacing the Virgin.

This is strikingly verifiable in politics. Marxism, with its "scientific" basis and its deterministic materialism, has turned into a

world-force appealing to instincts of a religious order. There are those who argue that the battle between Rome and the Kremlin represents the clash between an orthodoxy and its greatest heresy. One thing is certain: anyone who is prepared to dismiss religion as a dwindling relic will find it difficult to make sense of the present world picture.

The point is worth stressing, because it underlines the fact that much scientific education and thinking is based on a fallacious nineteenth-century picture of a "positive era." In the case of the chemist and physicist this is dangerous enough, and it leads to the unbelievable nonsense propounded by some of the world's leading scientific geniuses when they have to deal with political problems. In the case of the physician, it can be more than dangerous. The physicians who carried out elaborate medical experiments in Nazi concentration camps are the ultimate and terrible caricature of the scientific mind acting beyond good and evil.

The upshot of all this is plain: the physician will have to admit (and in more than a merely formal or official manner) that the priest is actually talking about *something*. This does not mean that he will necessarily agree with what the priest says, nor that he abandons his belief that the priest's domain represents that area which the physician and the biologist have not yet surveyed. It does mean that he will have to understand the way in which the two worlds overlap, and that the priest's *is* a world rather than an archaic hallucination or the uneasy remembrance of a great neurosis. What this means in reference to medical training I am not equipped to argue. But I venture to assert that the physician of to-morrow—particularly the psychologist and neurologist—will have to deal with religious experience and religious problems in a "non-pathological" way. Otherwise he will lag as far behind the subtle realities of his time as the pure Spencerian lags behind those of to-day.

Dramatists and novelists often anticipate conflicts of the spirit such as those represented by the priest and the physician. Shaw saw a *Doctor's Dilemma* as early as 1911. There have, moreover, been two recent plays in which some of the problems I have alluded to are dramatised. They are Eliot's *The Cocktail Party* and Graham Greene's *The Living Room*.

II

The Cocktail Party is dominated by the personage of a mysterious and omniscient psychiatrist. Sir Henry Harcourt-Reilly is a *deus ex machina* with the emphasis on *deus*. He knits and unravels lives with a therapy which has numerous similarities with religious ritual. Although the ordinary medical "properties" are there—the nurse, the couch, the sanatorium—Sir Henry is nearer to a Jesuit seminary than to Harley Street. He appears as "an unidentified guest," intervenes commandingly in the lives of the characters, and ends his office hours by drinking a ritualistic toast not unlike a prayer for the dead. What is most striking is the fact that this psychiatrist dismisses his patients with the words "Go in peace. And work out your salvation with diligence."

Sir Henry's therapy for neurosis can lead towards either of two "cures." In most cases his patients are sent back into ordinary life after a process of partial self-recognition and after their trauma has been shown to be something less interesting and dangerous than they might have wished. Sir Henry says to Edward and Lavinia:

Your business is not to clear your conscience

But to learn how to bear the burdens on your conscience.

The crux of this first cure is that the patient realises that most lives make the best of a bad business, and that in human relations "every moment is a fresh beginning." In other words, the neurosis is not cleared up by the creation of substitutes or psychological transfers, but by showing the patient how to live with it with a minimum of discomfort.

There is, however, a second cure which leads along mysterious paths into the heart of darkness and grace. It requires from the patient

The kind of faith that issues from despair.

The destination cannot be described;

You will know very little until you get there;

You will journey blind.

In Sir Henry's own words, that is the way of the saints and it cures those who can no longer accept the "cocktail-party" universe and the human condition. If the patient selects this way, the psychiatrist can only direct him "in the way of preparation." Both

therapies are necessary and neither way is better, but "It is also necessary to make a choice between them." In the case of Celia Coplestone the second way leads to martyrdom; she joins an austere nursing order and dies at the hands of rebellious natives—crucified near an ant hill.

It is important to note that Sir Henry can turn his patients towards the road of religious salvation, but that he cannot describe it in psychological and scientific terms:

But such experience can only be hinted at

In myths and images.

When it comes to those who suffer from a kind of neurosis of grace, moreover, Sir Henry's therapy seems to glide into the service of some higher power:

And when I say to one like her,

"Work out your salvation with diligence," I do not understand

What I myself am saying.

In the character of Sir Henry, Mr. Eliot has offered an interesting solution to the problem of the relationship between priest and physician. Both are united in one. It is the duty of the physician to diagnose the sacred malady, to respect it, and to aid in its consummation even at the cost of the patient's life. The priest, on the other hand, aids the physician by providing the structure of myths and images which the patient needs in order to find the new way to Damascus. Mr. Eliot's protestantism is shown by virtue of the fact that the patient must become a priest himself and cannot reach salvation through an intermediary. When he deals with Edward and Lavinia, Sir Henry is a physician; when he encounters Celia, he becomes a priest, albeit a priest outside the gates of the temple.

I think there is a good deal of confused thinking in this play. Surely, Celia has taken the first step towards sainthood—if sainthood can be defined as the gift of being irremediably truthful with oneself—before she comes to Sir Henry. And Mr. Eliot avoids the question of whether or not the kind of anguish which grips Celia can find solace within the framework of an organised church. He takes it for granted that the church has the kind of answers for which Celia is looking. That certain symbols, such as Sir Henry's mysterious sanatorium, and an image such as that

of the crucified Celia, have to be used in the play shows that it reaches for emotional effects where the thought is rather thin.

Nevertheless, it is a fascinating essay on the *limits* of therapy. The medical approach to neurosis has definite limitations; it cannot operate effectively beyond a certain level and that level is where religious experience intervenes. Mr. Eliot is not concerned with the false "body-soul" copula, but with a distinction between two kinds of "souls." The physician can recognise the peculiar scar left by the passage of grace and can get the patient to recognise it. But out of this self-recognition grows a new kind of sickness and glory and the priest is outside the consulting room. This is an interesting conception and it suggests that we may be working towards an alliance between the priest and the physician not altogether unlike that which prevailed in antiquity.

In *The Living Room* these problems are dealt with in a far cruder and more primitive way. The priest is represented by Father James Browne and the physician by Michael Dennis (although he is a lecturer in psychology and not technically an M.D.). Catholicism and scientific psychology wrestle for the soul of Rose Pemberton, and in the process she is miserably destroyed. On the face of it, it would appear as if Mr. Greene had matched his antagonists with dramatic impartiality. Father Browne is a cripple whose "desire to help" has been imprisoned in a chair for twenty years. When Rose flings herself at his feet in a desperate attempt to gain redemption, Father Browne can only tell her to pray. Reflecting on Rose's death, the priest wonders whether his guilt was an "incompleteness of love." Michael Dennis is equally unable to deal with the situation. He is attached to his hysterical wife and cannot bear to hurt her in order to save Rose. What terrifies him most, in fact, is the intensity of Rose's love. Instead of an affair, it is a *love affair*, and because the thing is too big for Dennis's text-book psychology, he lets Rose blunder into a futile death.

This equality between the two antagonists, however, is only apparent. The priest is actually far more powerful than the physician and psychology turns out to be a shoddy idol. True, as always with Mr. Greene, the servants of the church are incomplete beings with mire and darkness in them. But the Catholic doctrine is ultimately justified and triumphant. By juggling with theological

subtleties, moreover, Mr. Greene manages to sugar-coat the pill. When Dennis taunts him with the fact that Rose's suicide means damnation as far as Catholics are concerned, Father Browne demurs: "Only God was with her at the end. . . . It may not have been her last word, and even if it were, you ought to know you can't tell love from hate sometimes."

The triumph of the priest over the physician is brought about by two devices, neither of which is above suspicion. In the first place, Michael Dennis and the science he represents are identified, whereas Father Browne is always distinguished from the Church militant and triumphant. Dennis's psychological training and methods are made to look absurdly ineffectual because the man himself is ineffectual. By using Dennis's vocabulary against him, the priest makes it look silly: "I had a real vocation for the priesthood—perhaps you'd explain it in terms of a father complex." When the tragedy of the situation develops, Father Browne challenges: "Let's hear the wisdom of Freud, Jung, Adler. Haven't they all the answers you need?" Instead of telling the priest that this question is plain silly or a rhetorical trap, Michael Dennis stumbles over his own fear and inability to realise his abstract beliefs.

This question, moreover, contains the second and main device of the play. This device consists in making it appear as if the physician made the same claims as the priest. Specifically, Mr. Greene appears to think—or he wishes to make his audience think—that the techniques of the psychologist and those of the confessional are somehow analogous and competing.* Whereupon it is not difficult to prove that psychology cannot save a Catholic soul in torment and that the psychologist cannot comment on Rose's death with a comforting remark about "suffering not being a big problem" in His eternity. In other words, the priest is sure to win because the physician has to play the game according to the priest's rules. Whereas Mr.

* The act of confession and the process of self-revelation in psycho-analysis are totally and *organically* different. Confession to the priest presupposes the presence of a third party, the presence of God. The priest is an intermediary. Psycho-analysis, on the contrary, is *bilateral*. The frequent Catholic claim that they have practised psycho-analysis centuries before Freud is both inaccurate and self-deceiving.

Eliot's conception corresponds to and even anticipates the actual problems facing tomorrow's medicine. Mr. Green's fencing match between physician and priest is arranged in accord with outmoded conventions. This gives *The Living Room* its exasperating flavour of old lace and Oxford Movement fervour.

Here again, however, one is indebted to the dramatist because he has drawn attention to important problems. I am merely arguing that these problems have not been posed in a rigorous and adequate way. The solution is prejudged.

WARD SHOWS, 1953

A review in retrospect

by DOPPELGANGER

That revues were in vogue could be seen from "S'cowen, S'going, S'gone" by Dr. Scowen's and Mr. Hume's firms, and "Hormoney For All," produced by Dr. Spence's Clerks. Both shows lacked continuity, which is so vital for any revue; but certain sketches were well performed, namely, the one depicting the life of a Naval doctor and the Victorian melodrama acted by a solitary figure playing all the parts. "Folies Bougie" exemplified well a continuous revue and included a beautifully timed mime of the Andrew Sisters by an all-male trio. A colourful finale was achieved in this show with a delightfully danced samba accompanied by zealous percussionists.

"A Princess Once" lacked good songs. The show with the largest and most colourful cast was "Hula Baloo," designed as a pantomime for children. This musical extravaganza, with its escapist appeal, carried one away in the realms of fantasy to a pirate-infested cannibal island with women, too, in the shape of four charming hula-hula girls. Praise must be given for the subtle lyrics sung effectively by a large chorus and for the appealing singing in harmony by the quartet and finally for the rendering of that catchy camel song. As a colourful pantomime for children "Hula Baloo" was ideal.

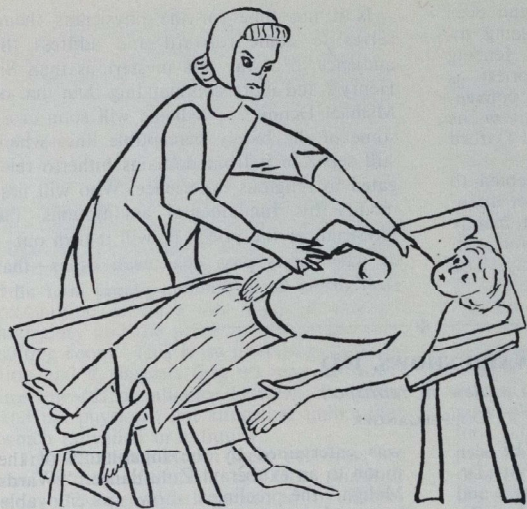
The Gynaecological Firm's "Beautie and the Beast," although it produced a highly talented magician whose tricks nearly always failed to work, was marred in places by its singing. Space travel no doubt proved the impetus that fired "Lunar Sea." Here one

Is it not time for the physicians themselves to come forward and address the audience in a way less mysterious than Sir Henry's and more commanding than that of Michael Dennis? Medicine will soon cross some of the barely perceptible lines which still separate it from domains hitherto relegated to religious experience. Who will first modify his fundamental assumptions, the physician or the priest, or will it turn out—as when stars pass near each other—that their orbits lie in different planes after all?

was entertained by the inhabitants of the moon to an exuberant Zulu dance. "Wards Malign," the preclinical show, was enjoyable in parts but rather disappointing.

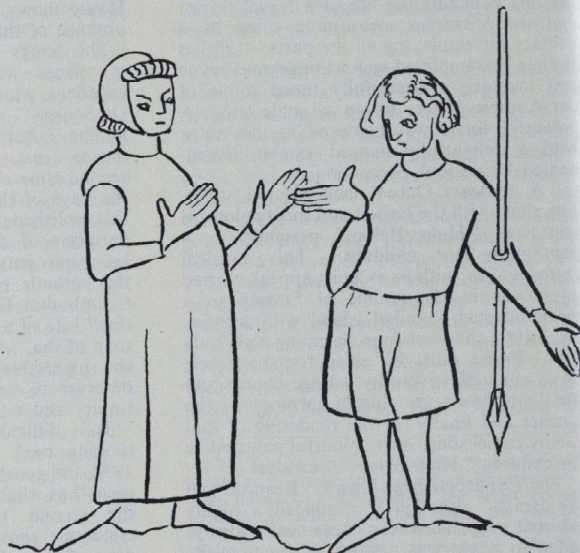
The Residents' performance of "Xmas Day in the Workhouse" was unable to live up to the very high standard set by previous House shows. This was probably due to the absence of the almost traditional ingredient, "The Songs of the Chiefs." The dialogue in places was subtle and the clowning excellent, whilst the song "We Are Enemies Of Society" was voiced expertly, especially in the falsetto register. Last, and by no means least, came "Show Boat," by the second time clerks, which took one back to the days of the Charleston. Outstanding in this polished show was the fine singing in harmony of cleverly arranged songs. The humorous patter and the antics of the clowns, the pathetic rendering of "I'm the Biscuit Crumb that Gets Beneath the Sheets" and the "Life of a Medical Student" sung to the tune of the "Ash Grove," were undoubtedly the highlights of this show which richly deserves to be praised for its smooth continuity and vitality.

It is difficult to make comparisons; but looking back on the Christmas Shows of 1952, the general standard of 1953 entertainment has slightly fallen. "Folies Bougie," the second time clerks' show and the children's show attained a very high standard. Let us hope that the 1954 Christmas entertainment will reach an even higher plane in the world of amateur variety.

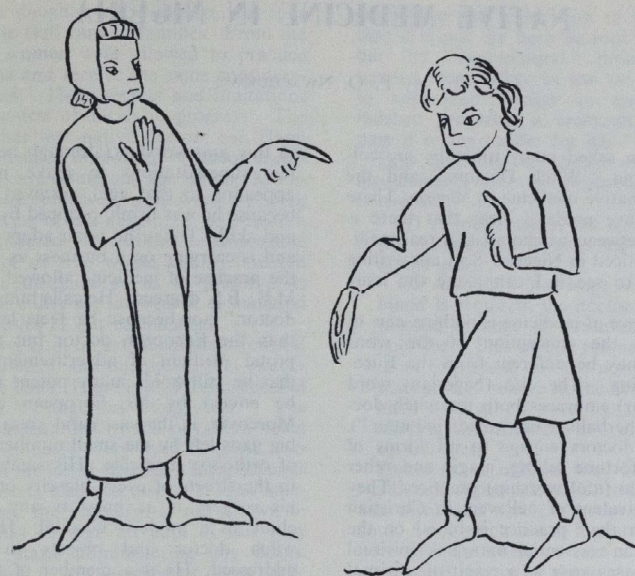


I. Just want to take a little blood. . . . Dizzy? Oh that's purely functional.

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II. Let's see the veins in your other arm. I want great, big enormous veins.



III. Don't you dare go and show Sister! It was your fault, you shouldn't have jumped.

Drawings by E. R. Nye, after some illustrations in the
Treatise on Surgery of Roger of Parna (13th century).

NATIVE MEDICINE IN NIGERIA

by P. O. NWACHUKWU

I HAVE been asked many times by my colleagues about "Witch Doctors" and the practice of native medicine in Nigeria. These questions have made it clear that there is confusion between witchcraft and real medicine as practiced in Nigeria. So I am writing this article to see if I can make the issue clearer.

The practice of medicine is nothing new to Africa, but the conception of the word "doctor" may be different from the European meaning. The Ibo (Nigerian) word *dibia* (doctor) embraces both the witch doctor and the herbalist (real "medicine man"). The witch doctors engage in all forms of witchcraft, fortune telling, magic and other forms of *juju* (idol worship) practice. They are the equivalent of believers in Christian Science: for their practice is based on the idea that man's essential nature is spiritual and his diseases arise as a result of spiritual disharmony, and can be cured by healing his spirit through religion (*juju* worship) and sacrifices to *juju* (gods).

Many years ago, before the advent of western civilisation, education and Christianity, these men reigned supreme because their seeds were sown on the fertile soil of *juju* worship, superstition and ignorance. They were capable of unearthing *wares* that caused delirium tremens: removing invisible poisons left by spirits and the "Long Dead" which caused the death of young children and made women barren. They communicated with the spirits and appeased the angry gods with sacrifices. Thus they removed fear and brought peace of mind, which accounted for their success. In their prominence they overshadowed their counterpart, the herbalist, whose mainstay is in the most valuable experience and technical skill, handed from father to son, coupled with a profound knowledge of botany and "pharmacology."

As the storm of western civilisation blew over Africa, education put ignorance on the run and the Christian faith dealt *juju* worship a death blow. *Juju* succumbed in the gale, and is only heard of in whispers across much of Africa. The real native doctor (herbalist), whose practice does not have its foundation

in this *juju* worship (although he took up a few superstitions to make his practice appealing to that age), survived the storm, because he was firmly propped by knowledge and skill. Today he is an adept in his field and is carrying on a business as lucrative as the practice of medicine allowed by London M.B., B.S. degrees. He calls himself "native doctor," not because he feels less qualified than the European doctor but rather as a proud medium of advertisement, believing that he still holds many potent remedies to be envied by his European counterpart. Moreover, in the vast rural areas he fills the big gaps left by the small number of doctors of orthodox medicine. His signboards hang in the streets of every big city or town, and his surgery is as busy as any out-patient clinic in a modern hospital. He is *not* a witch doctor and objects to being so addressed. He is a member of the medical profession.

Having made this clear we can start with genuine interest to find out the nature and basis of his practice, hoping perhaps we can learn something from him or, on the other hand, discovering his difficulties, will treat his shortcomings with sympathy.

"Native Medicine" is entirely in the clinical stage. Laboratories and complicated x-ray investigations are unknown. It is not based on scientific investigations and deductions or on a sound knowledge of human anatomy and physiology. Rather, it leans on experience gained by trial and error or come by accidentally, as is sometimes the case in modern medicine. Nevertheless, the practitioner must have his own idea of the structure and function of the human body, but this is the result of thinking, for anatomical dissections and experimental physiology are unknown.

It is interesting to look into the training of future native doctors. Practice of medicine is almost a family affair. Son succeeds father. The apprenticeship is sometimes extended to a few privileged people outside the family. The secrets are closely guarded and the knowledge is limited to a closed circle. Your certificate consists of your proving you are

the son or daughter of so-and-so; for it is believed the skill runs in families. From the beginning women were allowed to practice in medicine and receive the same consideration as men. These secrets and limitations are the greatest obstacles in progress. The result is that few native doctors can claim as wide a field as doctors of orthodox medicine; there are numerous specialists. Moreover, no one person can gain from the work or discoveries of his neighbour, so research is much hindered. It is still more lamentable for those of us who would like to research into native medicine so as to preserve its good parts, either for the benefit of mankind or as identities of our nationalism.

There are, also, no set standards or central board of control, and this means that quacks have a free hand. There is no Pharmaceutical Society or "Dangerous Drug Acts." The public is safeguarded by the physician being compelled to taste every drug he gives, forgetting that the lethal effect of a drug depends on the dose. There is also a second safeguard where the physician is not known to one: he has to take an oath of fair play before he starts administering any drugs. Coming back to the question of doses; it is worthy of notice that there is no standardisation of active principles, with the result that accidents from overdosage do occur. I can remember the case of a Yoruba woman who was given a drug to help her in labour and she suddenly died. Post mortem revealed ruptured uterus, and as there was history of administration of native medicine, the gastric contents were collected and investigated at the Physiology Laboratory of Ibadan Medical School. A few drops of this added to the Ringers solution in which a guinea pig uterus was suspended showed oxytocic activity far greater than that of equal volume of post-pituitary extract.

Another interesting aspect is the native doctor's concept of causes of disease. He can find causes of some diseases but when he encounters one which he does not know he falls back to sentiments and superstition. For instance, smallpox is regarded as a scourge sent by the gods as punishment for some evil done by a person or community. Hence part of the treatment will include sacrifices for appeasement of the gods. If the patient is convinced that the gods are appeased he will have no difficulty in trusting in the subsequent treatment, for it is then only secondary. Also, in order to impose

confidence and trust, most of them profess that it is not the herb or root which cures, but the "supernatural" power which is handed from father to son or from master to apprentice. After an apprentice has finished preparing a medicament he must pass it to the master for his "blessing."

Eggs, hens, lambs, etc., are asked for when medicaments are to be prepared. The reason is twofold:—

(1) A few drops of the animal blood in the medicament invokes the co-operation of the gods;

(2) As only a few drops of the animal's blood is required, the doctor carries away a good amount of livestock to augment poor fees. This second reason is by far the more important one for nowadays people who do not believe in the first reason can have a most effective treatment without offering the animals—provided they step up the fees.

Hence it is evident that between these rituals and superstitions lies some knowledge and technique which, if properly harnessed, could be of much use to humanity. This will become clear when we take a short survey of some of the native doctors' achievements. In medicine there are some spectacular successes in, for instance, the treatment of malaria and the associated jaundice, which is so common about the end of the rainy season. It is also a well known fact in Nigeria that mental diseases are better treated by native doctors than by "European" doctors. Surgery, on the other hand, lags very much behind. Although one occasionally hears of successful excision of inguinal herniae or drainage of an "abdominal abscess," the mortality rate is very high. But such things as excision of glands in the neck and opening superficial abscesses are well done, although the cosmetic effect of the scars are never considered. This backwardness in surgery is due to the lack of human anatomy, post-mortem or human dissection being regarded as an abomination.

It is in orthopaedics that the native doctor is most at home, and their success is a wonder. Nobody in Nigeria who has a fracture or dislocation will allow himself to be thrown into a "European" hospital where he is likely to have amputations or lie in plaster indefinitely. He will prefer a native orthopaedic surgeon who abhors amputations and can within a few weeks restore complete function to a limb crushed into

pieces. How he prevents osteomyelitis and gangrene without any of our potent antibiotics beats my imagination, especially when it is realised that he has not reached the age of aseptic surgery. He also meets with some success in obstetrics and gynaecology, though the varied and complicated, and perhaps more attractive, investigations and instruments of the European doctors is robbing the native practitioner of much of his fame.

Thus one sees in the native doctor a keen and active competitor with a lot of things which we cannot yet understand; things which will afford a rich harvest for an inquiring mind. Perhaps if one could break through this stone wall of secrecy, closed circles and selfishness, and sort out this jumble of knowledge, skill and superstition, one might discover things that would be of interest, if not of use, to humanity.

THE WAVE

by DONALD HILLS

The wave beat upon the shore;
An instant poised, teeth bared
Like some nocturnal predatory beast
Intent upon a kill.
With lip drawn up,
Each nerve and muscle tensed
In timeless set suspense.
Then the slow forward roll,
Accelerating and determinate,
With fear-inducing cry
Across the silent air,
And energy, to tear
Unmercifully apart
The limpet shell,
The slimy weed
So intimately bound
About its chosen rock.
The spiral fashioned cast
Of hidden worm,
The blood anemone,
With tentacles displayed
As ripples in an underwater breeze.
Then the relaxing,
Deeper drawn retreat;
Resurgent waters over hissing sand,
Singing the victor's song, now harsh, now sweet,
The threnody of triumph in defeat,
Clearing the littered debris away
As if by instinct, sliding back again,
Back to the dark, abysmal, cold unknown,
Taking the life that upwards it had thrown.
A folding of the hand that gave
Into a shadowed, ageless grave.

LETTERS TO THE EDITOR

BART'S SOCCER

Sir,
I was interested to read in the January issue of the *Journal* that the soccer section was recovering from a spell of depression, and that by their last wins must have acquired great strength or been playing feeble sides.

In my day, 1910-11, I had the honour of being the means of rescuing the same section from eclipse.

At that time the hospital had not gained the Inter-Hospital Cup for eleven years. My diagnosis of the lack of success was that the methods of play of the team were too gentlemanly. When elected captain I decreed that the hospital must enter for every kind of competition, both F.A. and A.F.A.

I had the unpleasant habit of raising my voice on the field, using critical expressions which generally were not quite parliamentary. This was accompanied by pretty rough play.

The result of the season was the winning of the following cups:—

The Inter-Hospital,
The Inter-London University,
The Middlesex A.F.A.

Whether the methods of those days would find favour with present-day notions, I could not say, but there is no doubt that meeting varied and often tough opponents brought the Bart's side up to success.

Yours faithfully,
R. MURRAY BARROW.

Stone,
Staffordshire.

NEW BOAT FUND

Dear Sir,
The Boat Club is hoping to expand its activities this summer. Their programme includes plans for the first eight to race in senior events and eventually at Henley. This policy is based on two beliefs. First, that the right aim is to produce a crew of a standard worthy to compete at Henley Regatta although the superficial results may not be, and indeed, are unlikely to be spectacular. Secondly, that such a programme should be based on a flourishing club, not on the fortuitous presence of a quorum of experts. This means that junior oarsmen must be trained and raced in their appropriate events.

We believe that the club has, after over eighty years of intermittent existence, achieved a state

which justifies such a programme. But, like a cuckoo in the nest, the club has an appetite which its offspring turned foster-parent, the Students' Union, is unable to satisfy.

To provide adequate facilities the club needs three new boats, which will cost in the region of £700. This cannot be met from any one source, so we are starting a New Boat Fund. If any of your readers, whether past members or not, would like to help, the Boat Club will be most grateful for any donations, however small, which should be sent to the treasurer of the club at the hospital, and which will be personally acknowledged.

Yours, etc.,
C. N. HUDSON,
Captain of Boats.
J. M. GRAY,
Secretary of Boats.

The Abernethian Room.

A BART'S REGISTER

Dear Sir,

With reference to Dr. Robert Hunt Cooke's letter regarding a Bart's Register, I have a Student's Union Year Book with Directory, published from the Journal office in June, 1923; this has proved to be very useful, but is now a little out of date! I trust it will be possible to publish a new edition very shortly.

Yours sincerely,
A. H. KYNASTON.

Wednesbury,
Staffs.

PALMS OF THE HANDS

Sir,

Dr. Bett, pleading so admirably for a little "judicious levity" in medical writing, might have used stronger language than he did about the ponderous, humourless, circumlocutory jargon which seems to pass for a "correct and splendid diction" with so many writers of papers and textbooks—both sides of the Atlantic. But if we "talk of palms of the hands" we err in distinguished company. Has Dr. Bett forgotten that they who went to bury Jezebel "found no more of her than the skull and the feet and the palms of her hands!" Can we doubt that if the dogs had been still hungrier and left only the soles they would have been described as "of the feet"?

Yours faithfully,
LINDSEY W. BATTEN.

Hampstead.

COLLEGE PRIZES

SENIOR SCHOLARSHIP

In Anatomy, Physiology and Biochemistry.

Awarded to: D. F. PARSONS.

Highly Commended: N. E. C. Coltart, S. Thomas.

HERBERT PATERSON MEDAL IN BIOCHEMISTRY

Awarded to: D. F. PARSONS.

HARVEY PRIZE

Awarded to: D. F. PARSONS.

FOSTER PRIZE

Awarded to: A. R. O. CHINERY.

Certificates: N. E. C. Coltart, J. M. Thirlby, J. N. Graham-Evans, D. F. Parsons, S. Thomas.

EXAMINATION RESULTS

PRIMARY F.R.C.S.
January, 1954

Hill, D. W. Mortimer, K. E. Lavy, G. A. D. Tomlinson, J. D. W.

FINAL F.R.C.S. EXAMINATION
December, 1953

James, J. A.	McIntyre, E. D.	Thorlakson, J. K.	Flatt, A. E.
Oliver, J. E.	Ferguson, A. F.	De Jode, L. R.	Retief, D. J.
Snyder, J. A.	Davies, D.	McGrigor, R. B.	Morgan, A. G.
Way, N. J.	Moffat, D. B.	Fison, L. G.	

CONJOINT BOARD
January, 1954

Add: Taylor, R. C.

UNIVERSITY OF LONDON
M.D. EXAMINATION
December, 1953

Part I: Amos, J. A. S., Thacker, C. K. M.

M.S. EXAMINATION
December, 1953

Part I: Monks, P. J. W.

EXAMINATION FOR THE ACADEMIC POSTGRADUATE CERTIFICATE
IN PUBLIC HEALTH
December, 1953

Boatman, D. W.

SPORTS REPORTS

RUGBY

Hospitals' Cup—Bart's 3 pts., Guy's 6 pts.

This twice-postponed match was finally played on February 15, conditions being soft from the previous snows and rains. Over a hundred supporters watched Bart's give their best display of the season, and an exciting finish nearly took us into the next round.

Guy's kicked-off against the wind, and for a while exchanges were even. Then a spirited forward movement took play into the Guy's "25," where an opponent was penalised. Badley missed what appeared to be a fairly easy kick and Guy's were fortunate not to be in arrears after only ten minutes. Hackett was hurt—being concussioned for a long spell, but the defence held out well. In the twenty-fifth minute a beautiful bout of passing enabled the Guy's speedy left wing to score in the corners. Soon after Hackett had to go off but he recovered by half-time.

The killing pace of the game was maintained in the second half, and the Bart's forwards played inspired rugby. Macadam hooked splendidly, and in the loose we nearly always won the ball. Here Tallack was in his element. Howells twice relieved pressure with lofty kicks, and it was against the run of play when Guy's increased their lead. Howells again missed their conversion. Bart's came back with even more determination, and would have done better to have "taken it in the loose" rather than feed the backs. Fifteen minutes from no-side, following a mêlée in the corner, Phillips ran inside to start an attack and Scott-Brown saw

his chance. Instead of passing he raced to the line with a fine turn of speed. No conversion. Another penalty chance failed, Tallack almost reached the line, and Phillips was narrowly beaten to the touch-down from a kick ahead. Lammiman went off with an ankle injury, and Tallack was surprisingly taken out of the scrum and put on the wing. Hackett was hurt again, but in the dying minutes, an intelligent bout of passing between forwards and backs gained sixty yards. But for a faulty pass this might well have been the winning try. Then it was all over. Bart's had lost the right to meet St. Mary's, but no one can deny they were unlucky and magnificent in their defeat. Nearly everyone rose to the occasion and played better than before. Why can't we play like this all the season?

BOAT CLUB

At a General Meeting in January, the following officers of the Club were elected for the coming season:—

President: Dr. A. W. Spence.

Vice-Presidents: Mr. O. S. Tubbs, Dr. M. Donaldson, Prof. A. Wormall, Prof. K. J. Franklin, Prof. L. P. Garrod, Dr. J. H. Coulson, Mr. J. H. M. Ward, Dr. E. F. Scowen, Dr. R. C. King, Mr. M. P. Durham.

Captain: C. N. Hudson.

Secretary: J. M. Gray.

Treasurer: R. L. Rothwell-Jackson.

Committee: E. J. G. Rossiter, C. C. H. Dale, D. Fairbairn.

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(Material received up to February, 10, 1954)

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

BOOK REVIEWS

PATHOLOGY OF TUMOURS, by R. A. Willis. 2nd Edition. Butterworth, 1953, pp. 997, illus. Price 84s.

The second edition of this book follows the same general plan as the first. Several sections have been brought up to date, notably the chapter on the experimental production of tumours and the sections on bronchogenic carcinoma, the rarer bone lesions and the chemoreceptor tumours. Two

appendices have been added, one describing conditions easily mistaken for malignant tumours and the other dealing with lesions associated with malignant tumours. These additions are only responsible for five more pages in a 997-page volume.

This book appears to be one of the most consulted textbooks in all morbid anatomy departments, and this should be sufficient praise. Most

of the thorny problems which daily face the morbid histologist are, clearly, well known to the author, and he deals with them in a manner which commends itself to both pathologist and clinician. Simplification in terminology and classification is almost an obsession in this book, but this is nearly always helpful rather than otherwise.

A tribute must be paid to the quality of the illustrations, the new additions maintaining the high standard of those in the first edition.

One hopes that just one or two sections might be expanded with benefit, particularly that dealing with thymic tumours. The index also might with some advantage be further sub-divided.

In the preface to the first edition Professor Willis writes: "... I am not without hope that clinicians also may find it useful, and that even elementary students may find it intelligible." I would not recommend any undergraduate student to buy this book for himself, but I am quite sure that very many would find certain sections not only intelligible but also interesting reading. If such students can find the time, during a very crowded medical course, to read some sections, for instance, those in part I of this volume, it would well repay them.

R. J. R. CURETON.

A SYNOPSIS OF ANAESTHESIA, by J. Alfred Lee. 3rd Edition. John Wright & Sons, pp. 457, 21s.

Dr. Alfred Lee has shared no effort in condensing a vast amount of information into as few words as possible. The result is a presentation of the essential facts of the subject in a form convenient for reference. The book is well planned. Brief accounts of anatomy, physiology, and pharmacology are associated with descriptions of various techniques. Subsequently the relative merits of these in dealing with different types of case are described and the complications that may occur at the time or post-operatively. Many of the more abstruse aspects of the subject are mentioned, and a few well-chosen references are a guide to further reading. This is an excellent book, invaluable to post-graduates studying this speciality.

J. MCINTYRE.

EDEN & HOLLAND'S MANUAL OF OBSTETRICS, by Alan Brews. 10th Edition. J. & A. Churchill, pp. 812, illus. Price 52s. 6d.

This is a well-known good obstetrical textbook, but the student whose interest in obstetrics will end with the passing of a qualifying examination will prefer a smaller, more concise book. Its text includes rather more than the minimum for qualifying examination requirements.

Not only is there much of academic obstetrics, enough to satisfy the examiners for the D.R.C.O.G., but the newly qualified general practitioner obstetrician will find in it the answers to the many practical problems that were never mentioned in his student days, including how to find the address of the local moral welfare worker of the appropriate denomination!

The presentation and lay-out are of the high standard of clarity one expects from its publishers. Drawings are clear, and one wishes all radiographs could be as good. Much and not too much of

modern trends has been introduced into this new edition, including a précis of Sheehan's recent monograph on renal cortical necrosis which must eventually find its way into all textbooks of obstetrics.

It is right that such a book should be dogmatic and, therefore, one cannot agree with the author in all things. Crédé's expression after half an hour of an uncomplicated third stage would not meet with the approval of all examiners, still less so would the three attempts advised with no direct mention of anaesthesia. It was disappointing to find so little written about the clinical assessment of the pelvis by vaginal examination in a chapter which included a description of the radiographic method of pelvimetry. There was also some slight divergence of views between the obstetric and paediatric authors on the inhibition of lactation and on weaning after a breast abscess.

This textbook has the great advantage of being eminently readable and, at the same time, being a good reference book.

R. A. STRUTHERS.

METHODS OF EXAMINATION IN EAR, NOSE AND THROAT, by W. G. Scott-Brown. Butterworth Ltd., 1954, pp. 100, illus. Price 18s. 6d.

This little book on practical examination of the ear, nose and throat should prove invaluable to students and general practitioners, as well as to candidates for higher qualifications in the specialty.

The importance of E.N.T. conditions in general practice is probably not fully appreciated by the student, who naturally concentrates on those branches of medicine and surgery likely to furnish questions in his final examinations.

Skill in handling the special instruments can most surely be acquired by constant practice, under proper supervision, in the out-patient department. But to supplement this "know how," or to regain it in after years, one cannot do better than study the technique and many useful tips admirably described by the author.

An excellent series of radiographs will help the student to interpret the difficult pictures of this region, often made even more difficult in small hospitals by failure of the radiographer to position the head with meticulous care.

A few minor points call for criticism. The apparatus described for the Proetz displacement technique is now largely supplanted by the much simpler and cheaper rubber suction bulb.

By some oversight a paragraph on page 44 is repeated almost word for word on page 50. Again, the lens on page 62, and that of the electric microscope on page 64 is, mistakenly, labelled 10 magnification instead of 10 diopters. Finally, the position of the head in direct laryngoscopy is stated to be one of flexion at the occipito-atlantal joint; this should be extension, and as such appears in the diagram.

These minor points apart, the book provides a wealth of information which will help the practitioner, not only to make the routine, though often very difficult, examinations of this region, but also to understand the rationale and interpret the results of the more technical examinations by the specialist.

N. A. JORY.

DIURETIC THERAPY. *The Pharmacology of Diuretic Agents and the Clinical Management of the Oedematous Patient*, by Alfred Vogl. Bailliére, Tindall & Cox, pp. 248. Price 38s. 6d.

The two most important pharmacological agents for the treatment of heart disease, with particular reference to congestive failure, are without doubt digitalis and the mercurial diuretics. This book is a comprehensive account of the therapeutic uses of the second of these. It gains in interest and in value from the fact that it is written by Dr. Alfred Vogl who, when he was assistant visiting physician at the Policlinic Hospital, Vienna, was the first to notice the remarkable action of novasurol. The drug was originally introduced in an attempt to introduce a new organic mercurial compound for the treatment of syphilis. In his words—"My interest in diuretic therapy began over thirty years ago when I chanced to observe the diuretic effect of a new organic mercurial compound, Novasurol, in a patient who had received it as an anti-syphilitic agent. Since that fortunate incident, which marked the advent of the mercurial diuretics, I have watched with steady and growing attention the development of diuretic therapy and the astonishing impact which it has had on the management of congestive heart failure."

The book is divided into the following main headings:—

Chapter I. Oedema, including its classification, pathogenesis and principles of treatment.

Chapter II. The indications for diuretic treatment. This chapter embraces all of the varieties of oedema, whether cardiac, hepatic, renal, or that due to other causes.

Chapter III goes with great detail into the pharmacology of the diuretic drugs, and deals with the osmotic diuretics, the acidifying and xanthine diuretics, the uracil compounds, the decholin and last, but not least, the organic mercurial compounds.

Chapter IV, which is short but important, describes the anti-diuretic agents which may interfere with the proper action of diuretics in sick persons.

Chapters V and VI. These go with great detail, but with corresponding clearness, into the practice of diuretic therapy. The chapter includes such points as the role of rest in diuresis, other principles affecting diuresis, and finally a long section on the mercurial diuretics and their action from every point of view.

It is impossible to do adequate justice to this most interesting and valuable book within the confines of a review, but it may be said once and for all that it should be available as a work of reference in the library of every physician interested in the subject of oedema. There is a full bibliography and a few clearly designed and useful tables and graphs. The style is clear and in spite of the complexities of such subjects as the role of the electrolytes, the water and acid-base equilibrium in diuretic therapy, and details of the mechanism of the low salt syndrome, hypochloraemic alkalosis, hypokalaemia and other such biochemical factors, the text is most readable, understandable and clear.

One of the very few points with which the writer of the review does not agree is the statement on page 99 that aspiration of unilateral pleural fluid is only rarely indicated in congestive failure unless

structural changes, such as fibrothorax or bullous emphysema have impaired the efficiency of the contra-lateral lungs. Surely the sudden release of a considerable area of collapsed or semi-collapsed lung for use as an oxygen conveyor is most rapidly achieved by paracentesis of a unilateral pleural effusion, even though this may not be large.

On page 109 it is interesting to see that on the whole the intramuscular use of mercurial diuretics in the opinion of Dr. Vogl is better and safer than the intravenous route. This is the experience of the writer also. Thiomerin is referred to very properly as being a modern mercurial diuretic with advantages over its predecessors. The fact that it is injected subcutaneously is a most valuable point in its favour. The statement on page 110 that in the use of this drug patients and sympathetic relatives are inclined to use too short a needle, which results in too superficial injection which may cause local necrosis, is an example of the detailed care with which the book has been constructed.

One of the valuable clinical points stressed is the value of mercurial diuretics as diagnostic agents, when used to distinguish cardiac from bronchial or spasmodic asthma.

It was with considerable interest also that I read on page 149 that Dr. Vogl has used mercurial diuretics in nephrosis and in the nephritic stage of glomerulo-nephritis with excellent symptomatic results, provided that injections are properly spaced and repeated only after adequate diuresis. It would appear that the chief danger in such cases is more that of retention of mercury in the body with delayed toxic effects than in poisonous action on the kidney tubules themselves. He does not use ammonium chloride in association with the mercurial diuretics as a general rule; but prefers to limit this acidifying agent to situations of unsatisfactory response to mercurial diuretics used alone, and particularly in the presence of potential or actual chloride depletion.

The section on the use of aminophyllin is valuable and useful. A clinical point worth stressing is that the diuretic action of aminophyllin is not impaired by giving it by mouth in association with aluminium hydroxide, which of course helps greatly to control the gastro-intestinal irritation which is often noticed in patients taking aminophyllin by mouth in adequate dosage. He mentions two proprietary preparations made up in this way, one being Aminodrox which contains 0.1 or 0.2 grammes of aminophyllin, and the second Cordalin, which contains 0.3 grammes of aminophyllin. Used in this combination the diuretic should be much more useful and more available to a considerably larger number of patients suffering from congestive heart failure.

GEOFFREY BOURNE.

RADIOACTIVITY AND RADIOACTIVE SUBSTANCES, by J. Chadwick. Revised and supplemented by I. Rotblat. 4th Ed., 1953. Pitman, pp. 120. 12s. 6d.

When this book first appeared in 1921 it received high praise and a warm welcome, for it provided an authoritative yet simple and concise account of

natural radioactive phenomena. Since the publication of the third edition, however, there have been fundamental discoveries in nuclear physics. As against the 47 natural radioactive elements now known, more than 700 radioactive isotopes can at present be obtained by artificial means, i.e. by the aid of the atomic pile or the cyclotron.

The revision of this book, involving the introduction of new material within the excellent general framework of the older editions, cannot have been easy, and Prof. Rotblat is to be congratulated on his achievement. The data and tables have been brought up to date, and a new chapter gives an excellent account of the structure of the atomic nucleus and the theory of transformation, with brief descriptions of artificial radioactivity and nuclear fission.

This book can be confidently recommended to those who are interested in the fundamentals of what has been termed "classical" radioactivity, or who require a short clearly-written introduction to the study of nuclear physics.

A. WORMALL.

AIDS TO SURGICAL NURSING, by Katharine F. Armstrong. 5th Edition. Bailliére, Tindall & Cox, pp. 432, illus. 6s.

Like most books in its series, this new edition represents very good value for money, and an effort has been made to bring it right up to date. Some more omissions could have been made, including references to drip methods of giving penicillin, knee pillows and Carr's splint for Colles' fracture.

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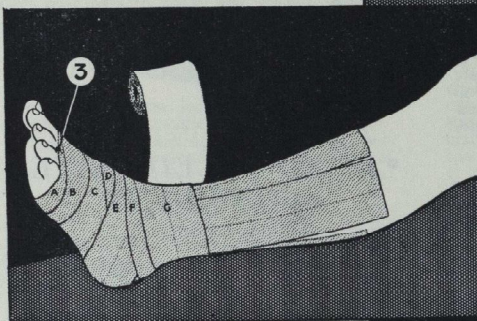
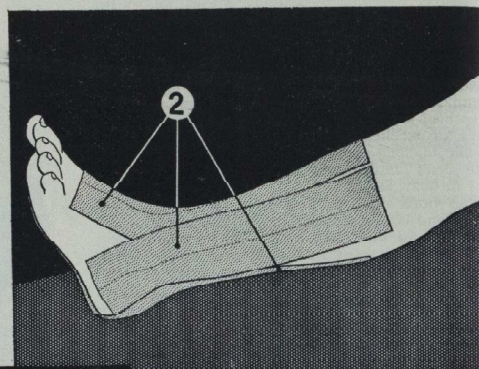
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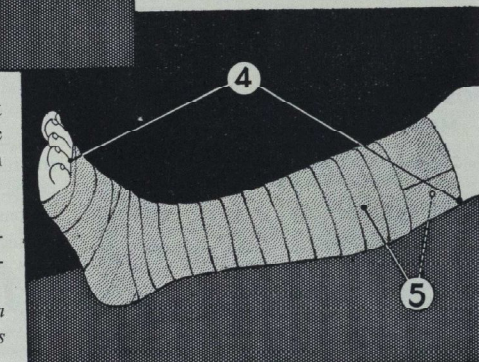
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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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No. 5

SING CUCKOO

There are those who spend their lives painting the word DOG on dogs' bowls. A few dogs are very well educated, taking tea on the laps of the dons of Newnham and Girton, chasing intellectual cats up ancient trees with the same petulance with which their mistresses would pursue a misquotation. And yet, not even the very best educated dog can read the word DOG. Neither does the writing of DOG on a dog's bowl seem useful from the owner's point of view, unless he is both absent minded and eats off the floor. Yet people go on doing it, even in Spring.

Other men go on being doctors. Why? There are many good reasons, a very adequate one being that doctors are a little uncertain of their ability to earn a living in any other way. The talent seen at Christmas suggests that some physicians and surgeons might find employment as conjurers, mountebanks, wandering minstrels or singers of comic songs. Others might get taken on as garage hands, for most medical men are fond of cars, and in a good-class garage the bedside manner would be marketable. "Nothing serious Madam, just a little trouble with his gaskets, we'll soon have him fit again." Yet the best and the most usual reason for remaining a doctor is that nothing else in the world seems half so interesting. If the doctor dreams of a change, it is only some day-dream compounded of the familiar images of the imaginary country practice, with roses, Cotswold stone, Cornish cream, and a Scottish salmon river at the bottom of the garden.

It is stranger that medical students go on being medical students. So much of it is like

painting DOG on a dog's bowl, quite useless, committing to memory knowledge that will only ever be applied in an exam and forgetting it once the exam is over, performing long chemical experiments that are neither educational nor interesting. In Spring, it is especially strange that medical students go on being medical students. In Autumn, the dead leaves float in the puddles, and nature is in tune with the medical curriculum. Winter comes, and it is a season for work. The wind blows and the lectures are well attended. But in spring, when all day the London sky is a smoky blue, all day with a tantalising early morning look about it, that is when temptation comes, the temptation to say casually, "Excuse me Sir, do you need a dresser this afternoon, I was thinking of going to Samarkand?" Or to the South Seas, but not to hold a retractor at a partial gastrectomy. Splendid fantasies of surf and sand go through the mind, of the Pacific booming onto the shore. Or of hills covered with snow just melting, and birch trees dripping in the sun. Then suddenly back to the Ward Round, and "Sorry, what was the question?"

What is there, short of getting out of London, to do in London on a Spring afternoon? One can get a train, and spend the afternoon walking through Epping Forest, or going round Kew, or wandering over Hampstead Heath. Yet there is probably a lecture at twelve o'clock, and a post mortem at one, and a class at two o'clock and exams in June and no more time to go to Hampstead Heath than there is to Samarkand,