

**Spot Diagnosis—Vol. II.** Harvey and Blythe Ltd. 8/6.

This volume is up to the standard of its predecessor. It consists of photographs, X rays, and E.C.G.'s together with some 'Notes on Therapy.' The photographs are good, but it is doubtful whether a black and white photograph is sufficient for making a diagnosis in some of the skin cases. Inevitably, a few conditions which are outside normal experience, such as Geographical Tongue, have been included because of their photogenic quality. Twenty minutes or so spent in looking

through this book should provide a welcome change from the customary pages of solid type.

**Aids to Surgical Anatomy, S.A.S.,** by D. B. Moffat and J. S. Baxter. Baillière Tindall and Cox. 8/6.

The fourth edition has been revised throughout and a new chapter on the spine added. The figures are clear and the text concise. Recommended for quick revision before operations and examinations.

**SHEARER'S MANUAL OF HUMAN DISSECTION** (3rd ed.). Edited by Charles E. Tobin. pp. 287 + xv. McGraw-Hill Book Co. Inc.: New York. 49s.

In British anatomy departments the student serves a fundamental apprenticeship to the constitution of the human frame and is expected to acquire a sufficient, personal familiarity with that machine which, as a medical practitioner, it will be his duty to tend or mend. In American anatomy departments the tradition is, for historical reasons, quite other: therein the enthroned idol is the serially-sectioned pig embryo, around which moves the elaborate departmental liturgy. Time and opportunity for acquiring even a minimal acquaintance with human anatomy are denied the student: atlases of anatomy have great vogue; most of the anatomy teachers are unqualified medically. Hence, from the hands of those gravely concerned at this state of things, books like the present, designed to offset the defects of the system and to assist the medical student in his time-pressed efforts in gross anatomy. Such a work, therefore, must be judged against its transatlantic background and, with its laudible aim in mind, it would be unfair to assess it wholly by British standards, though some such comparison is inevitable.

Its dissection instructions are sometimes inadequate and its anatomical descriptions not infrequently insufficient—e.g. four lines only are devoted to the trachea, without mention of its length, structure or relations. Portal-systemic anastomoses are omitted; the inferior mesenteric vein is sketchily described and without reference to a possible paraoduodenal fossa; the pelvic veins are mentioned merely in an instruction for their removal; and a curious gastric terminology is employed (the stomach 'body' being divided by the incisura angularis into 'cardiac' and 'pyloric' portions). Most surprising is the intentional omission of lymphatic and joint anatomy, an omission justified in the Preface (p. viii) on the

grounds that the student 'has neither time nor the skill to demonstrate these structures in his own dissections,' and that knowledge of these parts 'is best supplied by lectures, reading and demonstrations provided.' One asks, automatically, what profit there be in dissecting the axilla if its contained groups of lymph glands be not sought, seen and studied; also, how adequate knowledge of such structures is to be obtained otherwise than by dissection. And so with the articulations; only by personal dissection can their three-dimensional anatomy be appreciated.

The uncoloured line drawings are well planned; some, however, (Figs. 24, 27, 44) are unsuccessful, while others lack depth or appear confusing because of inability to distinguish easily lines of muscle fibres from lines of shading. The illustration (Fig. 23) of the line of pleural reflection would gain from the inclusion of the outlines of the ribs and sternum.

A curious and pleasant surprise is the retention of anatomical eponyms, now so universally—and so unwarrantably—decried in an illusory attempt at easing the student's burden. Meckel's ganglion, Winslow's foramen, Valsalva's sinuses, the fasciae of Camper and Scarpa, Alcock's canal, the glands of Bartholin and Cowper—these and other eponyms reappear here, trailing their clouds of anatomical history and defying the impersonal uniformity of modernistic usage.

Obviously this book cannot appeal to the British student, but in many American institutions it may well prove a boon to the conscientious dissector in his attempt, against the time-limits of an ill-conceived curriculum, to equip himself anatomically for his future work in pathology and clinical medicine.

A. J. E. CAVE.

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LIX.

SEPTEMBER 1955

No. 9

EDITORIAL

LORD HORDER

By the death of Lord Horder at his country home, Ashford Chace, on August 13th, the Hospital has lost one of her greatest sons. For half a century Lord Horder has added lustre to the name of Bart's; and his seat of honour among the great physicians and surgeons of the past, who form the tradition of this place, is assured.

As a teacher of clinical medicine he will be remembered with gratitude by generations of Bart's men; as a physician and champion of causes he will be remembered by the world at large, for his name has long been a household word. If any corroboration of this were needed, one had only to witness the many people who travelled from all parts of the country to attend his memorial service in St. Martin-in-the-Fields. There were relatives and friends, colleagues and former patients, and representatives from almost every medical society and institution of note. The Earl of Westmorland represented the Queen and Lt.-Col. Sir Howard Kerr, the Duke of Gloucester. The fifteen ushers were former house physicians.

The service was conducted with simplicity by the Rev. Geoffrey Holland, assisted by the Rev. S. G. Bush, Hospitaller and vicar of St. Bartholomew-the-Less. In his address Sir Henry Dale recalled his long friendship with Lord Horder and said that they had come to commemorate and to give thanks for "the beautiful life, the great work and the wonderful personality of a great physician". Dr. Geoffrey Bourne read the Lesson, the parable of the Good Samaritan; and a passage from Pilgrim's Progress was spoken by Sir Malcolm Sargent. A few days previously Sir Malcolm had dedicated a broadcast performance of Fauré's Requiem to Lord Horder's memory.

The moving tributes which have been published in the medical and lay Press are

eloquent testimony to Lord Horder's humanity and wisdom. These have set forth the milestones of his brilliant career and described the protean nature of his interests. We shall not attempt to emulate them.

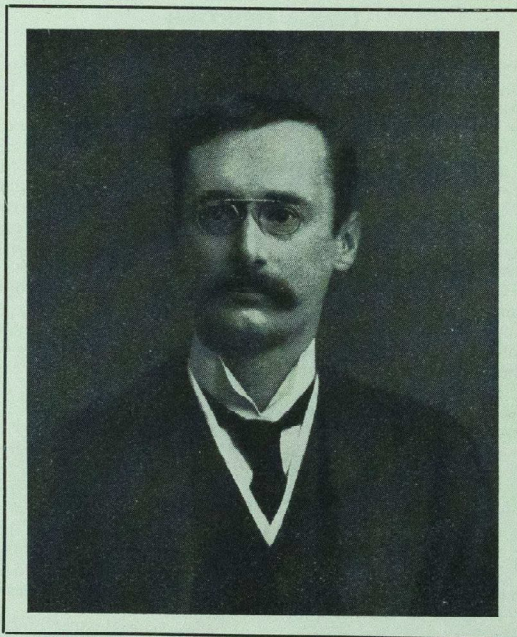
This *Journal*, too, feels his loss, for he was our most senior and distinguished Editor and was for many years Chairman of the Publication Committee. At the turn of the century, when he was 29 and a demonstrator in pathology, he wrote in an editorial (advising and welcoming the new intake of students):

"For once a Bart's man always a Bart's man is a feeling that appeals to all who have left the happy time of studentship behind them . . . *I have great confidence, Oliver Wendell Holmes once said, in young men who believe in themselves. When a resolute young fellow steps up to the great bully, the world, and takes him by the beard, he is often surprised to find it come off in his hand, and that it was only tied on to scare away timid adventurers.* And that front, which is best to face the world with, is also the most promising with which to face the facts of medicine, both known and unknown."

A precept which is as valuable today as it was then, and certainly one that Thomas Horder followed throughout his life. In still earlier *Journals* are recorded the prize-winning feats of his student days, while the later ones contain his lectures and collections of aphorisms, which remain a superb exposition of clinical medicine. More recently, in Coronation Year, there was the whimsical story of the Mayor of Burberry (did it, perhaps, have a basis of fact?) and the treasured letter he sent on our diamond jubilee. In looking back through all of these—and he was a prolific contributor one cannot fail to build up a picture of the man—fragmentary,

but sufficient to give an idea of the range of his learning and the magnitude of his enthusiasm.

When he was created a baron in 1933, the first Bart's man to be thus honoured, Bart's men from all over the world combined to present him with a portrait in oils, which now hangs in the Hospital. But the occasion which most are likely to remember is that of his farewell clinical lecture—it seems hardly possible this was as long ago as 1935. The



Lord Horder in 1910.

lecture theatre was crowded to capacity: never before had so many members of the Visiting Staff and such a large gathering of students attended a similar occasion. On the table lay a laurel wreath, a poignant symbol of the Hospital's affection and esteem. In his lecture Lord Horder gave a masterly résumé of his teaching on the practice of clinical medicine, concluding with these words:

"Well, I must bid you good-bye. It has all been, in schoolboy phraseology, great fun, and I have thoroughly enjoyed it. The

clinician's material has not been confined to the patients in their beds. For there have been the clerks themselves . . . and the rest of the firm . . . and the nursing staff . . . and the porters whistling outside the ward, under the echoing shaft of the lift . . . and the buzzer that calls for the anaesthetist who is never there . . . and this lecture theatre. More than all this, there has been the world outside—the domestic circle, the market-place, the forum. There has been the whole human

comedy as seen by Shakespeare and Molière and Cervantes, and the other great clinical observers. I hope I have not put too many of you, whom I have been privileged to teach, out of your stride. I trust my methods, and my teaching, have conformed in some measure to the great traditions of this place. But they have been largely, and of necessity, myself: *ay, there's the rub.*"

We salute the passing of one who was proud to call himself a Bart's man. He has become part of our heritage.

## LORD HORDER—A TRIBUTE

by GEOFFREY BOURNE

I FIRST met Tommy Horder in 1917 when I became house physician to the Drysdale firm, in which he was Assistant Physician. His personality and that of Drysdale were incompatible. They were both strong, forceful characters, and neither restrained his tongue. This clash of temperaments exemplified well the sort of fight Horder was engaged in for most of his life—individuality against conformity.

All individuals of strong conviction, with a burning love of truth and a hatred of compromise where truth and right are concerned, have similar battles, and fail as he did, and succeed as he did. Their failures are in political advancement, but their success is won in the hearts of those who think and feel as they do that Truth should be unsullied by mundane convenience.

It is largely for this reason that, although the greatest clinician of his age, he never became President of the Royal College of Physicians. He always spoke his mind, and had no talent for nor wish for the achievement of his end by careful political manipulation or by legitimate semi-canvassing, public or private. The same quality of fearless individualism clashed with the respectable orthodoxy of Bart's at the turn of the century. Those were still the days of frock coats and ceremonial. Horder's fight to be appointed Assistant Physician was a hard one, but when his early brilliance had caused him to be called in at the time of King Edward VII's illness, he said to a friend "They can hardly fail to take me now".

His combative love of intellectual freedom was his chief motive in the organisation of the Fellowship for Freedom in Medicine. He knew that the practice of medicine is essentially an affair of individual human contact—that of the physician, as one man, with the patient as another—and he felt deeply that socialisation and standardisation were incompatible with this ideal. He was an individualist. This indeed might be his epitaph, and since no human advance in science is ever made in the first instance except by

individuals, he belongs in memory to the greatest of all companies.

His meteoric rise to success in clinical medicine was largely due to the fact that—being gifted with a brain of exceptional scientific qualities—he was fortunate enough to be among the first to recognise the value of clinical pathology. In his own autobiographical words: "The young consultant, trained in pathology, was able to add to the examination of the patient's body the examination of the patient's blood, his cerebrospinal fluid, his secretions and excretions. This involved special tools and special techniques: syringes and needles for venous and lumbar punctures, tubes of broth and agar for preparing cultures at the bedside, cover slips for blood smears, swabs for throat and other secretions, 'stains' for blood films on the spot and a folding microscope for their examination. Then on reaching home, the culture tubes were put into the incubator in the little basement laboratory before going to bed, and only fatigue could cancel out the excitement of anticipating tomorrow's findings which would otherwise have prevented sleep!"

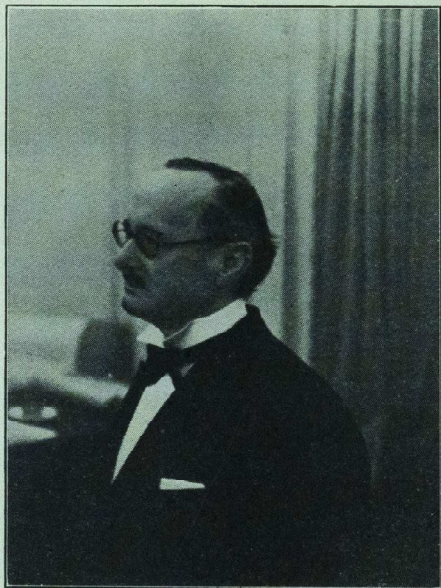
Around 1900 at the age of 29 he was already making a name for himself in the subject of applied bacteriology. He proved by blood culture studies that the blood in acute rheumatism was sterile. He also did original work in the bacteriology of subacute bacterial endocarditis, and his paper on the subject in the *Quarterly Journal of Medicine* is a classic.

It was in the middle years, as a house physician, that I first remember him.

He was working as Assistant Physician, and was already in great demand as a consultant. If he treated the Great of the medical world on what he considered their merits, so he considered the small. He would always listen carefully to the remarks, and even the clinical opinions of the most junior house physician carefully, and strictly on their merits. Condescension had no place in his character. In this quality of intellectual

generosity he was like Drysdale, an equally great but different personality.

I can even now, à propos of a patient with signs of thickened pleura or of pleural effusion, in whose case there was a difference of opinion, hear his slightly harsh and penetrating but not loud voice, say in an amused kindly way "Would you like to put a needle in and see?"



Lord Horder in 1937.

As a ward teacher he was good, as a trainer of the budding clinician superb, but as a lecturer too diffuse to be appreciated by most students. His lectures indeed tended to be somewhat discursively conversational—so different from the well paragraphed and arranged periods of many of his contemporaries who were far below him in clinical ability.

A year later I was house physician at the Evelina Children's Hospital, and while there contracted the virulent form of influenza, so fatal during the end of the First World War. The only other resident, worried at my

mounting fever, asked whether I would like a physician to see me. I replied, Yes, Sir Thomas Horder, if he could manage it. That evening and for several successive nights he came to see me, for I was severely ill. On one such occasion he was taking a scratch supper, having had no time to eat before, for the epidemic was overwhelming him with work. The Hospital Secretary appeared and rather

effusively thanked him for taking such trouble and pains about a mere resident. "Bourne and I are friends," was the reply. This was one example of innumerable such acts of his during a busy life.

After a long convalescence I returned to Bart's, as a Chief Assistant, and became better able to appreciate his powers as a clinician. He had the great gift of always seeing, in their proper value, the essentials of a case. The details did not escape him, nor did they bemuse him. "If you have to decide, in diagnosis, between three conditions, the evidence being about equal in support of

each, go for the commonest. In this way you will not only most often be right, but you will benefit most people."

The quickness of his mind and tongue can well be illustrated by an occasion when a rather self-satisfied colleague was Chairman at the Staff Dinner. The Chairman in starting his speech began as follows. "This gentlemen, is a unique occasion. Upon my right hand is seated Sir Norman Moore, President, gentlemen, of the Royal College of Physicians, (complacent pause) a St. Bartholomew's man; and, gentlemen, on my left hand is seated Sir Anthony Bowlby (complacent pause), also, gentlemen, a St. Bartholomew's man." Further complacent pauses, during which Horder, in not quite *sotto voce*, was heard to observe "Let us raise *three* tabernacles".

In his last decade I had on several occasions, recourse to him as a consultant, in difficult cases. Even if the recent advances in cardiology or biochemistry were after his time, his lucid brain and flair for weighing the essentials were always of the greatest value.

When the Health Service was planned I became an early writer and speaker on the subject of Professional Freedom; and feeling strongly that there could be no compromise on the main issue I found myself once more ranged very closely with Horder. I saw his fight from near at hand, and recognised the essential justice of it. At a critical stage he nearly became President of the Royal College of Physicians. Had he done so things might have been different and better. But outstanding genius is never popular with the English, especially if endowed with brilliant powers of speech. Indeed this combination is regarded as being not quite respectable. He retired, as Winston Churchill had done in another field, into the wilderness, so far as the College was concerned, beaten by politics. For him, unlike Winston, there was no come-back from such a position. He was Knighted in 1918, created a Baronet in 1923, and a Baron in 1933. His first loves, in their order, were intellectual and scientific truth; his fellow men as human beings; St. Bartholomew's Hospital; and his garden. He was a great man and a true friend.

---

## HORATIO GEORGE ADAMSON

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

WE REGRET to have to record that on July 6, at the age of 89, Dr. H. G. Adamson died. He was born in London on November 28, 1865 and was educated at Church House Grammar School, Ealing, and at University College School in Gower Street. In 1883 he entered St. Bartholomew's Hospital with a science scholarship. He graduated by obtaining the degree of M.B., B.Ch (Lond.) in 1889, and in the same year became house-physician at the City of London Hospital for Diseases of the Chest; in 1890 he was appointed house-surgeon at the Children's Hospital, Paddington Green. Further house-appointments followed at the North-Eastern Hospital for Children, and in 1892 he obtained

the degree of M.D. (Lond.). Adamson was then appointed Physician to Out Patients at the North Eastern (now the Queen's) Hospital for Children and later became one of the Physicians to that Hospital. About this time he became assistant to Dr. J. J. Pringle in the Skin Department at the Middlesex Hospital; and retained this post until he married in 1896, when he left London to become a general practitioner in Guildford. For seven years he remained in Surrey, and it is of interest to note that during part of this period he was medical officer to the Broom House School—for Ringworm.

In 1903 Adamson returned to London and in the same year obtained the diploma of

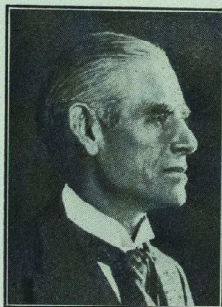
M.R.C.P. He became assistant to T. Colcott Fox in the Skin Department of the Westminster Hospital, and Physician in Charge of the Skin Department at the Paddington Green Children's Hospital. In 1908 he became Chief assistant to J. A. Ormerod in the Skin Department of Bart's, and a year later was appointed Physician to this Department. Hitherto the Skin Department had been supervised by a junior assistant physician or a junior assistant surgeon, but with Adamson's appointment it became an autonomous department with its own physician in charge. He was elected F.R.C.P. in 1911 and remained on the Honorary Staff until 1928, when he resigned at the age of 62.

Those who remember Adamson, will recall the immaculate perfection of his clothes, the bowler hat with the flat brim, his acute powers of observation, his prowess as a draughtsman on the blackboard, his quietness and dry humour, and his gift of inspiring affection in those who worked for him. They may not know that in 1945 a sherry party was held in his honour at the house of the late Dr. Henry Corsi, and that he was then presented with a silver rose bowl subscribed for by thirty of his former house-physicians and assistants, some from places as far away as Australia, South and East Africa; the gift was particularly appropriate because Adamson was fond of gardening and loved roses.

Adamson's career was remarkable in many ways. It was unusual that a man who was red-green blind should even consider dermatology as a vocation. He won his place on the Staff of Bart's by "the hard way"; although, if asked, he probably would have agreed that his experiences in general practice made a valuable foundation for a career as a specialist. He was a pioneer in the treatment of skin diseases in children and in 1907 published a small book *Skin Affections of Childhood* which attracted much attention: in 1913 he wrote the chapter on diseases of the skin in Garrod, Batten and Thursfield's *Diseases of Children*. He was also a pioneer in X-ray treatment, and few pioneers in this form of therapy survived to such a great age. He was a prolific writer and published about 70 papers and articles on dermatological subjects between 1894 and 1949.

Finally he was widely recognised as a very great authority in his speciality, a fact which was attested by the conferment of numerous

honorary corresponding memberships and memberships of dermatological societies abroad, by his appointments as President of the British Association of Dermatology and Syphilology (1924), President of the Section of Dermatology of the Royal Society of Medicine (1922-23), and President of the Section of Dermatology at the Annual Meeting of the British Medical Association in 1926. But, of all the work he published he will be chiefly remembered for his modifica-



Courtesy of the B.M.J.

tion of Keimöck's method of using X-rays for epilation of the scalp, which was described in *The Lancet* in 1909. This is always referred to as the "Adamson-Keimöck" technique and is still a standard method and used throughout the world: it seems probable that he developed this method just before his appointment to Bart's while he was radiologist for ringworm cases to the Metropolitan Asylums Board School at Sutton. Needless to say, when he became Physician to the Skin Department at Bart's, he persuaded the Governors to furnish the new department with an X-ray plant, an innovation for which he and his successor Dr. A. C. Roxburgh were always thankful.

It is only fitting that in concluding this brief account of such a brilliant and useful life, we should offer to Mrs. Adamson our sympathy in her great loss.

R. M. B. MACKENNA.

## JOHN DENNIS MARTIN-JONES

M.D., D.O.M.S.

IN King Henry IV Sir John Falstaff says, *Will you tell me, Master Shallow, how to choose a man? Care I for the limb, the thewes, the stature, bulk, and big assemblance of a man! Give me the spirit, Master Shallow.*

John Dennis Martin-Jones was indeed a man of spirit in both work and play, but neither in mundane ambition nor in reality was he a giant in our profession. Characteristic of his qualities of mind and heart he did whatever lay clearly at hand with efficient and conscientious thoroughness, meticulous care, with kindness, and with that sound common sense which dominated his judgment in all matters. Much of his well balanced thinking and behaviour, his poise and purposefulness and well timed actions were compatible with his physical make-up, for he possessed the compact, well proportioned and slight physique of the outdoor games player and sportsman.

Such a distinguished anatomist as the late Professor Woollard held that there are men in whom there is combined an aristocracy of both mind and body. This harmony of both mental and physical qualities was evident in John Martin-Jones.

He was born on March 29, 1907, the elder son of the late Martin Llewellyn Jones, F.R.C.S. and Mrs. Martin-Jones of Aberdare, Glamorganshire. From his father he inherited an aptitude for surgery and good literary taste, for both father and son read widely.

He was educated at Denstone College and then at Emmanuel College, Cambridge where he obtained honours in the Natural Sciences Tripos.

In January 1931 he entered St. Bartholomew's Hospital and in 1934 qualified. He became House Physician to Dr. Hinds Howell and later House Surgeon to the Eye Department 1935-36. In 1936 he took his Cambridge M.B., B.Ch. and in 1938 passed the D.O.M.S. He was Resident Surgical Officer and then Registrar at the Royal Westminster Ophthalmic Hospital and there as Cruise Research scholar he investigated uveal sarcoma, on which subject he wrote a thesis for the Cambridge M.D. which he gained in 1939. This thesis had the distinction

of being published as a Monograph supplement of the British Journal of Ophthalmology in 1946.

He served in the Army from 1940-45 and spent four years overseas as an ophthalmic specialist in hospitals in the Middle East and in a Mobile Ophthalmic Unit in Normandy. Despite the stressing and often difficult conditions of active service the excellence of his work never varied. The field medical cards which accompanied the wounded who had passed through his capable hands were marked with his neat handwriting setting out concisely and clearly every essential detail. I do not think that the smallest lesion at the extreme periphery of the ocular fundus ever escaped his notice. He possessed that admirable quality, so essential in our professional behaviour, of imperturbability (Osler's 'Aequanimitas') and such never left him in the stress and squalor of war and in handling large convoys of wounded. Indeed I never saw him out of temper or other than neat, debonair and well dressed whatever the conditions; a tribute to his self-discipline, control and poise.

On leaving the Army he decided wisely that the unbalanced and madly competitive career of a consultant in London was not his way of life. In the Cathedral Close of Salisbury and on the Consulting Staff of the General Infirmary he found the suitable medium for his unhurried and thorough clinical work. In Salisbury he was fortunately spared the isolation that specialists may endure in a provincial town, for near by there lived his old Chief, Robert Foster Moore, to whom he went both for advice and for the recreation of fishing. Theirs was a friendship which was perfectly complementary. Soon he established in Salisbury an efficient eye unit which gave good service of a high clinical order to a wide area of surrounding country. His loss will be felt acutely by the hospital team he has trained and by the many patients he has treated with such characteristic care and kindness. He was a competent operator, inclined to be too modest about his ability. His many friends and patients will for ever remember his absolute honesty, his modesty and integrity.

At Salisbury he led a well-balanced life enjoying to the full his work, his outdoor games, his fishing and shooting and above all his family life in an admirable home. It is tragic that he died in his prime. His loss is irreparable.

able but the memory of his many fine qualities as a doctor and a man will endure with the wide circle of his friends who held for him an affectionate regard and loved his constant good nature and kindness, and en-

joyed his gaiety and the spontaneous warmth of his friendship.

To his wife and two young daughters we extend our sincere sympathy in their great sorrow and tragic loss.

H. B. STALLARD.

### Births.

BOULTON.—On July 7, at St. Bartholomew's Hospital, to Helen (née Brown) and Dr. Tom Boulton, a daughter.

CARDWELL.—On July 19, at St. Bartholomew's Hospital, to Elizabeth and Sqn. Ldr. John Cardwell, M.R.C.S., L.R.C.P., a daughter.

COX.—On July 19, at Portsmouth, to Molly (née Grimson) and Dr. John S. Cox, a daughter (Jacqueline Mary).

CROOK.—On July 28, at Southsea, to Rachael (née Simmonds) and Dr. Raymond Crook, a daughter (Yvonne Susan).

ELMHIRST.—On July 6, at Ipswich, to Sheila and Dr. Edward Elmhirst, a son.

MACADAM.—On July 21, at St. Bartholomew's Hospital, to Diana (née Duncombe) and Dr. F. I. Macadam, a son (Charles Francis).

MANNING.—On July 13th at Haverfordwest, to Margaret (née Jones) and Dr. Eric Manning, a daughter.

PEARCE.—On July 20, to Rosalind (nee Bell) and Harry A. Pearce, F.R.C.S., a son (Timothy Martyn Lees).

ROXBURGH.—On July 6, at St. Bartholomew's Hospital, to Gillian (née Norton) and Dr. Ian Roxburgh, a daughter.

TODD.—On July 6, at St. Bartholomew's Hospital, to Jean (née Noble) and Ian P. Todd, F.R.C.S., a daughter (Caroline).

TOWNSEND.—On July 23, at Cherries, Playden Rye, to Betty (née Stone) and Dr. W. H. Townsend, a son.

WATERHOUSE.—On July 14, at St. Bartholomew's Hospital, to Hazel and Dr. John Percival Waterhouse, a daughter.

WRIGHT.—On May 12, to Lillian and Dr. W. J. Wright, a daughter (Susan Elizabeth).

### Deaths.

CHRISTOPHERSON.—On July 21, Dr. J. B. Christopherson, aged 87. Qualified 1893.

CLAYRE.—On July 7, Dr. O. T. John C. de H. Clayre, aged 63. Qualified 1919.

COLE.—On May 25, Dr. Bernard Hedley Cole. Qualified 1920.

GILLET.—On June 26, Dr. Henry Tregelles Gillett, aged 84. Qualified 1895.

MCCURRICH.—On July 16, Hugh James McCurrich, M.S., F.R.C.S. Qualified 1915.

### Engagement.

MACLAY—COOPER.—The engagement is announced between Dr. W. S. S. Maclay and Miss E. A. Cooper.

### Marriage.

CASSELLS—MCANDREW.—On July 23, at the church of St. Mary Aldermary, London, Dr. Michael John Cassells to Dr. Irene Margaret McAndrew.

### Change of Address.

STUART.—Dr. Richard Stuart to Barham House, Harrold, Beds.

CALDERWOOD.—Mr. R. W. L. Calderwood, F.R.C.S., to "Glencoe," Sutton Lane, Brotherton, Knottingley, Yorks.

COOK.—Dr. A. B. Cook to Moorfield, Greenfield, Yorks (via Oldham).

AUSTEN-LEIGH.—Mr. R. A. Austen-Leigh to Great Abshot, Titchfield, Hants.

## ROUND THE FOUNTAIN

### Henry and the Pigeons

There is an interesting story told by David Lack, the well-known ornithologist, about robins—notoriously rapid nest builders—that built a nest on an unmade bed between the time the occupier went down for his breakfast and the time he came back for his shave. Being a warm-hearted soul this worthy moved into another room and let the robins rear a family on his bed.

Likewise, we should congratulate ourselves on our forbearance regarding the pigeons that nested in Henry VIII's crown. Nobody seems to have witnessed the actual building process, but that it happened can be verified by looking upwards just before entering the Henry VIII gateway. Once seen, the advantages of the situation are obvious: it is a covered dry spot with a fine outlook on Smithfield Meat Market, and within easy flying distance of the river and the midday sandwich brigade in Postman's Park. The main disadvantage of the site would seem to be over-exposure to carbon monoxide fumes drifting up from vast Bentleys and Rolls-Royces ("Chief" types) as these grandly await the opening of the gates. Perhaps in fact *our* pigeons (one can't help feeling vaguely possessive about them now) are the first to rear chicks with Osler-Vasquez disease, thus compensating for high carboxy-haemoglobin levels.

We hope they are there again next year.

### Dream fulfilled

Mr. R. M. Robins, surgeon at the Radcliffe Infirmary, Oxford, writes: Last month we had two Nigerian students in Casualty. A small girl, aged five, returned a week after a small cut in her knee had been sutured. When her father remarked, *The stitches were put in by a coloured gentleman, doctor*, her face lit up and she added, *Yes Duddy, a real live golliwog!*

### Athletics

A report of the Athletics Club's activities appears in the back of this *Journal*. We congratulate the ladies on their performance, and

were particularly pleased to see physiotherapists among their numbers: may the co-operation long continue.

### The Cricket Club

The Club has again enjoyed a successful tour at Rottingdean. The side has been better than those of recent years, and it is a pity that the overall results do not do them full justice. On more than one occasion, however, defeats by good opponents could have been avoided if the whole of the 1st XI had been available. More co-operation in the planning of holidays and weekends is clearly required.

The Cricket and Boat clubs share the honour of being the oldest sports club in the Hospital; both are known to have existed for over a hundred years. It is very satisfying that they are striving to recapture the splendour of their achievements in the pre-war era.

### The Rugby Football Club

It is unusual at Bart's for the captain of a sports club to be elected for a second term of office. The amount of time and work involved with the ever present spectre of examinations make this an undesirable general practice; in certain circumstances, however, there can be no denying that the re-appointment is justified, at any rate from the club's point of view. The Rugger club re-elected E. F. D. Gawne for a second season a few years ago; this year they have decided to re-elect I. S. T. Tallack. A new spirit pervaded the Rugger club last year, and, if Tallack can bring about as much improvement again this year as he did the last, we can look forward to a season of hard fought and exciting games. The Inter-Hospitals Cup has been absent from the library showcase for too long; its return will depend on how much support the members of the club are prepared to give the captain and his committee. Before the war the club could boast of seven teams; nowadays there are only four, and of these the extra "A" and "B" lead a precarious existence. It is true that the student body is smaller; but it should be remembered that the health of the club depends as much on the junior sides as it does on the senior.

Incidentally, we were pleased to see a former star of the Rugby club who visited us in order to introduce his son to the Royal and Ancient. This was P. L. Candler, a former Cambridge blue and English international. The visit was a rare one for he is a gynaecologist resident in Nairobi.

#### Shortage of Beds in the Provinces ?

Dr. John Squire of Sussex received this unusual note from an obstetric registrar:

*Just to let you know that your patient has been booked for confinement, under Miss Watson's car, on the recommendation of the Public Health Authority and as she is rhesus negative.*

#### Tropical tendencies

An appropriate time elapsed before the recent hot weather brought about any lightening of the sartorial hue to be seen in the Square. First one, then another, of the Harley Street subfuscus gave way to lighter garments, until some were overtly Tussore.

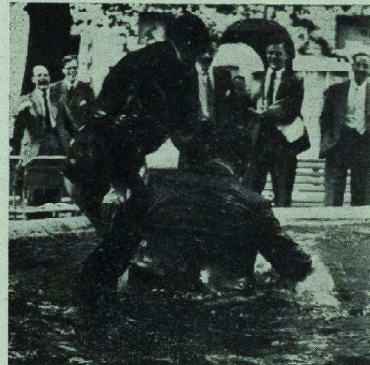
The ladies, uninfluenced by masculine conservatism in the matter of dress, blossomed out immediately like a summer showing. Dare we suggest that perhaps some overdid it, or is it old fashioned to think that stockings should be worn about the Hospital.

#### Not as strangers

Among the first climatic chameleons were those recently returned from across the Atlantic and also our four "visitors from America." We prefer Dr. Gibb's description to their own of "foreign students." If their "ice-cream suits" seemed funny to us, they had the last laugh as we sweated in our more conventional coverings. Their presence here together is a coincidence, for they come from different hospitals and for different reasons. The welcome they received took unusual forms. One was attacked with a scalpel and will return to America with his appendix in vitro. The luckless patient confessed naively, when the procedure became imminent, that he was apprehensive because he had never been in hospital before! Another, albeit unwillingly, was accorded the peculiar Bart's honour of immersion in the fountain. Is he, we wonder, the first American to undergo this baptism?

#### One way to keep cool

The occasion of the Boat Club photograph was no less eventful than that of the Rugger Club, which we described in our August number. True, there was no black cloud, but there was the fountain — and water has an irresistible attraction for the boatsman. The victim of the plot was the 1st VIII's American cox, Keith G. Dawson. In America Dawson coxed the Princeton Jayree Heavies, and the Boat Club lost no time in press-ganging him into the 1st VIII, which he coxed in the regattas subsequent to Henley. At Henley he took part in giving commentaries over the public address system; under false pretences, for this is a British prerogative. The required English accent was successfully maintained until the Thames Cup, when his enthusiasm at seeing his compatriots in the lead proved too great, and he reverted to native tongue and idiom. The instigator



*In their element*

of the fountain plot, we regret to say, was none other than our Sports Editor. There are times when the devil fails to look after his own and this was one. A mighty scrum developed, which would have done credit to the XV, and despite protestations the leafy reflections were soon shattered by two floundering bodies. The laughter of one spectator was short-lived, however, when it was pointed out that his white flannel trousers, misguidedly loaned to one of the performers, were now mud coloured and draped with water weed.

#### Royal College of Physicians.

The following have been elected examiners:—

Dr. E. R. Cullinan.—*Panel of examiners for membership examination.*

Dr. A. W. Spence.—*Medical anatomy and principles and practice of medicine.*

Mr. D. B. Fraser.—*Midwifery and diseases peculiar to women.*

Dr. A. W. Franklin and Sir Geoffrey Keynes have been elected to the Library Committee.

Dr. R. M. B. McKenna is to give the Watson Smith lecture for 1957.

#### Royal College of Surgeons.

Mr. J. D. Griffiths is to give an Arris and Gale Lecture on the surgical anatomy of the blood supply of the distal colon.

#### APPOINTMENTS

##### University of Cambridge.

Dr. D'A Kok, Chief Assistant at St. Bartholomew's Hospital, has been appointed a lecturer in medicine at Cambridge.

##### University of London.

Mr. G. W. Taylor, Acting Assistant Director of the Surgical Professorial Unit at St. Bartholomew's Hospital Medical College, has been appointed to University Readership in Surgery at the college.

##### University College of Khartoum.

Dr. Harry Butler, Reader in Anatomy at the Medical College, has been appointed to the Chair of Anatomy, at Khartoum.

##### Hospital Appointment.

Dr. A. B. Anderson, pathologist at the Hospital, has been appointed lecturer in chemical pathology.

#### NOTICES

##### The Tenth Decennial Club

The Annual Dinner of the 10th and associated 8th and 9th Decennial Clubs will be held at the Bath Club, 74, St. James' Street, S.W., on Wednesday, October 26, 1955, at 7 for 7.30 p.m.

Dr. Lindsey Batten in the Chair.

\* \* \*

##### The Rahere Choir

The choir will start rehearsing during September for the Christmas concert which is to be given in St. Bartholomew's-the-Great. Details of the time and place of the rehearsals will be posted on the notice boards. Anyone interested in joining the choir will be very welcome.

\* \* \*

##### The Art Exhibition

The Exhibition will be held in The Great Hall of St. Bartholomew's Hospital, from 6th-12th October. The opening ceremony will be performed by Lady Kelly at 3.15 p.m. on Thursday, October 6th.

Contributions to the Exhibition will be welcomed from past and present members of the Hospital and Medical College staff, Old Bart's Men, nurses, lay staff and medical students.

Further information may be obtained from any member of the Committee: Dr. Geoffrey Bourne (Chairman), Dr. J. Coulson, Mr. E. A. J. Alment, Dr. J. S. Malpas, Miss L. Rowsewell, Nurse Biffen, and L. J. Chalstrey (Secretary).

Doctor and Parson joined in one,  
Most suitably we find.

The one the suffering body heals,  
The other soothes the mind.

The Parson shows the way to Heaven,  
And then with tender care,  
The Doctor consummates the work,  
And gets the Patient there.

## A HISTORICAL SURVEY OF MEDICAL ETHICS

by ROBERT FORBES

ORIGIN and evolution are commonly of great interest and importance for the full understanding of a subject, and I therefore thought it might be helpful in our present deliberations if I gave a short summary of the history of medical ethics.

The story begins in Babylon, where in 2700 B.C. a treatise was published dealing with the regulation of the conduct of a physician. The celebrated Babylonian Code by Hammurabi appeared about 2250 B.C. In this "the oldest code of laws in the world" is contained the idea of the personal responsibility of the physician, and, on the principles of the *lex talionis*, it lays down on the one hand the fees payable for certain medical and surgical services, and on the other the penalties for negligent or unsuccessful practice. Some of this "eye for an eye" legislation is very interesting in the light of present-day practice and experience.

215. If a doctor has treated a man for a severe wound with a bronze lancet, and has cured him, or has opened an abscess of a man's eye with a bronze lancet, and has cured the eye, he shall take ten shekels of silver.

216. If the patient be the son of a poor man he shall take five shekels of silver.

217. If he be a servant the master of the servant shall give two shekels of silver to the doctor.

218. If the doctor has treated a man for a severe wound with a bronze lancet and has caused the man to die, or has opened an abscess of the eye with a bronze lancet and has caused the loss of the man's eye, his hands shall be cut off.

219. If a doctor has treated the severe wound of a slave of a poor man with a bronze lancet, and has caused his death, he shall render slave for slave.

220. If he has opened his abscess with a bronze lancet, and has made him lose his eye, he shall pay money, half the price of the slave.

221. If a doctor has cured a man's shattered limb or has cured a diseased bowel, the patient shall give five shekels of silver to the doctor.

222. If he is the son of a poor man he shall give three shekels of silver.

223. If he is a servant the master of the servant shall give two shekels of silver to the doctor.

Dr. Robert Forbes, J.P., M.B., Ch.B., is Secretary of the Medical Defence Union and Chairman of the Central Ethical Committee of the British Medical Association.

The fees prescribed seem to have been adequate, for a shekel of silver was equivalent to 2s. 6d. of our money, and its purchasing power was probably from twenty to thirty times as great. The doctor who cured the severe wound with a bronze lancet would therefore have received no less than twenty-five guineas.

Dr. John D. Comrie of Edinburgh, in a lecture entitled "Medicine among the Assyrians in the Year 1500 B.C.," suggested that the abscess of the eye mentioned in the code was probably a condition produced by couching the cataractous lens. This operation was frequently performed among primitive people by travelling charlatans, who depressed the lens and so restored some degree of vision. They then collected their fees and moved to their next centre of activity before the abscess developed. Perhaps the penalties prescribed by Hammurabi were directed towards unscrupulous practitioners of this order.

The imposition of penalties on unsuccessful treatment must have checked to some degree the progress of medicine, and the Babylonians were not the only people to prescribe such punishments. An Egyptian physician whose patient died in an unorthodox manner—that is, in a manner which was not recognised by the governing authorities—might be sentenced to death. Some 3,000 years later, when sixth century Europe was suffering from a visitation of the plague, a Duchess of Burgundy, who was one of its victims, accused her physicians of administering potions intended to kill, and extracted a promise from the king that the crime should be punished. After her death the king, in accordance both with his promise and with the Teutonic law, secured the death of the doctors involved.

### THE HIPPOCRATIC OATH RESTATED

The Greeks had no legal code like that of the Babylonians to guide the physician in the details of ethical procedure. A physician

was guided solely by his desire to help suffering humanity, and his conduct was based on traditional religious teaching and national customs and on his artistic instinct. It is to a Greek that we owe the fullest concept of the responsibilities devolving upon medical practitioners. This is embodied in the famous Oath of Hippocrates, of which the following is a translation by Francis Adams of Banchory, the Deeside scholar.

I swear by Apollo the physician, and Aesculapius, and Health, and All-heal, and all the gods and goddesses, that according to my ability and judgement I will keep this oath and this stipulation: to reckon him who taught me this art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked; nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practise my art. I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption and further from the seduction of females or males, of freemen and slaves. Whatever, in connexion with my professional practice or not in connexion with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in my times! But should I trespass and violate this oath may the reverse be my lot!

The oath is worthy of the highest admiration, and its spirit is still applicable to the general conduct of the medical practitioner. Many medical schools still administer the Oath to their graduands in a modified form, which omits the pagan references.

But if we are to maintain those ethical standards which are necessary for the successful pursuit of the art and practice of medicine the rules contained in the Oath require to be restated from age to age. Its chief obligations are that a practitioner should summon a consultant when he is in doubt as to the prognosis, diagnosis, or treatment of a case;

that he should be reasonable in his charges or, if necessary, forgo them altogether; that he should lead a pure and moral life; that he should endeavour to be a philanthropist; that he should respect at all times his medical teachers; that he should not give, or sanction the giving of, a poison, cause or encourage abortion, use his position to debauch a patient or any member of a patient's household; that he should not divulge information about a patient; that he should not advertise in any way; and that he should not be ostentatious in dress or bearing. These simple criteria, succinctly expressed, of professional dignity and duty have been the ideals of medical ethics for nearly 2,000 years, and they constitute the foundation on which have been built up our modern codes. There has been scarcely an age in medicine in which some great leader has not underlined and endorsed the basic principles of ethics as enunciated in the Hippocratic writings.

### HIPPOCRATES AND THE ART OF MEDICINE

The father of Medicine went further than the mere enunciation of a code of ethics. In that part of his writing called "The Law" he defines with great precision the requisites necessary to acquire eminence in the pursuit of the art of medicine.

Admirable as "The Law" is in its demand for high standards, its application must have been restricted, in some measure, the flow of medical thought and practice.

The Romans delayed the legal control of medical conduct until it became necessary to protect the public against quackery and the sale of proprietary medicines. Antoninus Pius (A.D. 138—161) passed an edict restricting the number of physicians practising in the community, prescribing certain tests as to their character and ability, and exempting them from taxation and certain public duties. The practice of medicine thus became an honourable profession, and physicians had no longer to grovel basely before the rich. After the fall of Rome, however, a *lex talionis* was introduced. There was very little difference between quacks and responsible physicians in Graeco-Roman times because there were no academic degrees and no legal qualifications. Neither ethics nor etiquette nor any other

power can suppress quackery in all its various phases. Some have suggested that it might be suppressed by a strictly applied test and the prohibition of practice by persons who have not submitted themselves for examination. There are others who hold that even the law cannot abolish the practice of quackery, since quackery is not unknown within the ranks of the registered medical profession itself.

#### LICENCE TO PRACTISE IN THIRTEENTH CENTURY EUROPE

The first extensive law relating to the practice of medicine in Europe was established by the Emperor Frederick II in 1224. That law required that each practitioner should undergo a particular form of instruction for a specified period, and submit himself to an examination. If he satisfied his examiners he received a licence to practise. The law also regulated the fees that a physician might charge his patients. A similar enactment was passed by Charles IV for the German States in 1347, and for Italy in 1365. The need for some such regulation is illustrated by Bruno of Lambardy's interesting sidelight upon the status of the healers in the thirteenth century. He says that the majority of those who practised surgery in his time were uneducated persons, boors, and imbeciles.

Generally speaking, medical practice and public opinion were working in the same direction towards a standard ethical procedure. The practitioner no longer guaranteed a cure, but bound himself to bring to his patients a fair and reasonable degree of skill and knowledge and a desire to exercise to the full such supervision as might result in the restoration of the health of the patient. The force of public opinion, conscious of the necessity of adequate protection, gradually obtained regulations prescribing certain standards of instruction and certain tests that had to be passed before the examinee was permitted to practise medicine. The exercise of the art, therefore, came to be restricted to those who had legitimately pursued a course of instruction at a medical school or university, and had satisfied examiners that they were trustworthy and in possession of a sufficient degree of knowledge. A licence to practise was issued to the successful candidate, and

any individual practising without that licence was subject to punishment.

In South Italy, at least, the standard of medical practice in the Middle Ages was of a very high grade and creditable in character. Physicians were precluded from business relations with apothecaries, and they were obliged to visit their patients twice a day and, if a patient desired it, once at night. They had to devote themselves to the recognised books of Hippocrates and Galen, and had to be taught theoretic as well as practical medicine.

#### THE SURGEON ACCORDING TO LANFRANC AND DE MONDEVILLE

These requirements related to physicians. Here are the requisites which Lanfranc in 1295 considered essential for a surgeon.

Needful is it that a surgeon be of complexion well proportioned . . . He must have hands well shaped, long, small fingers, and his body not quaking. Also he must be of subtle wit, for all things that (be)longeth to surgery may not with letters be written . . . Let him be no glutton, nor envious nor a niggard; let him be true, humble, and pleasingly bear himself to his patients; let him speak no ribaldry in the sick man's house; let him give no counsel unless he be asked; let him speak with no woman in folly in the man's household, but courteously speak to the sick man, and in all manner of sickness promise him health although he despair of him, but nevertheless tell his friends the truth. Let him love no hard cures and undertake no desperate cases. Let him help poor men as far as possible and ask good reward of the rich. Let him praise not himself with his own mouth, nor let him blame over sharply other leeches. Let him love all leeches and clerics, and, as far as possible, make no leech his enemy. So should he clothe himself with virtue that he may obtain a good name and a fair reputation. This is the ethical teaching.

A similar summary of the qualities necessary in a surgeon is given by Lanfranc's contemporary, Henry de Mondeville:

A surgeon ought to be fairly bold. He ought not to quarrel before the laity, and although he should operate wisely and prudently, he should never undertake any dangerous operation unless he is sure it is the only way to avoid a greater danger. His limbs, and especially his hands, should be well shaped, with long, delicate, and supple fingers, which must not be tremulous. He ought to promise a cure to every patient, but he should tell the parents or the friends if there is any danger. He should refuse, as far as possible, all difficult cases, and he should never mix himself up with desperate ones. He may give advice to the poor for the love of God only, but the wealthy

should be made to pay well. He should neither praise himself nor blame others, and he should not hate any of his colleagues. He ought to sympathize with his patients in their distress and fall in with their lawful requests so long as they do not interfere with the treatment. Patients, on the other hand, should obey their surgeons implicitly in everything appertaining to their cure. The surgeon's assistants must be loyal to the surgeon and friendly to his patients. They should not tell the patient what the surgeon said unless the news is pleasant, and they should always appear cheerful. They must agree among themselves as well as with the patients, and they must not be always grumbling, because this inspires fear and doubt in the patients.

It is often said that an ethical code which is unwritten is more binding than a written one, but practical considerations often predominate over moral philosophy, and we find that medical schools, associations, and faculties attempted to define a code of ethical conduct. The surgeons of Paris in 1370, the barbers of Alsace, the medical faculties of Leipzig, Cologne, and Vienna all laid down punishments, fines, or imprisonment for unethical behaviour.

#### FOUNDATION OF THE COLLEGE OF PHYSICIANS OF LONDON

In 1518 Sir Thomas Linacre founded the College of Physicians of London in order that its members by constant association, might improve the standard of their learning and the practice and morals of their profession. They were also required by law to be properly clothed and gowned on great occasions, at feasts of the College, at funerals, and at anatomical demonstrations, and they were enjoined to be circumspect in consultation and jealously to guard the reputation of a colleague.

The gradual severance of the medical profession from its connexion with the Church had a profound effect on the outlook of practitioners. One result of the separation was the institution of a standard of remuneration for services rendered. Doctors thus acquired a pecuniary interest in the continuance of the ills of humanity, which was opposed to their ideal of eliminating those ills, and a *via media* was provided by the establishment of codes of ethics which included scales of fees. It is interesting to note that from the earliest times the magnitude of fees has borne a definite relation to the social status of the patient.

#### PERCIVAL'S "CODE OF MEDICAL ETHICS"

At the beginning of the nineteenth century there appeared a publication which became a prominent landmark in the progress and evolution of medical ethics. This was Percival's *Code of Medical Ethics*. No later work has modified in any material degree the precepts and practice defined by Percival for the conduct of a physician. Thomas Percival was born in 1740, at Warrington, Lancs. His parents died when he was three years old, and he was reared under the guardianship of an elder sister. It is stated that he was handicapped physically by poor vision and frequent migraine. He was a scholar and a cultured and judicious thinker, and he conducted many philosophical and experimental investigations. Social problems of his time, including that of factory hygiene, interested him very much. He was an excellent practitioner, highly respected by the community for his personal charm and his high standard of conduct. His whole life was dominated by love of his fellow men.

Percival emphasized the need for combining tenderness with steadiness, and concession with authority in the management of hospital and charity cases. He deprecated the discussion of the case before the patient, particularly when the outlook was bad, and exhorted practitioners to observe secrecy with respect to those facts which they culled in the course of their professional work. He said that talent for a medical practitioner consisted of certain personal qualifications which could not be transferred from one person to another, and he stressed the importance of discrimination, presence of mind, resourcefulness, tact, and immediate decision in a crisis. In dealing with the physician in later life Percival says:

"The commencement of that period of senescence, when it becomes incumbent on a physician to decline the offices of his profession, is not easy to ascertain, and the decision on so nice a point must be left to the moral discretion of the individual. But in the ordinary course of nature the bodily and mental vigour must be expected to decay progressively, though perhaps slowly, after the meridian of life is past. As age advances, therefore, a physician should from time to time scrutinize impartially the state of his faculties that he may determine *bona fide* the precise degree in which he is qualified to execute the active and multifarious offices of his profession."



Percival was asked by the Trustees of the Manchester Infirmary to prepare and submit a scheme of ethical conduct relative to hospitals and medical charities. He did not show any desire to turn the attention of his readers from the spirit to the letter of the law, but his attempt to formulate rules of medical practice resulted in more emphasis being placed upon the letter of the law. Many wranglings as to the application of the rules and the appropriateness or otherwise of the professional penalties followed. There is, however, no recognition in Percival's *Code* of the conflict between idealism and materialism. The *Code* was presented to the surgeons and physicians of Manchester University in the spring of 1792, and its substance constitutes the laws by which that institution is now governed.

Bacon says in the preface to his *Elements of the Common Laws of England*:

"I hold every man a debtor to his profession, from the which as men of course do seek to receive countenance and profit, so ought they of duty to endeavour themselves by way of amends, to be a help and ornament thereunto. This is performed, in some degree, by the honest and liberal practice of a profession when men shall carry a respect not to descend into any course that is corrupt and unworthy thereof; and preserve themselves free from the abuses wherewith the same profession is noted to be infected. But much more is this performed, if a man be able to visit and strengthen the roots and foundation of the science itself, thereby not only gracing it in reputation and dignity, but also amplifying it in profession and substance."

Mr. Justice Brewer (United States Supreme Court, *Hawker v. New York*, 170 U.S. 192) also speaks of the importance of character.

"The physician is one whose relations to life and health are of the most intimate character. It is fitting not merely that he should possess a knowledge of diseases and their remedies, but also that he should be one who may safely be trusted to apply those remedies. Character is as important a qualification as knowledge, and if the legislature may properly require a definite course of instruction, or a certain examination as to learning, it may with equal propriety prescribe what evidence of good character shall be furnished. These propositions have been often affirmed."

Robert Louis Stevenson, in his *Classic Tribute to the Physician* aptly describes the essential components, the standards and

*The substance of this article has appeared in the British Medical Journal and is reprinted by kind permission of the editor.*

*(To be concluded)*

ideals of a worthy practitioner:

"There are men and classes of men that stand above the common herd—the soldier, the sailor, and the shepherd not infrequently; the artist rarely; rarer still, the clergyman; the physician almost as a rule—he is the flower (such as it is) of our civilization; and when that stage of man is done with, and only to be marvelled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has, such as is possible to those that practise an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Herculean cheerfulness and courage so that he brings air and cheer into the sickroom, and often enough, though not so often as he wishes, brings healing."

#### MEDICAL ETHICS AND CONFLICTING INTERESTS

An analysis of the principles of ethics and a reference to Percival's *Code* shows two distinct positions. There is the position of the idealist who stresses the interests of humanity as a whole, and there is the position of the materialist who emphasizes the material instincts of the individual. The one is communal, the other individual; the one idealistic, the other selfish and personal; the one looks out upon society, the other looks in upon the individual rendering the services to society; the one is extravert and the other introvert. At times these two interests clash, and a man finds himself the subject of divided loyalty, a loyalty towards the high ideals defined for his profession and a loyalty, say, towards himself and his family. The materialistic motive is here legitimate and essential, since a practitioner must provide for himself and his dependants the necessities of life. He must have regard for his own kith and kin, and yet he must also have regard for the patients who summon his help. Compromise is to be found in the principle of the utilitarian philosophers of "the greatest good for the greatest number." The *via media* must be followed, though it is often difficult to see the path. The traveller may take Percival's *Code* as his guiding star, and he will also obtain supplementary assistance from other lesser luminaries.

## THE INSULINS, THEIR USE IN THE TREATMENT OF DIABETES

by R. C. KING

APPROXIMATELY 75 per cent of adult patients are overweight when they first seek medical attention because of their diabetes and the majority of these can be controlled on diet alone. Insulin therapy is, however, needed at once in diabetic children and underweight adults, in pregnant women and patients having acute medical or surgical complications, and in patients with a short history of a sudden onset of diabetic symptoms. Insulin may subsequently be necessary in a proportion of the overweight diabetics, either because a reduction in weight fails to control the condition or more commonly because the patient is incapable of adhering to a rigorous reducing diet. At the present time there are seven different preparations of insulin available in this country. They are the short acting soluble insulin; the longer acting protein bound insulins, globin, protamine zinc and N.P.H.; and the new insulin zinc suspensions, semi-lente, lente and ultra-lente. The purpose of this article is to assess what part these various insulin preparations should play in the current management of diabetes mellitus.

#### Principles of Treatment

The aims of treatment are to provide relief from symptoms, to restore and maintain a high standard of nutrition with a normal body weight and to promote normal physical and mental development. To achieve these aims a normal physiological state must be maintained, with freedom from hyperglycaemia, glycosuria, hyperlipemia and hypercholesterolaemia. As a result the tendency to diabetic complications will be reduced to a minimum. At the same time care must be taken to ensure that complications of insulin therapy such as hypoglycaemia and local allergic reactions do not occur.

The type and dose of insulin needed depend on several variable factors. It is often said that one unit of insulin will "look after" a certain number of grammes of

carbohydrate. Although the insulin need does not conform to any such exact equivalent, both the carbohydrate and the total calorie content of the diet do influence the amount of insulin the patient may require. Similarly variations in physical exertion will affect the dose of insulin needed, an increase in exercise usually being associated with a reduction in the insulin dose. The severity of the diabetes and the sensitivity to insulin vary from patient to patient, a reduced sensitivity usually occurring with obesity and in the presence of acute infection. These four factors, diet, physical exertion, insulin sensitivity and severity of the condition, all affect the *dose* of insulin needed. The type of insulin which will best suit the patient depends very much on the patient's individual reaction to insulin. Hallas-Møller et al. (1952) have classified diabetics into three groups depending on their response to insulin. To illustrate these three groups he gave the same dose of N.P.H. insulin to three clinically similar patients. The first patient reacted quickly to the preparation but the effect was insufficient during the night (*A reaction*, shape of curve ~), the second patient reacted satisfactorily and the insulin supply was adequate for 24 hours (*B reaction*, shape of curve —), while the third reacted slowly and the insulin effect was insufficient for the daytime requirements (*C reaction*, shape of curve ~). Intermediary types classified as AB and BC also occur. The knowledge that a patient reacts quickly and for a short period (A), evenly and for a prolonged period (B), or slowly with initial hyperglycaemia (C), enables one to decide whether a slow acting, evenly acting or rapidly acting insulin preparation is required.

Having regard to the factors mentioned above, which affect the dose of insulin needed and the different types of response which influence the preparation which best suits the patient, it will be found possible to stabilize satisfactorily the majority of diabetics, usually with one injection of a long acting

preparation. There remains a small minority in whom the severity of the condition and the sensitivity to insulin appear to vary from day to day. These so called "brittle" diabetics are difficult to stabilize satisfactorily on any regime, and usually require two, three and sometimes four separate injections in the 24 hours.

I now wish to consider the various preparations of insulin available at the moment in this country and discuss the indications for their use.

#### Soluble Insulin

This is a solution of crystalline zinc insulin. Its maximum effect is exerted within two hours and its action wears off after a total of eight hours. Because of its short action very few patients can be controlled on one dose alone, but soluble insulin in divided doses remains one of the most effective means of controlling diabetes. As many patients prefer to have only one injection, it has been replaced to a large extent by one of the newer insulins, given as one injection, either alone or in combination. Some diabetics still prefer to be controlled on twice daily injections of soluble insulin, as the rigid timing of the evening meal is not then so important. The evening dose can be taken prior to the evening meal, whatever time that may be. There remains the small group of "brittle" diabetics for whom soluble insulin given, two, three or four times a day, either alone or in combination with a longer acting preparation, provides the only effective means of control. Soluble insulin is still indicated in the treatment of diabetic ketosis or coma and in the management of diabetes complicated by acute infection, surgical operation or pregnancy. It rarely gives rise to local allergic reactions.

#### Protamine Zinc Insulin

Protamine zinc insulin is soluble insulin combined with protamine to which a small quantity of zinc has been added. Its maximum effect is exerted from 6 to 18 hours after injection and the duration of action is 24-30 hours. It was hoped that with protamine zinc insulin it would be possible to control the majority of diabetics with one

morning injection. In fact only a very small number of mild diabetics can be so controlled, hyperglycemia tending to occur during the early part of the day in more severely affected patients. Increasing the dose to control this initially high blood sugar frequently results in hypoglycaemia during the night. The addition of soluble insulin to the protamine zinc insulin improves its sphere of usefulness, but if the two are mixed before or at injection, the excess of protamine in the protamine zinc insulin converts some of the soluble insulin to protamine zinc insulin and mixtures having a variable effect are produced. If the two insulins are given by separate injection then variable responses are avoided and a large number of moderately severe diabetes can be controlled with two morning injections. Still more can be controlled if a small injection of soluble insulin is given in addition in the evening. With the advent of the newer insulins such complicated regimes can be avoided and it seems likely that protamine zinc insulin will in time be completely superseded by these newer preparations. As it contains combined protein, local allergic reactions are particularly liable to occur.

#### Globin Insulin

This is a combination of soluble insulin with the protein globin derived from haemoglobin. Its maximum effect is exerted within 8 hours and its duration of action is 16-22 hours. When first introduced it was considered to be an advance on protamine zinc insulin in view of its more rapid action, but it often failed to prevent early morning hyperglycemia. Rather more patients were, however, controlled with one injection of globin than with one injection of protamine zinc insulin and many "brittle" diabetics were satisfactorily controlled on twice daily injections of globin. Results when globin insulin was mixed with soluble were unpredictable and, as with protamine zinc insulin, the combined protein often gave rise to allergic reactions. It seems that this insulin also will be superseded by one of the newer preparations.

#### N.P.H.

N.P.H. or "Isophane" insulin is a protamine zinc combination with no excess of protamine. Its duration of action resembles

that of globin but it has the great advantage that it can be mixed with soluble insulin without converting it to protamine zinc insulin. It is the most popular insulin in use at the moment in the United States of America where it is claimed that given alone or with soluble once or twice a day it is capable of controlling even the most difficult diabetic. Its use in this country is restricted to those difficult diabetics who cannot be satisfactorily controlled on the newer insulin zinc suspension or the older combinations. Given with soluble insulin twice a day it provides a greater degree of 12 hour flexibility than any of the other combinations, the maximum effect towards the beginning or the end of the 12 hour period being easily obtained by varying the proportion of soluble and N.P.H. in the mixture. It is a protein bound insulin and as such may give rise to allergic reactions.

It seems unlikely that N.P.H. insulin will be superseded by the new insulin zinc suspension in view of its use in the treatment of these "brittle" diabetics.

#### The Insulin Zinc Suspensions

Hallas-Møller (1954) has given an excellent account of the background of the new insulins. He discovered that the addition of a small quantity of zinc (0.5-2 mgs./1,000 units) to soluble insulin buffered with an acetate buffer at a pH. of 7.3 produced an insoluble zinc-insulin compound, which separated either in the amorphous or the crystalline state. He found that the amorphous fraction (called semilente) had an action slightly more prolonged than soluble, while the crystalline fraction (called ultra-lente) had a duration of action longer than protamine zinc insulin. Between pH. 5 and 6 the amorphous fraction was slowly converted to crystalline but between pH. 6 and 8 the two fractions could be mixed without risk of conversion of one to the other. Below pH. 4.5 both were dissolved to form soluble insulin. Having regard to the types of patient response to insulin (A, B and C) Hallas-Møller felt that a mixture of amorphous and crystalline insulin zinc suspension in the proportions 3:7 should be capable of controlling the majority of diabetics with one injection only. This preparation he called lente. Soluble insulin cannot be mixed with the insulin zinc suspensions as it is buffered at a pH. of

3-3.5. If the two are mixed pH. may fall below 4.5 in which case the insulin zinc suspension will go into solution and become soluble insulin, or the resultant pH. may lie between 5 and 6 in which case the soluble insulin, together with any amorphous insulin zinc suspension present will be deposited in crystalline (long acting) form. Insulin is normally derived from ox or pig pancreas. Hallas-Møller found that while crystalline ultra lente derived from the ox pancreas always had a prolonged action when tested on rabbits, that derived from the pig pancreas usually had a short action. The same effect is not normally observed in humans, but occasionally patients may react quickly to ultra-lente derived from the pig pancreas. For this reason the amorphous (semi-lente) insulin is derived from the pig pancreas and the crystalline (ultra-lente) insulin from the pancreas of the ox. Crystalline insulin zinc suspension, although long acting, has no combined protein and is not therefore so liable to produce local allergic reactions as are the protein bound insulins.

#### Clinical Results with the Insulin Zinc Suspensions

Four years of clinical experience have proved that the insulin zinc suspensions are indeed a definite improvement over previous methods of insulin treatment (Nabarro and Stowers 1953, 1955; Venning, 1954). In different centres it has proved possible to control 90-96 per cent of diabetics on a single injection. Of patients so controlled approximately 80 per cent are satisfactory on one injection of lente, while the remainder need either semi- or ultra-lente added. Most of the patients previously on protamine zinc insulin alone, and approximately one third of the patients on soluble twice daily or protamine zinc insulin and soluble in the morning, are better controlled on one injection of insulin zinc suspension. An increase in total dose is usually required on transferring to insulin zinc suspension. Patients on soluble b.d., globin, or soluble and protamine zinc insulin as a mixture need an average of a 10 per cent increase, while patients on protamine zinc insulin alone need at least 20 per cent, and on occasions as much as 100 per cent, increase on the previous dose. The total dose needed is usually between 30 and 70 units per day, though amounts exceeding 100 units per day

have been successfully given, one patient receiving 160 units per day in one injection. New diabetics and children are similarly better controlled on the new suspensions, although if severe they respond less quickly than to soluble insulin in the initial stages. Soluble insulin may on occasions be temporarily necessary in the management of such cases. Hypoglycaemic reactions still occur with the new suspensions and are most frequent in the morning and afternoon. They tend to be of slow onset and the patient therefore receives adequate warning. Local allergic reactions also occur but are less frequent. If acute infection occurs, patients controlled on insulin zinc suspensions tend to lose that control more easily than those controlled on soluble insulin. Should thirst and polyuria develop during the course of such an infection it is recommended that the insulin dose be increased at once by 20 per cent and more if necessary. The insulin zinc suspensions do little to help the "brittle" diabetics. These cannot be controlled by a single dose technique, and for these patients some multiple dose regime involving the use of soluble and N.P.H. insulin is necessary.

Patients satisfactorily controlled on one of the older insulins or insulin combinations should not necessarily be switched to the insulin zinc suspensions without adequate reason. The main indications for changing are: poor control on present insulin, the dislike of multiple injections, and the occurrence of frequent local allergic reactions.

#### Summary and Conclusion

This is not a comprehensive article on the treatment of diabetes mellitus and I have not discussed details of dietary requirements or methods of stabilizing and controlling new or old patients with the various insulin preparations.

Soluble insulin is still one of the most effective preparations for the control of most diabetics, but, as multiple injections are usually required, it will be largely replaced by the insulin zinc suspensions. Soluble insulin is, however, invaluable, for the control of difficult diabetics: it is always needed in the treatment of diabetic ketosis or coma and for the management of diabetes complicated by acute infection, surgical operation, or pregnancy. Protamine zinc and globin insulin were a definite improvement on soluble insulin when first intro-

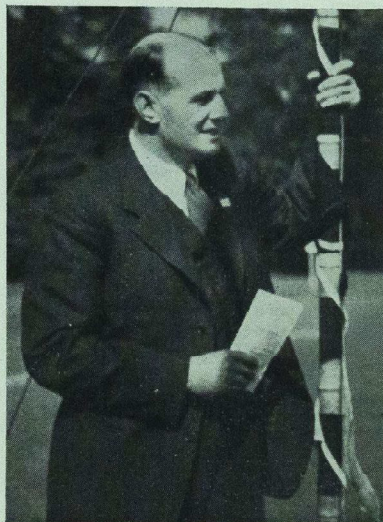
duced, but they have no advantages and several disadvantages when compared with the insulin zinc suspensions. It seems likely that they will be abandoned in the future in favour of these newer preparations. Such is not the case with N.P.H. insulin, as, combined with soluble in two daily injections, it provides one of the most effective means of controlling difficult diabetics. The large majority of patients can be controlled on one daily injection of various combinations of the insulin zinc suspensions, and these insulins are at the moment undoubtedly the most effective for the day to day management of diabetes mellitus.

#### References

- Hallas-Moller, K., et al, (1952) *J. Amer. Med. Soc.*, 150, 1667.  
 Hallas-Moller, K., (1954) *Lancet*, 2, 1029.  
 Nabarro, J. D. N., Stowers, J. M., (1953), *Brit. med. J.*, 2, 1027.  
 Venning, G. R., (1954), *Lancet*, 1, 480.  
 Stowers, J. M., Nabarro, J. D. N. (1955), *Brit. med. J.*, 1, 68.

\* \* \*

#### CANDID CAMERA



*If only I'd been a Barber-Surgeon.*

## LETTERS TO THE EDITOR

### LORD HORDER

Sir,—I can remember two little incidents which occurred when I was clerking for the then Sir Thomas Horder, way back in 1915.

The first happened when Sir Thomas asked a member of the firm to count a pulse, but only for a half-minute, and then double the pulse-rate for comparison with the normal. The nervous clerk came out with an uneven number much to the amusement of Horder who made many quips at the expense of the student, who could see no cause for merriment.

The second concerned myself. Horder handed over to me a conical glass with its usual fluid and asked me to comment on the contents. I, equally nervous, became muddled over *casts* and *threads*, and holding the specimen up to the light commented on the presence of the former.

Sir Thomas, always ready to catch a little humour from routine, hailed my remarks with pleasure, saying, "Hear, gentlemen. We have a man with a microscopic eye; we must make use of his powers."

I enjoyed the time spent under his tutorage, but was always a trifle in awe of the great man.

Yours faithfully,

LLEWELLYN PRIDHAM.

### A QUESTION OF DIAGNOSIS

Sir,—As retiring President of the Abernethian Society I should like to discuss briefly three of the points raised in your article on the Society in the July issue.

First—Nepotism is defined in the O.D. as "the practice of favouring nephews (or other relations) in the conferring of offices." As it happens, none of my nephews is a member of the student body here: and only two of the members of my committee had attended the older universities—one myself an aeon past and in a non-medical capacity. The fact that five Oxonians figure in the present committee is an interesting coincidence, but no more. Both the list for nominations and the election date were prominently displayed a fortnight before the event took place, and presumably the officers returned unopposed met with the satisfaction of the electorate prior to polling day.

Second—far from our inclusion of a Charterhouse representative being pathognomonic of the widening rift between hospital and preclinical, I would submit that we are one of the few bodies who are contributing something to a narrowing of that rift by constitutionally electing a Charterhouse member: and also by our assiduous advertising at Charterhouse, and by holding the majority of our meetings at 5.30 p.m. at Charterhouse.

Third—it seems clear from your statement "that the recent history of the Society shows it to have the signs of being mortally sick," that you and I

have learned our physical signs in different schools. Perusal of the Attendance and Minute books for the last two or three years would, I think, demonstrate the specious nature of the diagnostic acumen displayed in your observations.

I am, Sir,

Yours faithfully,

NINA COLTART.

The Abernethian Room.

Our Columnist writes:

Miss Coltart objects to the usage of the word nepotism. Surely the metaphorical extension was justified; for have not the retiring President and the new committee the same Alma Mater?

The super-abundance of Oxonians is, as I anticipated, described as "an interesting coincidence, but no more." May I compound the coincidence by pointing out that the two Presidents preceding Miss Coltart were also Oxonians. To the less credulous the committee would appear a closed shop; the qualification for admittance being a B.A.(Oxon.).

It was unwise for this selective refutation of my criticism to include a reference to the Charterhouse representative. For the fact is—at the time of writing—there is no pre-clinical representative on the committee, democratically elected or otherwise. By the time one is found the program for the session will have already been arranged.

The last paragraph, which I find difficult to reconcile with the paucity of non-official committee nominations, so incensed the Editor that he is resolved to conduct a deeper inquiry into the state of the Society. Since he and I have much in common I will not presume to anticipate his revelations.

### POOR ATTENDANCES

Sir,—Your columnist who, in his review of the shortcomings of the Abernethian Society in the July number of the *Journal*, quoted the Natural History Society and Physiological Society as being the results of needs *not* fulfilled by their more august sister is correct up to a point only.

So far as I am aware none of the College Societies are getting the support commensurate with the size of our student population and nursing staff (to whom the activities of the Abernethian Society and Natural History Society have always been open).

It is difficult to believe for instance that a meeting will have a different attendance if organised by the Abernethian, Physiological or Natural History. The fact remains that meetings of none of the societies are particularly well attended— notable exceptions being the Abernethian Society meetings where the speakers were a crime reporter and a well known sexologist (who with excellent discretion *did not* talk on sex).

Writing on behalf of the naturalists I find it remarkable that a profession which laid the

foundation of the science of Biology, and whose contributions to the field of nature study have been so extensive, both now and in the past, should have so few of its members in this Hospital interested in subjects having such a close affiliation to its own. It is hardly possible to open a copy of the National Formulary at a page which does not include some drug derived from a plant. In the Accident Box at this time of year hardly a day passes without a patient saying, *It's a bite, doctor, Of little importance? Possibly, but there are about sixty different species of biting insect in these islands, each one a fund of interest and unsolved problems for the amateur naturalist. It was a doctor who wrote:*

*I cannot see what flowers are at my feet,  
Nor what soft incense hangs upon the boughs,  
But, in embalmed darkness, guess each sweet  
Wherewith the seasonable month endows  
The grass, the thicket, and the fruit tree wild;  
White hawthorn, and the pastoral eglantine;  
Fast fading violets cover'd up in leaves;  
And mid-May's eldest child,  
The coming musk-rose, full of dewy wine,  
The murmurous haunt of flies on summer eves.*

Yours sincerely,  
E. R. NYE.

The Abernethian Room.

#### "MICHAEL SCOTT"

Sir,—It is with some distress that I have today read Mr. J. D. Parker's article *Why I Baptised Michael Scott*, in the July edition of the *Hospital Journal*.

Mr. Parker is evidently not aware of the responsibility taken in this matter by any member of the nursing staff in charge of sick children.

Details of religion and baptism are taken in the case of all ill babies or children admitted to hospital and the baptism of those who appear unlikely to survive their illness is one of the first concerns.

We are fortunate here in having our own resident hospitaler, who performs the baptism wherever possible. In cases of extreme urgency, it would be, and is, performed by the day or night sister in charge at the time.

Had Mr. Parker made any inquiries in the ward, he would have found that Michael Scott was in fact baptised by the Rev. R. B. Ney in the ward on November 29, 1954, one day after his birth, and admission to hospital, and in the presence of his father, grandfather, and myself.

I must also protest against the alleged disinterest of his parents. On arriving in the ward with his newly-born son, one of the father's first requests was that I should arrange for the child's baptism.

I feel that Mr. Parker and the readers of the *Journal* ought to be more accurately informed in this matter.

Yours faithfully,  
J. M. JOHNSON.  
(Sister Lucas).

Lucas Ward.

#### BAPTISM

Sir,—The *Journal* gains enormously from every article on an unusual subject or from a vigorous point of view. In spite of this I must criticize the article, in your July issue, *Why I baptised Michael Scott*.

There are several things in it with which most Christians will agree. There is authority for them both in Scripture and in the age-long teaching of the Christian Church. But the Christian Faith is harmfully represented by the statement that *Baptism is necessary for salvation rather like the 1st M.B. is necessary for a medical qualification*. This can only mean in its context (unless an unusual weight is attached to the word "rather") that unless a man receives the Sacrament of Baptism he is beyond salvation. The author of this statement may know the facts but he has hidden them from his readers. God has chosen to work among men through the Sacraments but it is a mistake to think that he cannot and does not save men without them. To refuse baptism may be to put oneself outside the Church with all its consequences, but even that does not make it true that to be without baptism is to be beyond the reach of God's love. Our Lord accepted the unbaptised into the Kingdom of Heaven and forgave them their sins, and St. Augustine observed that many who seem to be within the Church are without and many who seem to be without are within (*De Bapt. V, 38*). A more reflective view than that of your contributor sees in the Christian practice of baptising infants a clear statement that the love of God seeks all men without distinction, child or grown-up, black or white, sane or mentally deficient, baptised or unbaptised.

Like popular science, popular theology is a blunt and brittle thing.

Yours sincerely,  
R. E. NOTTIDGE.

The Abernethian Room.

#### OVERCROWDING IN LIMBO

Sir,—The very interesting statement of the doctrine of Limbo (*Why I baptised Michael Scott*—This *Journal*, July, p.216) suggests several questions. Does an unbaptised child cease to be eligible, at death, for Limbo at any age at which he commits his first sin? What is the difference in regard to Limbo between, say, an infant dying unbaptised at the present day, and a virtuous adult who died before the institution of Baptism? Are all the unbaptised debarred from the Resurrection of the Body?

What is the Biblical foundation for the doctrine of this Limbo? This place, where souls live for ever in "perfect natural happiness," must be entirely different from the one often given the same name, to which Jesus descended to preach on the Saturday before Easter (*1. Peter 3, 18-20*), a journey established by the Apostles' Creed, although Jesus never spoke of it himself. Some persons had spent whole ages there under distressing conditions, the

duration of their sufferings thus depending, not upon their merits, but upon the date of their death. Artists, from Giotto and the Yugoslav fresco painters of the 13th century up to the present day, have given us many horrible pictures of this scene, while S. Bonaventura, Doctor Seraphicus, in his *Mirror of the Blessed Lyf of Jesu Christ* tells us, more agreeably, that Jesus returned with a multitude of angels just before dawn, re-entered his own corpse, and then emerged from the Virgin's Womb as easily as he had escaped from the Virgin's Womb (an illuminating, if not, to us, very elegant, analogy). The few verses of the Epistle referred to above include a most remarkable correlation of Noah's Flood with Baptism which is well worth the attention of students of the subject of Limbo. The undefined usage of the words Limbo, Hell, and Hades causes endless confusion.

The older theologians of course did not tell us at what stage in the evolution of man Limbo was instituted, but we may well ask that question today. One wonders what is the total of its vast and ever-growing population, drawn from all the non-Christian peoples of the earth, past and present.

E. L. KENNAWAY.

Chelsea.

MR. PARKER writes.—

I much enjoyed reading this letter and I would like to comment on some of the points raised:

1.—There is no direct Biblical reference to the authenticity of Limbo but its conception is arrived at by a process of elimination, since the punishment of an immortal but innocent soul in Hell is inconsistent with belief in a God of infinite mercy.

The "Limbus Infantum" is sometimes distinguished from the Limbo of the faithful or "Limbus Patrum" where the just who died before the coming of Christ were detained. In Luke's second parable of warning where . . . *the beggar died and was carried away by angels into Abraham's bosom (Luke XVI 22)* the last phrase has been considered a reference to Limbo by many theologians, denoting a place where the just remained in loving intercourse with Abraham the father of the faithful. Others maintain that when Christ spoke to the good thief on the cross: "*Today thou shalt be with me in Paradise (Luke XXIII 43)*". He was referring to Limbo, since he was not to ascend into Heaven until forty days after the Resurrection.

We regret that owing to the increased time taken in seeing the *Journal* through the Press it was not possible to publish these letters in the August number.

#### SO TO SPEAK . . .

##### Auroscopes at the ready

Excited nurse bursting into Path. Room: "The round this afternoon is going to be on sub-arachnoid haemorrhoids."

2.—There is no question of an unbaptised child becoming "ineligible" for Limbo simply by committing sin, though as a result of the sin he might become eligible for a worse fate, that is, if the sin were sufficiently grave and he were to die unrepentant.

3.—It has long been held that Baptism is not such a closed shop as it might appear and that in fact a *desire* for Baptism may suffice even if the sacrament has not been physically performed. This desire may be implicit in the sense that a savage may, by following the dictates of his conscience, reap the fruits of the sacrament knowing nothing of the Christian faith or of Baptism.

St. Cyprian says of the early Christian martyrs that they died *with the most glorious and greatest Baptism of blood* even if they had never been baptised with water.

#### REWARDS IN PRACTICE

Sir.—I see in the June number of the *Journal* that Dr. Bergel pays one visit to his patients to 43 attendances.

My own record for the past nine months is 3.29 visits to 2 attendances.

Thus do practices vary, though the payment is the same!

Yours faithfully,  
H. K. V. SOLTAU.

19, The Avenue,  
Clifton, Bristol.

#### EXETER

Sir,—It was extremely kind of Mr. J. L. Thornton to review so appreciatively the catalogue of the Exhibition "Medical Art and History in Exeter." Exeter, your reviewer says, *was a prominent medical centre at one time*. I hope the readers of the *Journal* will not think that it is anything but a prominent centre at the present time. It just happens that some other centres have advanced a little since Exeter's early days!

Yours faithfully,  
NORMAN CAPENER.

12, Barnfield Hill, Exeter.

## THINGS AIN'T WHAT THEY USED TO BE

### AN INTRODUCTION TO JAZZ

by DULCIE V. COLEMAN

*There are two kinds of fools: those who say, "This is old and therefore good," and others who say, "This is new and therefore better."*

Dean Inge.

IT IS to be hoped that the Phillistines of College Hall will not be unduly alarmed by the addition of four new jazz records to the Burroughs gramophone library. As far as I see it, the only undesirable event arising from this innovation is that a review of these recordings has to be submitted to the *Journal* and it is my task to write it.

When I was twelve, my uncle Johnny took me to the Music Hall in the Edgware Road in order that I might hear Miss Sophie Tucker (otherwise known as *the last of the red hot mamas*) sing *One of these Days*. As it happened, however, Johnny spent the evening with his cronies in the bar and returned to his seat just in time for the "Evening Nudes" and the National Anthem; and I spent the interval trying to work out the jokes.

I next saw Miss Tucker during regatta week at B—mouth. She was one of the judges at the annual beauty competition, which is a grand display of local talent (mostly of girls with whom I was at school). She sang a little song called *Abie, Abie, Abie my boy, what are we waiting for now?* which rather shocked the mayor and corporation and caused quite a stir among the youth of that highly respectable borough.

Several years ago her autobiography\* was published in which there is a perfectly excellent bar-to-bar account of her rise to fame through the saloons and nightclubs of New York and Chicago. She writes happily about the blues singers of the 1920's—Bessie Smith and Ma Rainey; and of the jazz singers of the 1930's—Ella Fitzgerald and Al Jolson; and talks sadly of the crooners and the commercial exploitation which followed. I feel sure that Stan Freberg is just the sort of crooner that Miss Tucker would lament—and so do I.

Now my uncle used to be a soft shoe dancer quite as good as Fred Astaire until he was involved in a divorce suit and was obliged to migrate to Canada. He returned

to England at the age of eighty and while doing the Charlston at his wedding, slipped on the floor and fractured his femur, which rather upset the bride, and brought his career as a dancer to a very sudden end. Johnny was an exponent of the New Orleans style of jazz and, when in a more expansive mood, he would talk of the early bands and the "boys" in Chicago, and of the differences between traditional and modern jazz. In both of these forms of jazz a melody is chosen and variations and improvisations upon it are played quite spontaneously; for jazz musicians have a contempt for the written note. In classical jazz (of which the recording *Here come the Lions*<sup>2</sup> is a perfectly clear example; and Woody Herman's *Wild Apple Honey*<sup>3</sup> a less transparent one) these variations are confined to the treble section of the band, the bass being concerned only with the maintenance of the rhythm. In modern jazz, both treble and bass indulge in improvisations and the rhythm is almost completely neglected.

I once went to a jazz club with a gangly youth who insisted on saying "Hep it sister, let's tear up the carpet." whenever he wished to dance, and "Dig me duchess, the joint's a hoppin'," when the thought there was going to be a police raid. He admired, I remember, the jazz pianists Pine Top Smith, Fats Waller, and Duke Ellington; and pointed out that Contant Lambert has claimed Ellington to be *the first jazz composer of distinction*. However that may be, a number of critics agree that his music lacks variation; and truly, even after listening to the new, very pleasant piano recordings<sup>4</sup> a number of times. I am still unable to distinguish between *Things ain't what they used to be* and *Who Knows*.

In order that any newcomer to jazz should not be deterred from further listening by what he has heard on the first occasion, I suggest that he listens to these four new records in the following order: First, Duke

Ellington; then Jazz Studio Two; Woody Herman third (with the volume well controlled) and Stan Freberg—not at all.

\* *One of these Days*.—Sophie Tucker's autobiography.

<sup>1</sup> *Stan Freberg*: Any Requests, The World is Waiting for the Sunrise, I've got you under my skin, John and Marsha, Try.

Capitol EAP 1-496. 45 r.p.m. Extended Play.

<sup>2</sup> *Jazz Studio Two*: Vol. 1. Laura, Here come the Lions

Brunswick OE 9031. 45 r.p.m. Extended Play.

<sup>3</sup> *The Woody Herman Band*: Part I. Wild Apple Honey, Boo Hoo, Hitting the Bottle.

Capitol EAP 1-560. 45 r.p.m. Extended Play.

<sup>4</sup> *The Duke plays Ellington*: Part I. Things Ain't what they used to be, Who Knows, Reflections in D. In a Sentimental Mood.

Capitol EAP 1-447. 45 r.p.m. Extended Play.

\* \* \*

### MOZART

Concerto No. 3 in G major for Violin and Orchestra (K.216)

Concerto No. 7 in E flat major for Violin and Orchestra (K.268)

Christian Ferras

with the Stuttgart Chamber Orchestra conducted by Karl Münchinger. Decca L.P. 12in. IXT 5044.

After listening to these two Concertos, there is no doubt about Mr. Ferras' capabilities; he has good technique and accurate intonation.

I liked the First Movement of No. 3, Mr. Münchinger obtains a beautifully controlled lilt from the orchestra; but, unfortunately, this is not recaptured in the last movement which is rather lifeless. The slow movements of both Concertos are played with just that serene and reflective manner which is required. The First movement of No. 7 is brilliantly played, the double stoppings appearing effortless; unfortunately the last movement of this Concerto is disappointing, the rhythmic point has gone, the sparkle is lost. I think a slightly quicker tempo would have been better.

### DELIUS

Summer Night on the River

A Song of Summer.

The London Symphony Orchestra conducted by

Anthony Collins. Decca Medium Play, 10in.

LW 5173.

In these two short orchestral pieces Delius has captured the sleepy atmosphere of summer; they give that feeling of rest and peace. Their appeal is not instantaneous, but on repeated listening they seem to take shape; the chromatic harmonies of *A Summer Night on the River* become the shifting shadows of the night, and in *A Song of Summer* one can almost hear the rippling of the waves.

Having familiarised myself with these two works, I found them most refreshing and enjoyable.

The performance and recording are very good.



## The Edible World

When Mr. Chaplin peppers a daisy before consuming it, or Mr. (Harpo) Marx chews up a telephone with relish, I blush for my own lack of enterprise. Probably most of my environment is eatable, if I would only get my teeth into it. Perhaps if I had taken more pains with my chemistry I might at this moment be biting bits off the roof like Hansel and Gretel, or crunching coal as puppies and babies do. This idea is not as far-fetched as scoffers may suppose, for coal, that universal provider which already gives us heat, light and raiment, now looks like serving us with edible fats as well; and it can only be a matter of time before the chemists offer us bread from a stone.

Minerals apart, there are many members of the animal and vegetable kingdoms which never reach British dining tables, though they would in fact repay the attention of a thoughtful cook. I am not speaking merely of the frogs and snails . . .

*What a pity. We have not got the space to publish the rest of this fascinating essay, which appeared originally in The Times. However, by way of compensation we have reprinted a number of the now famous Podalirius pieces in a special booklet entitled "The Pravings of Podalirius." Would you like us to send you a copy?*

## VITAMINS LIMITED

DEPT. (G.5)

Upper Mall, London, W.6

Makers of

BEMAX VITAVEL SYRUP VITASPRIN

RECOVITE BEFORTISS PREGNAVITE COMPLEVITE

FERTILOL CREAM CHOLINVEL ETC.

Save time on urine tests with ...

# CLINITEST and ACETEST

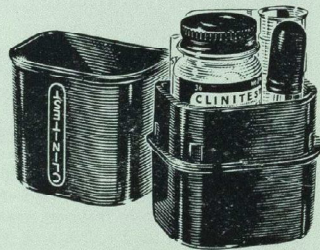
Reagent Tablets  
for the detection of Glycosuria

Reagent Tablets  
for the detection of Ketonuria

**Both tests performed simultaneously in 1 minute!**

Specialists, General Practitioners, Clinics and Hospitals in all parts of the country have used and prescribed 'Clinitest' Reagent Tablets since 1947. Many valuable hours have been saved. Now after intensive research work and clinical trials the makers of 'Clinitest' Reagent Tablets have produced 'Acetest' Reagent Tablets for the detection of Ketonuria. With 'Clinitest' and 'Acetest' Reagent Tablets, reliable routine sugar and

acetone tests can be carried out *simultaneously* in one minute!



## CLINITEST

No external heating · No measuring of reagents  
Approved by the Medical Advisory Committee of the Diabetic Association. The 'Clinitest' set, refills and accessories are all available under the N.H.S. on Form E.C.10. (Basic Drug Tariff Prices: Set 6/8 complete. Refill bottles of 36 tablets 2/4.)

## CLINITEST HOSPITAL EQUIPMENT

An invaluable time-saver in wards and clinics. Write for details and hospital prices.



### The advantages of

## ACETEST

Reagent Tablets

Quick and reliable, a single tablet provides all the reagents to perform a test. Low cost permits this tablet test to be used as a screening procedure or as a routine for diabetic patients. No danger of false positives with normal urine. No caustic reagents.

#### TO PERFORM A TEST:

- 1 Put 1 drop of urine on tablet.
- 2 Take reading at 30 seconds. Compare tablet to colour chart provided.
- 3 Record results as negative, trace, moderate or strongly positive.

Supplied in bottles of 100 tablets with colour scale.

'Acetest' Reagent Tablets (diagnostic nitroprusside tabs.) are also available under the N.H.S. on Form E.C.10. Basic Drug Tariff price 3/10 per bottle of 100 tablets (with colour scale)

#### REFERENCES

- Nash J., Lister J., Vobes D. H. (1954) 'Clinical Tests for Ketonuria', *Lancet* April 1/11, pp. 801/804
- Nabarro J.D.N. (1954) *Medicine Illustrated*, May, p. 289
- Varley H., (1954) 'Practical Clinical Biochemistry', *Heinemann*, p.74
- Beckett A.G., Galbraith H.J.B., Pugh D.I. (1954) 'Clinical Tests for Ketonuria', *Lancet*, July 10th, p.95



**AMES COMPANY (LONDON) LTD.**

Sole Distributors for the United Kingdom and Eire

**DON S. MOMAND LTD.**

58 ALBANY STREET  
LONDON, NW1



## EXAMINATION RESULTS

### UNIVERSITY OF OXFORD

2nd B.M. Examination  
Trinity Term 1955

*General Pathology and Bacteriology*  
Creightmore, J. Q. O'Sullivan, D.

#### Medicine

Fairbairn, D. Mitchell, M. A.  
Pearson, J. M. H. Viner, J.

#### Surgery

Fairbairn, D. Keene, M.  
Mitchell, M. A. Pearson, J. M. H.  
Viner, J.

#### Midwifery

Fairbairn, D. Holden, H. M.  
Mitchell, M. A. Pearson, J. M. H.  
Viner, J.

The following completed the examination for the Degree B.M., B.Ch:—

Fairbairn, D. Mitchell, M. A.  
Pearson, J. M. H. Viner, J.  
Keene, M. Holden, H. M.

### UNIVERSITY OF LONDON

Examination for the Academic Postgraduate  
Diploma in Public Health  
June, 1955

Krister, S. J.

## JOHN ABERNETHY

by John L. Thornton

First published in 1953, this biography of the virtual founder of the Medical College contains eight plates, five figures, a chronological list of Abernethy's writings and a comprehensive bibliography.

Published at 25s., copies are available to readers of the *Journal* for 5s. 6d. post free) upon application to:—

The Librarian, Medical College Library, St. Bartholomew's Hospital, E.C.1.

### UNIVERSITY OF CAMBRIDGE

M.D. Examination

Fison, T. N.

Final M.B. Examination  
Easter Term 1955

#### Pathology and Pharmacology

Beard, R. W. Dawrant, A. G.  
Rycroft, P. V. Smith, G. W. T.  
Tait, J. A.

#### Principles and Practice of Physic

Beard, R. W. Buckle, R. M.  
Church, J. C. T. Earnshaw, G. J.  
Maclay, W. S. S. Miller, A. B.  
Nottidge, R. E. Phillips, B. S.  
Rycroft, P. V. Struthers, J. L.  
Tait, J. A.

#### Principles and Practice of Surgery

Beard, R. W. Church, J. C. T.  
Dinkel, P. A. Earnshaw, G. J.  
Jewell, G. J. Maclay, W. S. S.  
Miller, A. B. Norbury, K. E. A.  
Rycroft, P. V. Struthers, J. L.

#### Midwifery and Gynaecology

Buckle, R. M. Church, J. C. T.  
Dinkel, P. A. Earnshaw, G. J.  
Jewell, G. J. Maclay, W. S. S.  
Miller, A. B. Norbury, K. E. A.  
Phillips, B. S. Rycroft, P. V.  
Struthers, J. L. Tait, J. A.

The following completed the examination for the Degree M.B., B.Chir:—

Church, J. C. T. Maclay, W. S. S.  
Miller, A. B. Rycroft, P. V.  
Smith, G. W. T. Struthers, J. L.  
Dinkel, P. A. Earnshaw, G. J.

\* \* \*

### Sports Fixtures at Chislehurst

#### RUGBY

Sat., Oct. 8.—1st XV v. Woodford.  
Wed., „ 12.—A XV v. R.N.C. Greenwich.  
Sat., „ 15.—A XV v. R.M.A. Sandhurst.  
Sat., „ 22.—A XV v. Old Whitgiftians.

## SPORTS NEWS

## ROWING

**Putney Town Regatta: Senior VIII's.**

Westminster Bank was the only other crew which had entered for the senior event. Bart's were on the outside of a long bend over which the race was rowed, with unfortunately no compensatory advantage of the tide. The Bank crew took an early lead, but Bart's settled down well in the rough water to row past and win by one length. This is the first open Senior VIII's event the Hospital has ever won.

Crew as at Henley with the exception of the Cox who was A. R. Geach.

**Thames Ditton Regatta: Junior VIII's.**

**v. Haberdashers' School.** Lost by 2 lengths.  
CREW: Bow, R. White; 2, M. Burfoot; 3, P. Fenn; 4, J. Chalstrey; 5, G. Hall; 6, M. Besser; 7, A. Ellison; Stroke, R. Marshall; Cox, D. Sadlik.

## MARLOW REGATTA

**Marlow VIII's (Thames Cup)**

**1st Heat v. 1st and 3rd Trinity "B," and St. Thomas's Hospital.** The 1st and 3rd crew quickly took the lead and left the Hospital crews, rivals of old, battling for second place. At the end of a minute Bart's were slightly ahead; they then quickly drew away from St. Thomas's to come within half a length of 1st and 3rd. This proved a very keen race, for it was only near the finish that Bart's were able to draw slightly ahead to win by six feet, in a fast time.

**Semi-final v. Molesey, and Crowland.** It was all the more disappointing after their earlier performance that Bart's should have failed to settle down into an effective rhythm in this row. Molesey went ahead, but for just a while it seemed that Bart's was going to repeat their feat of rowing into the lead. But it was not to be; the row became what can best be called a scramble, and Molesey finished  $1\frac{1}{2}$  lengths up.

**Town Cup IV's.**

**1st Heat v. Putney Town.** Bart's never looked comfortable in this row, and several times their precarious lead was all but lost by a succession of miniature shipwrecks. The Hospital crew finally crossed the line half a length ahead.

**2nd Heat v. Kettering.** This was a much better row, despite the fact that this was the fourth time in the afternoon the crew had rowed over the course. Kettering went steadily into the lead to win by two lengths.

Crews as at Henley.

## HENLEY ROYAL REGATTA

After Marlow, the crew moved to Henley for the final stage of training. The VIII was coached by Dr. A. G. S. Bailey; and the IV by Dr. J. Blow, who also coxed the VIII—a most welcome return to Boat Club activities. The crews made good progress, and were not required to row in preliminary heats. In particular the VIII had a good full course on the Saturday; it was a pity they did not maintain this form the next week.

**v. 1st and 3rd Trinity "B."** This was the crew that Bart's had just beaten at Marlow, and expectations of another keen race were not disappointed. Bart's led off the start, but again could not hold Trinity over the first minute and the latter went ahead by half a length. From then on, it began to look very like Marlow, with Bart's slowly narrowing the lead. But they could never quite get on terms, and towards the mile post 1st and 3rd were able to increase their lead again and they won by one length in 7 minutes 47 secs.; a fast time for the conditions then prevailing.

CREW: Bow, B. P. Harrold (U.C.S.); 2, D. A. Chamberlain (Ratcliffe and Queens'); 3, T. P. Ormerod (Forrest); 4, T. W. Bolton (Kingswood); 5, C. C. H. Dale (Oundle); 6, J. F. Pigott (Westminster and L.R.C.); 7, C. H. Hudson (Radley and Queens'); Stroke, G. D. Stainsby (Oundle and Downing); Cox, R. J. Blow (St. Albans and L.M.B.C.).

**Wyfold IV's v. R.A.F.** This was to be the third time that the R.A.F. had beaten Bart's at Henley. But they did not do so easily. They led from the start, as Bart's nearly hit the booms, but could never clear the Hospital crew, who rowed extremely well against their powerful opponents. The steering of both crews was indifferent, Bart's after the start being rather the better. The R.A.F. won by one length in 8 minutes 9 seconds, the fastest Wyfold time of the day.

CREW: Bow, steers, C. N. Hudson; 2, J. F. Pigott; 3, C. C. H. Dale; Stroke, G. D. Stainsby.

**Spare Men's Pairs**

A cup is presented for this event each year by Jesus College Boat Club, and the races are held on the Monday and Tuesday of Henley week. The Bart's spare man, G. M. Besser, who started rowing only this year, paired with M. D. Wood of Balliol College. They had little practice together as first Besser and then Wood were required to row in their respective VIII's during the week before the event. Nevertheless, they settled down together well, and won the two heats and the final: all in a convincing manner. They beat Corpus, Oxford, easily; Queens' College with Magdalene College by  $1\frac{1}{2}$  lengths and Jesus College (Cambridge) by 2 lengths.

We take this opportunity of congratulating our war-time hosts, Queens', with whom we still maintain a friendly fixture, on their victories in the Marlow VIII's and Ladies Plate.

## KINGSTON REGATTA

**Wyfold Class IV's**

Heat v. Westminster Bank. Bart's suffered an early crab that was almost catastrophic; for Bow came near to making an involuntary and undignified exit from the boat. This left the Hospital three lengths down, but they rowed back with great determination to a dead-heat.

**Re-row.** This time the Hospital went cautiously down over most of the course. A spurt gave them the lead, but before they were clear of the Bank crew, there was a clash of blades and Bart's were disqualified.

Crew as at Henley.



The 1st VIII at Henley.

George Bushell.

## MOLESEY REGATTA

**Wyfold Class IV's**

**1st Heat v. London Rowing Club.** Bart's held London on the start, and thereafter drew away to one length. Bart's then hit the buoys and London simultaneously, but rowed on and won by one length.

**2nd Heat v. Barclay's Bank.** Bart's won easily.

**Semi-final v. Molesey.** The Hospital took an early lead and half-way over the course were nearly two lengths up. Here they were surprised by Molesey who took three-quarters of a length back within a minute. Bart's were shaken and lost their rhythm, scrambling past the finish three feet down.

**Thames Class VIII's**

v. National Provincial Bank. Lost by half a length.

**Metropolitan Regatta: Horton Cup (IV's)**

v. Putney Town and London Rowing Club. Bart's had previously beaten both these crews. They had the Middlesex station and never really took their share of the tide. London won by  $1\frac{1}{2}$  lengths, Putney Town coming in just ahead of the Hospital. The steering was poor.

## STAINES REGATTA

**Wyfold Class IV's**

**1st Heat v. Thames Tradesmen.** Bart's won easily.  
**Semi-final v. Westminster Bank.** The Hospital took an early lead and won by three quarters of a length. The steering was moderate.

**Final v. Thames R.C.** Thames had the benefit of the first bend and took three-quarters of a length—as was expected. Bart's then made several unfortunate strokes which together with indifferent steering caused them to drop a further length. But they rowed back hard and with the advantage of the second bend crossed the finish only three-quarters of a length down.

**Senior VIII's**

v. Molesey B.C. Although Bart's rowed well Molesey took three quarters of a length lead. Hospital held on until the last bend where their opponents increased their lead to win by  $1\frac{1}{2}$  lengths. In spite of the result, this was a good row. Molesey

went on to win the event. Crews at Molesey, Metropolitan and Staines Regattas as at Kingston.

## REVIEW OF THE SEASON

The Hospital won its first Senior VIII's Cup, a Junior Senior IV event, and shared the Cup for the Henley Spare-Men's Pairs. At Henley the standard of VIII and IV—benefiting from increased experience—was appreciably higher than that of last year. With more luck in the draws they should have gone further. Members of the 1st VIII enjoyed this rowing sufficiently for all to wish to continue after Henley.

This has been a satisfactory though not outstanding year, and it was disappointing that the VIII did not fulfil its early promise of being one of the better crews in the Thames Cup. At times the rowing went very well indeed; but unfortunately this form was not reproduced consistently.

We wish to thank our coaches, particularly Joe Bailey and John Blow, without whom we should have achieved little. They were at different times: T. Edwards (1st and 3rd Trinity and L.R.C.), A. C. Sheed (Clare), J. H. M. Ward (L.M.B.C. and T.R.C.), J. W. B. Palmer (S.B.H.B.C., Clare and L.R.C.), R. P. M. Bell (Jesus and L.R.C.), Dr. A. G. S. Bailey (Catus), Dr. R. J. Blow (S.B.H.B.C. and L.M.B.C.).

Honours were awarded to C. C. H. Dale and C. N. Hudson.

Colours were awarded to T. W. Bolton, G. D. Stainsby and K.G. Dawson (*honoris causa*).

## ATHLETICS

## CLUB MATCHES

- v. London and Guy's. May 4 at Hale End. Lost.  
 v. Westminster Bank. May 11 at Norbury. Won.  
 v. Goldsmith's College. May 18 at Chislehurst. Lost.  
 v. King's College Hospital. May 23 at Dog Kennel Hill. Lost.  
 v. Westminster Hospital. May 25 at Chislehurst. Won.  
 v. Imperial College. June 1 at Harlington. Lost.  
 v. St. Thomas's Hospital. June 22 at Chislehurst. Lost.

A ladies' athletic match was also held on the evening of May 23 against King's College Hospital. We would like to congratulate the students and physiotherapists, who combined to form the first Bart's Ladies' team that has existed for many years. Miss J. Thwaites won both the 100 yards and the javelin.

## United Hospitals Championships

Unfortunately we were not able to improve on our last year's position. The standard of competition was again very high, and our only victory came from a fine race by Roberts in the half-mile. Our tug-of-war team, recruited from non-members, had the necessary enthusiasm, but not the practice required to win this event.

880 yds.: 1, C. P. Roberts.

120 yds. Hurdles: 3, D. O'Sullivan.

440 yds. Hurdles: 2, D. O'Sullivan; 4, A. S. Tabor.

High Jump: 3, C. P. Roberts.

Medley Relay: 2, C. P. Roberts, R. C. Whalley, M. Birt, D. O'Sullivan.

Bart's entered a team for the Ladies' Section of the Championships, and did well in obtaining a number of finalists. Miss J. Chambers unfortunately injured herself in the final of the 100 yds., and this prejudiced our chance in the relay also.

## Tug-of-War

A match was arranged with the City Police on June 3. This had to be cancelled owing to the disastrous effect of the rail strike on the off-duty time of the policemen.

## BOOK REVIEWS

*He who first praises a book becomingly is next in merit to the author.*

Walter Savage Landor.

**CARDIAC SYMPTOMS IN THE NEUROSES** by Doris M. Baker, M.D., F.R.C.P. 2nd Ed. 1955. H. K. Lewis and Co., Ltd. 6s. 8d.

This little book is concerned with the most common of the functional cardiac symptoms. Since a very high percentage of patients coming with heart symptoms have in fact no organic disease, a small book on these subjects provides a practical and valuable way of emphasizing the importance of this fact. Dr. Baker's book is well written, concise, and comprehensive. The title is possibly slightly misleading since it leads one to enquire which particular forms of neuroses show which particular symptoms. Functional heart symptoms such as left chest pain, sighing respirations, palpitation, and heart consciousness are not restricted to patients suffering from hyper-sensitive conditions of the nervous system to which a specific label has been attached. They are common in individuals who are not necessarily suffering from anxiety states, hysterical manifestations, or the obsession syndrome. They may be present in any human

being whose attention has been unnecessarily or unwisely directed to the heart. It is not easy however to choose a title which would cover the situation; cardiac symptoms in the nervous might perhaps be vaguer and more accurate.

There are certain other small matters of detail which a reviewer, placed automatically in the position of a critic, may be allowed to point out. In dealing with the hyperaesthesia so often present in left inframammary pain, one specific tender spot very commonly found is at the lower end of the insertion of the pectoralis major to the chest wall. Dr. Baker is wise to stress the commonness of exhaustion in these patients. It is certainly the most constant of the associated symptoms. In the section dealing with palpitation there is no reference to anaemia as a cause of heart consciousness.

These are minor criticisms of a useful little book which should be read widely by general practitioners since the syndrome it describes is so extremely common.

GEOFFREY BOURNE.

## WOMAN—MAN'S EQUAL

By Sir Adolphe Abrahams, O.B.E., M.D., F.R.C.P. Christopher Johnson. 10s. 6d.

The author very wisely does not dare to answer this question himself, but has contented himself with collecting together an entertaining motley of snippets of poetry and philosophy, law and history, science and medicine, relating to Woman, and left the reader to weigh the evidence for himself—if he wants to. Most people will probably agree with Sir Adolphe when he says *Is not the rational conclusion to drop all idea of inferiority and superiority and accept as fundamental that men and women are—different and complementary to each other?* Not so your reviewer, whose special experience allows him to pronounce definitely in favour of the superiority of the male sex.

This special experience is obtained on a daily journey in the underground from King's Cross in the rush hour. Here one sees women for the frail wretched creatures that they are—in direct competition they have no chance. One sees the effortless ease with which a well built young gentleman can drive and barge his way to the front past these poor female types and grasp an empty seat without disturbing the set of his tie or the slant of his bowler; and how the older gentlemen, gamely refusing to let their age put them at a disadvantage, exercise great skill and cunning in elbow work and side-

stepping in their manoeuvres to beat the female every time. How powerful and over-mastering are those bowler-and-brolly Lords of Creation, sitting at ease while their puny rivals stand beaten before them, plain testimony to the inferiority of the female sex. Unfortunately your reviewer gets less pleasure than he might from this triumph of masculinity, for like Sir Adolphe he is *old-fashioned enough to feel disgusted at the spectacle of youths seated in public vehicles whilst women even those of an advanced age, are compelled to stand.*

This book is not crammed with useful data and it will not help anyone through his exams. It ranges widely through many fields of knowledge, but rarely more than superficially; it contains no shattering new theories or screamingly funny anecdotes. It is a quietly amusing, mildly thought-provoking book, written by an old Bart's man, who as M.O. to our Olympic team has had many years' experience of some of our finest young men and women, and it will give you a pleasant and profitable evening's reading. Because of its broad humanistic approach I would recommend it particularly to those in their first clinical year, as a helpful introduction to the study of people.

J. H. COULSON.

## PRINCIPALS OF MEDICAL STATISTICS

By A. Bradford Hill. Published by The Lancet Ltd., p.314. 6th Ed. 10s. 6d.

much ground in such a lucid and readable fashion.

*Sixth Edition: revised and enlarged.* Professor Bradford Hill writes in his preface that it was his secret ambition to break new ground by issuing this new edition *revised and greatly reduced*, but he confesses that the task was beyond him. We should not deduce that the book is unbearably long; that there is much dead wood that needs cutting out. Indeed it would be hard to find a textbook in any branch of statistics that covered so

The most important new matter is a chapter on clinical trials which fulfils a long-standing need; this is a topic that Professor Hill has made particularly his own but his writings on the subject are not easily accessible. He introduces a discussion of the place of experiment in clinical medicine by emphasizing that every administration of a



drug or performance of an operation constitutes an experiment. In the pages that follow we are shown, in entirely non-technical terms, the conditions under which a controlled clinical trial is a permissible extension of this idea. The chapter can be treated quite independently of the rest of the book; that it should be compulsory reading for anyone planning a clinical trial goes without saying; it might be even better if it could be read by the many thousands of practitioners who have to decide from the published accounts of clinical trials whether or not to accept and act upon their results.

Little need be said about the rest of the book, which has held the field for nearly twenty years—a long time in this subject. It deals with almost all the statistics that need to be known by the research worker in clinical medicine or public health (but not the laboratory worker). And lastly there is nothing in it that need scare off the non-mathematician.

M. P. CURWEN.

**BACKACHE IN WOMEN** by E. Schleyer-Saunders, M.D., F.I.C.S. John Wright and Sons. 7s. 6d.

This monograph is written by a gynaecologist with the hope that it will assist practitioners in dealing with their female patients who have this very common complaint.

Although it tends to be a catalogue of possible causes, the main classification into gynaecological, orthopaedic, and "rheumatic" is concise, and could be a useful method of approach by a practitioner.

This is a practical book, although there is a considerable amount of discussion of theoretical points, this tends on the whole to hold ones interest. Some statements such as *Anxiety neurosis . . . leads to congestion and spastic contraction of the sacro-iliac ligaments and subsequent backache and the first symptoms of carcinoma of the pelvic colon or rectum are usually low backache and bilateral sciatic pains* are open to doubt.

The section on treatment in psychoneurotic backache is very good, and would be well read by every practitioner.

In such a complex subject as this the author has revealed that he has faced the problem many times and has given as the benefit of his experiences as regards diagnosis and treatment, and also of his sincere efforts to cut down the amount of post-operative and post-partum backache. The simple measures he advocates should go a long way to preventing this miserable complication occurring.

In conclusion, it can be said that this book is disappointing in that it does not lay open the subject completely and precisely, but this is more than anybody can do at present and it gives a reasonable resume of the present status of female backache.

S. F. HANS.

**PHARMACOLOGY IN MEDICINE.** Edited by Victor A. Drill. McCraw Hill Book Co. Inc.

With such rapid advances in pharmacology and therapeutics and the ever increasing number of new and better drugs, it becomes an extremely difficult problem to keep abreast of this subject.

An even more difficult problem is to collect all the information necessary to publish a book dealing with this vast study. Indeed for any one person to attempt such a work would take so long that it would almost certainly be out of date before it was published.

In *Pharmacology in Medicine*, Dr. Victor Drill has overcome this difficulty by using the knowledge of some eighty other authorities in various branches of pharmacology. With careful planning and editing their style has been kept uniform throughout which is a great advantage.

The general plan has been arranged to cover all aspects of each drug in a uniform scheme: in chemistry, effect on organ systems, absorption, fats and excretion, routes of administration (and official and proprietary preparations where applicable), toxicity and therapeutic uses and doses.

After a brief introduction dealing with the historical background and general principles of drug action, there is a chapter giving advice on the writing of prescriptions, and references to various laws concerning drugs in the U.S.A. and Canada.

Dr. Drill's teaching experience has enabled him to produce a book which is equally suitable for student or physician and which includes in many instances hitherto unpublished data. The latter in some cases tends to change the present conception of the action of some drugs.

J. C. B.

**MEDICAL STUDENTS AND MEDICAL SCIENCES** by D. C. Sinclair, M.A., M.D. Oxford University Press. 25s.

Dr. Sinclair has made a detailed study of medical education in the United States and certain of the British Medical Schools. His exhaustive analysis is contained in a preface and fourteen chapters divided into four groups: the student, the teaching, the material taught and educational experiments. The preface is the key to this book, especially the last full page in which Dr. Sinclair outlines some of his "prejudices." These prejudices appear to be common to all senior teachers, or would-be teachers, of medical students and do not express any new or profound approach to the subject. The rest of the book is difficult to assimilate and while including many facts, and unfortunately all too few fancies, does not culminate in any constructive deductions or suggestions.

It is true that this book contains a mass of interesting material culled from the U.S.A. and compared, not always favourably, with methods of teaching and conditions in this country, but while we may read for a short time with interest and admiration for the author's industry we are left little wiser about our own shortcomings. One gains the general impression that all teaching of medical students is an uncontrolled experiment, frequently quite useless and anyhow it really depends on the students and teachers and where they work—in fact where, we were.

E. G. TUCKWELL.

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LIX

OCTOBER 1955

No. 10

## EDITORIAL

*The object of the Society is the reading and discussion of papers and the presentation of addresses and debates and the exhibition of cases and specimens relating to medical science and practice.*

—*The Laws of the Abernethian Society.*

THREE MONTHS AGO we had occasion to comment on serious shortcomings in both the management and policy of the Abernethian Society (this *Journal*, July, p.210). Our aim in so doing was not to pillory individuals, but to provoke change. We were, however, quite unprepared for the attitude adopted by the small but influential group of the Society's former officers, who condemned these comments as ill-considered and even vicious. In our opinion, this opposition stems more from a sense of inadequacy and wounded pride than from an objective assessment of the facts. Since it is becoming increasingly clear that any change in the conduct of the Society will have to be initiated by its rank and file members, we consider it necessary to counter-balance the rumblings of the Old Guard by setting forth the arguments of our Columnist in greater detail.

At the head of this page we have printed the object of the Society—its first *law* (the other member clubs of the Students Union are content with mere *rules*). This stated object has not changed in substance since 1832, when the Abernethian Society was founded on the ruins of the old "Medical and Philosophical"; yet the present activities of the Society are scarcely comparable with those of 50 or 100 years ago. Successive Presidents have chosen to interpret the object in varying ways, often without due regard to the Society's traditions. In particular, our examination of the Society's papers reveals that there has been a pernicious ten-

dency, exacerbated by two world wars, for an undue proportion of the Society's time to be taken up with "the presentation of addresses". It is this substitution of passive receptivity for active participation that is the chief cause for complaint. Our Columnist put the matter succinctly when he wrote, "The Abernethian Society as it is today would give no opportunity to a Paget".

During the 1954-55 session over two-thirds of the Society's meetings were devoted to addresses, some of which had no relation whatsoever 'to medical science and practice'. There is nothing reprehensible in the lecture qua lecture and the Committee, particularly in the last two years, have taken considerable pains to see that these are varied and interesting; but the Abernethian Society used to be something more than an organization for the provision of visiting lecturers. Our point can best be made by quoting from *introductory* addresses given to the Society in former years. These are the words of the celebrated physician Dr. Samuel Gee:

"The most obvious purpose of a scientific society, I suppose, is the getting of truth: ours is a medical society, and our object is medical truth. Now it seems to me that medical societies may be of two kinds. First, there may be societies of men who are no longer students in the common sense of the word—men who know what is already known, and whose object is the winning of new truth out of the boundless world of the unknown. Next, there may be societies of men who are still students, commonly so called—men whose business is not so much to discover new truth as to make themselves master of the old.

"The Abernethian Society, whatever it may formerly have been, is now of the second kind rather than the first: that is to say, it consists in greater part of students, from whom we do not expect truths absolutely new, so much as truths which are relatively new—truths which are new to most of the hearers, or old truths arranged in a new fashion. The papers which are read here are almost always, and almost necessarily, of this kind. We are not ashamed here of old truths. We welcome the new, but, as I said before, we do not much expect them; for, in Milton's words, "Our wings here are fledgling; we may meditate a future flight, but our Pegasus soars as yet on feeble pinions."

"Our wings, our Pegasus. I have hinted, before I meant it, at another, and indeed at the chief, use of our Society. Hereafter I will speak of this topic more at large, but let me say now, that if the Abernethian Society did nothing more than scatter a few truths abroad, it would have small reason to show for its existence. But ours is a dialectic society. We discuss the papers we read; we question, doubt, deny; we look at a reputed truth, whether new or old, from all points of view; we confront it with contrary and contradictory truths; and in doing so we strengthen the very spirit of truth itself. Under this discipline our wings grow strong, and our Pegasus comes to soar on pinions which carry him up to the very sun of truth, . . .

The Abernethian Society is a discussion society, and this is its chief use. For discussion is the great means of developing the spirit of truth which is within each one of us. . . . The Abernethian Society will probably afford you the only opportunity which you will have in your life of cultivating your powers in the way I have spoken of, namely, by discussion. I invite you all to join it; I would even urge you all to join it, because I am confident that you will find it to be for your good."

The whole of this remarkable and delightful address may be found in the *Hospital Reports*, XIII, pp.313-26. Dr. Wickham Legg had this to say about the objects of the Society (taken from the minutes):

"He began by pointing out that in all education there were two kinds of knowledge to be imparted, first, the mere storing of facts; second, the digestion and assimilation of facts: the first, a mere exercise of the memory; the second, the exercise of the higher faculties of the mind. For the first there were the lectures, demonstrations, class examinations, medals, and academic rewards, while for the second there was at St. Bar holomew's the Abernethian Society, in which the student who had learnt his facts was taught to ponder over and reflect upon the ideas that he gained. The Abernethian Society being, in fact, an intellectual gymnasium, in which the mind was trained and exercised, just as it was in the disputations and exercises of the mediaeval universities.

Finally, here is an extract from the minutes of an address given by Mr. Power:

"The speaker proceeded in the first instance to point out the objects of the Society, which were, he said, first, to be the means by which cases of interest occurring in the Hospital might be brought under the special notice of the students, particular methods of treatment described, the practice of

different surgeons compared, and general interest in the internal life of the Hospital awakened, secondly, to be the means of promoting habits of exact observation in those commencing professional life, and of inducing them to make some efforts toward original research and incidental advantage by no means to be overlooked was the acquirement of the art of debating, a process that required much practice and experience in the speaker, and much patience in the hearers."

Even the most prejudiced supporters of the present day Society can hardly claim that it is an intellectual gymnasium. The Society's decline, for such we take it to be, can be ascribed to many causes. Jeremiahs have invoked apathy (does the reader know that only last year the Students Union appointed a committee to investigate this baneful, if somewhat nebulous, disease?); while others of a more practical nature have spoken of examination fever, televisionitis and a general desire for spoon-feeding. These explanations may or may not contain some elements of truth. It is, however, our contention that the decline is due in part to mismanagement.

The Committee is surely mistaken when it equates success with large attendances at lectures; for the real business of the Society, so eloquently stated by Dr. Gee, has been neglected. It is useless for the Committee to protest that they are unable to persuade students to read papers or to take part in discussions. The Junior Osler Club was formed in 1952 expressly for this purpose. Here are two extracts from its charter: (1) "It is not the purpose of the Club to draw great audiences by having celebrated speakers, but rather to rely upon our members to write their own papers and read them to and discuss them with the other members of the Club." (2) "If there is a noble aim, it is to encourage ourselves to think, to research and to write upon the broader aspects of medicine, and in doing so to gain both knowledge and amusement." Members of this flourishing Club actually *do* read and discuss their own papers. It is not difficult to infer why the Club was formed, though it seems a pity that the traditions of Abernethy can only continue under the aegis of a foreign deity.

The recent formation of a pre-clinical Physiological Society again draws attention to the inadequacy of the Abernethian Society's programme. The Committee claims pre-clinicals are not interested in their meetings. This is hardly surprising when one considers the precarious nature of the liaison

between the two. If the Committee contained three or four pre-clinical members this difficulty might well be overcome. In view of the fact that a first year student once brought resounding fame to the Society, their present treatment of the pre-clinicals is most shameful.

To summarize: We consider there has been a loss of prestige with a consequent loss of interest in the Society due, in the main, to successive committees who have failed to implement its object. In order that our criticism may not be considered as merely destructive, we venture to make the following suggestions:

- (1) The Committee acquaint themselves with the Society's traditions.

#### Congratulations

to Dr. E. F. Scowen, on his appointment as Director of the Medical Unit.

to Dr. R. Bodley Scott, on his appointment as Physician to Harvey and Luke Wards.

to Mr. G. W. Taylor, on his appointment as Assistant Surgeon to the Surgical Unit.

#### Journal Staff

Mr. G. D. Stainsby has been appointed Assistant Editor.

#### Extension to College Hall

Seven more rooms on the first floor became available for students on October 3rd. These were previously occupied by the resident domestic staff, who have now moved to the two floors that have been added above the kitchen, at the north-east corner of the block. The staff moved early in September in order to leave time for redecoration.

The total number of students living in College Hall, which is still the finest hall of residence in the University, is now at the century mark, eighty three men and seventeen ladies.

- (2) The Committee should be representative, i.e. contain members from each clinical year and, in addition, three or four Charterhouse members.
- (3) Let there be fewer lectures; but *more* Clinical Evenings, *more* debates, *more* exhibitions of specimens and objects of interest, and *some* papers read by students with time for discussion.
- (4) The Junior Staff used to take an important part in the activities of the Society. Cannot they be persuaded to do so again? They could, for example, discuss the research work that is being carried on in both clinical and pre-clinical departments.

#### Dramatic Society

On Thursday and Friday, November 17 and 18, the Dramatic Society is hoping to produce Oscar Wilde's comedy "The Importance of Being Earnest." An audition meeting to read the play and select the cast was held early in October in the Recreation Room, College Hall. About 30 people attended and after an enjoyable reading the cast was selected by the producer, Robert Sheaf (who produced "Captain Carvallo" so well two years ago).

Tickets will be on sale at the beginning of November. They may be obtained by post from the Business Manager, St. B.H.D.S., St. B.H., E.C.1. Offers of help in the selling of tickets and programmes will be gratefully received, and the Society looks forward to good support from everyone and a full house on each night.

#### The Journal

Contributors are reminded that the *Journal* goes to Press on the 1st of the month preceding that of publication. Articles, sports reports and notices *must* reach the *Journal Desk* on or before the 1st of the month in order to be included in the ensuing number. Contributors are urged to make their writing legible, to leave wide spaces between the lines and to use only one side of the paper.

### Professor Christie

Bart's has been distinctly unlucky with its Professors of Medicine; Professor Witts was charmed away to Oxford by Lord Nuffield, and now his successor, Professor Christie, has succumbed to the blandish-



Professor Christie

ments of McGill University in the New World. It really is too bad.

Professor Christie came to Bart's a few years before the war and his modest yet unhesitant manner soon gained him affection and respect. The *Journal* remained a little quizzical, however; for the photograph on this page—a Candid Camera study originally published in 1939—was given the mildly irreverent caption, "This Chair takes some filling. What?" The Professor

certainly looked young, but then he still does (the unconvinced should compare this photograph with those in the *May Journal*, p.133). If we were doubtful once, we are now sure; but to correct any impression that the *Journal's* deep-dyed conservatism in this matter lingers on, we will hasten to add that

Professor Christie now shares our fullest approbation, and indeed has done so for many years. He is in fact most popular and we are all sorry to see him leave.

Quite a large number of students found time to meet in Garrod Ward for the farewell teaching round. After inviting us all to be seated as "cerebration is best in a relaxed position," the Professor led us delightfully up the garden path over the interpretation of the physical signs of (as we thought) a

bronchiectatic chest. Our disillusionment was complete when, during the discussion in the path. room, X-rays were produced that showed a large and ominous shadow. "All very revealing." There is no doubt that Professor Christie's power as a teacher rests on his remarkable lucidity; one never fails to consciously realize that one has learnt a great deal at the end of one of his ward rounds or lectures.

He sailed for Montreal in late September to take up his new appointments at McGill University: Professor of Medicine, Chairman of the Dept. of Medicine and Physician-in-chief of the Royal Victoria Hospital. He is, of course, no stranger to McGill, for he held a research post there in the early thirties, gaining a Master of Science degree in 1933.

We shall miss him, and, despite the skiing and skating, hunting and canoeing, we feel sure that there is one thing he is going to miss too—the good old London smog.

### Professor E. G. D. Murray

Professor Christie's arrival at McGill coincides with the retirement of an old Bart's man, Professor Murray, from the Chair of Bacteriology and Immunology.

After the 1914-18 war, in which he gained the O.B.E., Professor Murray returned to Bart's to take up a post as demonstrator in pathology. He later became a Fellow of Christ's, Cambridge, his old university, and it was not until 1930 that he moved to Montreal.

Our Canadian Correspondent has sent us Press cuttings describing the ceremony held in June by the University of Montreal, at which he was conferred with the honorary degree of Doctor of Medical Sciences. The Rector, Mgr. Maureault, P.A., was much impressed by Professor Murray's achievements, for in the course of the citation he remarked: "Nous n'avions qu'une idée vague de l'activité qu'il déployée au cours de ses quarante années de profession. Les six pages de papier-ministre, bondées de faits et dates, que j'ai eues entre les mains, m'ont rempli d'admiration et de cette sorte d'étonnement que les Anglais traduisent par le mot 'awo' . . ."

Under the guidance of Professor Murray the Department of Bacteriology at McGill has become one of the finest in Canada, while his own work on meningitis has earned him the Flavelle medal of the Canadian Royal

Society. But his interests range far outside the fields of medicine and biology; he has, for example, been a member of the Montreal City Council since 1947. He is also, we are told, "one of the most colourful personalities on the McGill Campus" (The image of eye-offending tartan shirts springs irresistibly to mind).

We wish him well in his retirement.

### THE LIGHTER SIDE

Our request for amusing letters and incidents produced a fair response, principally from the General Practitioners. All the stories we received were amusing, but the possibility of intervention by the Postmaster General prevents us from publishing some of the choicer ones. If the supply continues—and there must be many readers who possess scores of such drolleries—we hope to publish a selection each month.

### Economy versus Health

The following letter, addressed to "St. Bartholomew's Hospital near Old Bailey," eventually found its way into the capable hands of Sister Surgery:

Dear Madam,

*I am very sorry that I cannot come as the fare money is 2/8 so it is not worth it.*

Yours sincerely,

— (Mrs.)

\* \* \*

### Diagnosis please

Dr. C. J. Hart had to make up his mind about this one:

*Dear Sir my boy stay it hurt him to pass is water he keeps wanting to go only does a little at a time and it hurt he once today he said there was a spot or two blood he may have a cold or some think in back send shilling up friday night.*

Yours Sincely,

— (Mrs.)

\* \* \*

### Inside information

Dr. D. J. Batterham of Devonshire writes:

"An ex-patient of mine, a teenager and proper simple (as they say in Devonshire), had just been discharged from hospital after an unfortunate attack of *salpingitis*.

She attended at the Surgery for her weekly N.H.S. certificate. When she was asked

what disease the hospital doctor had written on her first certificate she replied: 'I couldn't read his writing very well, but I think he wrote *Saturdayitis*.'

This story is quite true, and she didn't mean to be funny!"

---

## NOTICES

---

### Lectures on General Practice

Tuesday, November 1, at 12 noon.

Dr. Lindsey Batten of Hampstead will give a lecture in this series entitled:

THE ESSENCE OF GENERAL PRACTICE  
in the Hospital Lecture Theatre.

\* \* \*

### Junior Osler Club

Monday, October 17, at 7.45 p.m.

Dr. A. W. Franklin will speak on:

SIR WILLIAM OSLER  
in the Music Room, College Hall.

\* \* \*

### Abernethian Society

Thursday, October 27, at 5.45 p.m.

Dr. G. O. Barber of the College of General Practitioners will speak on:

A DAY IN COUNTRY PRACTICE  
in the Physiology Lecture Theatre, Charterhouse Square.

Tuesday, November 15, at 5.45 p.m.

Sir Geoffrey Keynes will speak on:

WILLIAM HARVEY  
in the Recreation Room, College Hall.

\* \* \*

### Physiological Society

Monday, October 24, at 5.30 p.m.

Surgeon Commander W. H. B. Ellis will speak on:

SOME PHYSIOLOGICAL ASPECTS OF FLYING.

Monday, November 7, at 5.30 p.m.

Professor G. B. Verney will speak on:

THE WORK OF E. H. STARLING.

In the Physiology Lecture Theatre, Charterhouse Square.

### Wessex Rahere Club

The Autumn Dinner will be held at Fortis Restaurant, Milsom Street, Bath, on Saturday, October 29.

It is hoped that Mr. Ogier Ward will be present as Guest of Honour.

Membership of the Club is open to all Bart's graduates practising or resident in the West Country: there is no subscription. 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.

\* \* \*

### The Tenth Decennial Club

The Annual Dinner of the 10th and associated 8th and 9th Decennial Clubs will be held at the Bath Club, 74, St. James' Street, S.W., on Wednesday, October 26, 1955, at 7 for 7.30 p.m.

Dr. Lindsey Batten in the Chair.

\* \* \*

### Church of England Chaplain to Medical Students

The Bishop of London has appointed the Rev. R. C. R. Mander as chaplain to the students of the twelve Teaching Hospitals in London. The Chaplain would like to meet as many students as possible—particularly those coming up for their first term—but, to a great extent, he must rely on people getting in touch with him. His centre is the C. of E. Chaplaincy to the University of London, 13, Woburn Square, W.C.1 (MUSEUM 5572).

From Sunday, October 16, Christchurch, Woburn Square, will be used by the Chaplains as a church for the student population of London. The Sunday services will be at 9 a.m. and the special course of Sermons at 8 p.m.

\* \* \*

### Alpine Club

There will be a meeting of the St. Bartholomew's Hospital Alpine Club on Tuesday, November 8, at 8 p.m.

Dr. Cullinan has kindly invited all past members and all those interested in joining the Club to meet at his house. Details of the meeting will be posted.

## "BOWLBY AS I KNEW HIM"

by REGINALD M. VICK

WHEN I arrived at Bart's on October 1, 1906, committing the appalling solecism of driving into the Square at 1.30 p.m.—where only the carriages of the senior consultant staff were allowed—Bowlby had been a full surgeon for three years. The lectures of the Senior Surgeon at that time were so Rabelaisian in character that students had to queue up to get in. Bowlby was, then, 51 years of age.

His father, Thomas William Bowlby of Durham and Darlington, who was at one time surgeon to the 73rd Regiment had, ultimately, become Correspondent to *The Times* in China. While acting in that capacity, he was taken prisoner by the Chinese and about a week later died in captivity after great suffering. His body was brought to the English Camp and he was buried in the Russian Cemetery on October 17, 1860. At that time Bowlby was only five years old, but I do remember to have heard that *The Times* ever afterwards took an interest in the education and career of this boy.

He was educated at Durham School and came straight from there to Bart's in 1876. It should, therefore, be noted that he was a North Countryman and this may well have accounted for some of his characteristics, such as determination and tenacity of purpose. He qualified as M.R.C.S. and L.S.A., which was the custom of those days, in 1879. Like so many successful surgeons before and since, he was a keen Rigger player. There is no record of his obtaining an entrance Scholarship as the result of his prowess in the Rigger field. That practice came later, for he obtained the Brackenbury Scholarship in Surgery. He became F.R.C.S. in 1881 and, that year, he was appointed Curator of the Museum which at that time was recognized as one of the paths to the staff. He held this post for three years and, in 1884, he was appointed Surgical Registrar, which meant his ultimate election to the Surgical staff. While Curator of the Museum

An address to the Osler Club of London on May 20th, on the occasion of the Centenary of his birth.

he conceived the idea of writing his successful book *Surgical Pathology and Morbid Anatomy* which held the field as a standard text book for many years.

He was elected Assistant Surgeon in 1891 and full Surgeon in 1903. In 1899, he went as Senior Surgeon to the Portland Hospital in South Africa, where he was associated with Sir Cuthbert Wallace—and acquired his knowledge of Military Surgery, which stood him in such good stead in the Great War. In 1901, he published *A Civilian War Hospital* in which he gave an account of his experiences.

In 1904, he was appointed Surgeon to the Household of King Edward VII and, in 1910, Surgeon in Ordinary to King George V.

In 1905, he became a member of the British Red Cross Society Council—then newly formed—and this Society became one of his greatest interests to the day of his death.

In 1906, he joined the Territorial Army as Major R.A.M.C.T. being attached on Mobilization to the First London General Hospital, which was staffed from Bart's. However, as soon as the War came, he offered his services to General Headquarters and was sent as Consulting Surgeon to the Forces in France in September, 1914. He was given the rank of Major General.

On the formation of the Second Army, Sir Cuthbert Wallace was appointed Consulting Surgeon to the First Army and Bowlby to the Second Army. Later, with the adjustment of the staff owing to the establishment of additional armies, new consultants were sent out and Bowlby became a Super-Consultant and General Adviser to the Director General, Army Medical Services. After the retirement of Sir George Makins he became Adviser in Surgery to the whole of the British Area, Front and Base.

My first memories of Bowlby are vivid. In those days surgical consultations at Bart's provided one of the outstanding entertainments of the week. No dresser would have

dreamed of missing them. They were held at 1.30 p.m. on Thursdays in the old Theatre "A" which besides being one of the largest lecture Theatres in the Hospital was, also, an operating Theatre. When consultations were over the floor was cleared and operations started. Later, Surgical Consultations moved to the present surgical Outpatient Department. Although only three years a full surgeon in 1906, Bowlby's surgical opinion was one of the best of the lot. While Sir Henry Butlin (who still rode to the Hospital on his black horse with its long tail) was brilliant, while Lockwood was cynical, Bowlby was dogmatic and definite, and rarely wrong. He always expressed himself with a clarity which appealed to the students.

I can remember two stories about Bowlby in consultation—both of them, curiously enough, associated with Mr. McAdam Eccles. On one occasion, Eccles showed a man with a vastly distended abdomen. When Bowlby came to examine the patient he discovered a small puncture mark on the front of the patient's abdomen. He asked Eccles what this was and Eccles replied: "Ah! I am not going to tell you until you have expressed your opinions." Bowlby answered, "If Mr. Eccles knows what is the matter with the patient he should tell us. I have not come here to take part in a guessing competition," and he refused to take any further part. The patient's abdomen was almost entirely occupied by an enormous hydatid cyst.

On another occasion, Eccles asked his colleagues to go and see a patient in one of his wards, who was too ill to be moved from his bed. Bowlby went to the ward surrounded by his dressers and examined a man with advanced arthritis of his knee. He then said, "I should try Bier, Eccles," to which Mr. Eccles replied, "We don't have beer in my wards, Sir Anthony." Bowlby's answer was "Bier, Eccles, Bier" [Bier's passive congestion].

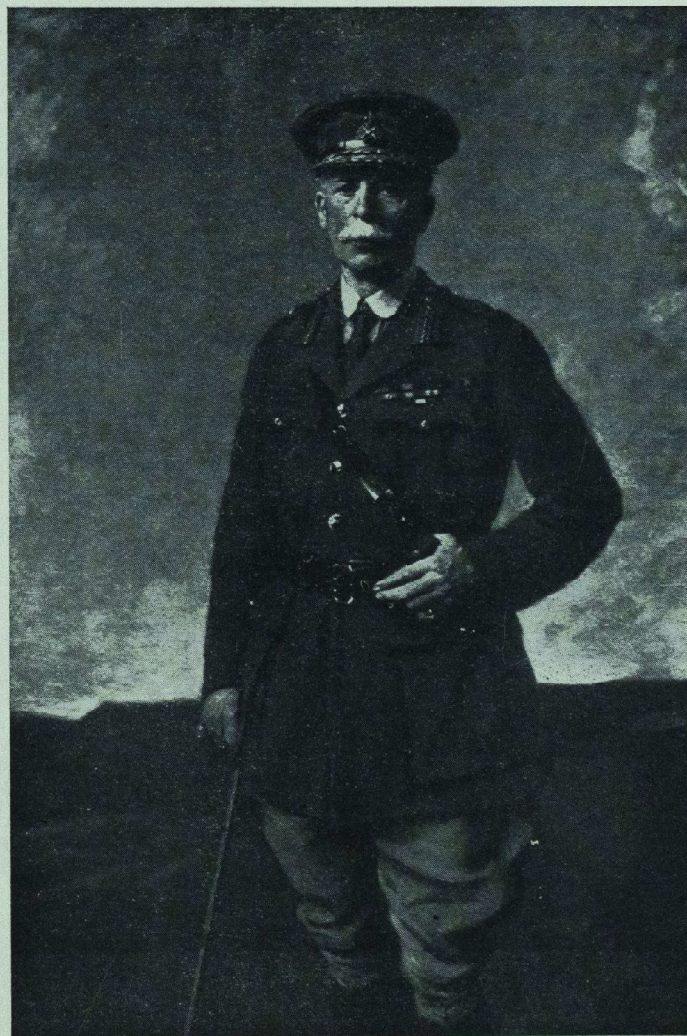
In those far off days it was not the custom for dressers to go round with other firms. It was looked upon as almost a disloyalty to do so. This was, of course, a most unfortunate tradition, long since dead. But the result of it was that I had very little knowledge of Bowlby as a clinical teacher. I do remember his clinical lectures which were wonderful. At that time, the routine surgical lectures were given by the two most senior surgeons and were insufferably dull.

At one time, when I was a Demonstrator of Pathology, I was for seven weeks a patient in a nursing home to which Bowlby sent his patients. Hardly a morning passed without his popping in with a cheerful story or a bit of news, which provided a great relief to the tedium of the day.

During the 1914-1918 War I got to know Bowlby better. When my Field Ambulance was in Ypres in 1915, he visited us regularly always bringing around advice and, even, urgently needed splints. It is interesting to record that, in those days, Thomas's splints were not included in the equipment of a Field Ambulance. I remember his telling me one day that, although he was consulting surgeon to the Army he was never told when or where any battle was to take place. This official secrecy was later abandoned, and soon the consulting surgeons knew where the next battle was to take place almost as soon as the Germans themselves. Bowlby was always a great friend to young men—all young men—but especially as in private duty bound to young Bart's men. One day he came to see me and said "You do want to get on to the staff of Bart's after the War don't you?" When I said that I hoped so, he went on: "Well, in that case you must stay with your Field Ambulance; I will get you appointed surgeon to the Casualty Clearing Station at Poperinge, and you will be one of the first Fellows of the College to operate in the Front Line." But it was not to be. As soon as the project was mooted my C.O. and the A.D.M.S. of my division went to Army Headquarters and very soon an order came out: "*In future, no Territorial Officer will be moved from his Unit without direct permission from Army Headquarters.*"

I did not leave my Field Ambulance for the Base until late 1916 and Sir Thomas Fairbank, the famous orthopaedic surgeon who was in the same unit, was in charge of mules until September of that year. I ought, perhaps, in fairness to say that we did not mind very much. We were all friends together in our own Territorial Field Ambulance—four surgeons including Ernest Wagget the E.N.T. Surgeon, who never left it, and Julian Taylor.

It was during the War that Bowlby rose to his greatest heights. To say that he enjoyed every minute of it would be an exaggeration, but he was happy doing the work he loved. One of his finest bits of work was due to his



SIR ANTHONY A. BOWLBY, K.C.B., K.C.M.G., K.C.V.O., D.S.M., F.R.C.S.  
(From the portrait by Sir William Llewellyn)

insistence that surgery should be done at the front, and it was due largely to his efforts that the Casualty Clearing Stations were changed from relatively small units into large hospitals where major surgery could be done. There is no doubt that this early surgery, for the inception of which he was to a great extent responsible, saved the lives and limbs of thousands of wounded men, and was one of the chief reasons for the commendations of the medical services in that War. How pleased he would have been to see the organization of surgery at the Front in Hitler's War.

At Bart's Bowlby was known as the "Baron"; during the War, he became the "Baron of Bapaume." Sir William Osler once described him as the "Great Consoler," as it was so often his painful function to report the death of their sons to so many of his friends. He was uniformly cheerful—and apparently never had any doubt who was going to win the war. He was a great purveyor of rumours—all exciting, but perhaps not always true.

His connection with the Royal College of Surgeons was long and distinguished. He became a Councillor in 1904, and served without a break until 1920, when he became President. He delivered the Bradshaw lecture in 1915 on "Wounds in War" and was Hunterian Orator in 1919, when he reviewed military surgery from the days of Hunter until that date.

When he came back from the War he never resumed active work at Bart's. But he was a regular attendant at Surgical Consultations and you may well imagine with what awe we regarded him. He continued to live a very active life as Chairman of the Radium Institute, Chairman of the Board of Management of King Edward Convalescent Home for Officers at Osborne and as a working member

of the Executive Committee of the British Red Cross Society. He was knighted in 1911, created K.C.M.G. in 1915, K.C.V.O. in 1916, K.C.B. in 1919 and a Baronet in 1923—the year of the Octocentenary of Bart's. A portrait of him by Sir William Llewellyn, R.A., was presented by his past students and his colleagues, and stands in the Great Hall at the Hospital. He is wearing the uniform of a Major General.

Bowlby was a man of keen intellect and strong character. If he believed a thing to be right he proceeded with a quiet determination to carry it out. He was a practical teacher with a knack of making his points. It is said that he wrote with difficulty. He was of medium height, of a slight build and very active. He had been a keen Alpine climber. He made friends very easily and retained the friendship of hundreds of his old students who looked upon him with affection and veneration. He worked for years with Sir Thomas Smith and Professor Howard Marsh—the last Professor of Surgery at the University of Cambridge—and modelled his work upon them. His undoubted success in private practice was due to his sound judgment, which was his outstanding characteristic. He died in 1929, while on holiday at Lyndhurst, at the age of 73.

This is my picture of Bowlby as I knew him and I hope it has given you some idea of the man and his work. In those days the students and the junior staff looked up to the staff as Olympians. We certainly looked up to Bowlby as some one far above us—to be revered, admired and loved. And you can imagine our joy when he stepped down from the clouds and came among us, as he so often did. It is the custom to-day for the older generation to say that such men do not exist now. This may or may not be true, but it is certainly unfortunate that there are not more people like Bowlby.

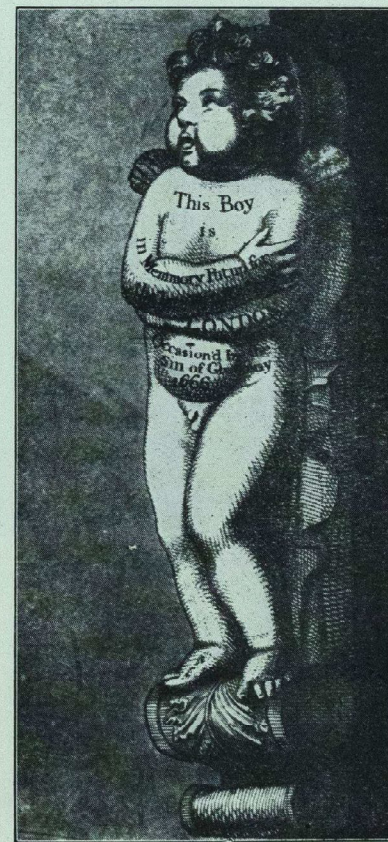
## THE GOLDEN BOY

At the corner of Cock Lane and Giltspur Street, high on the wall of the office buildings, there is a small, plump, gilded boy. You can see him from the Abernethian Room. He stands on a stone platform, is two feet eleven inches high, and is carved out of a solid piece of oak. No one we spoke to seemed to have a clear idea of why he was there, or what he symbolised, and at length our curiosity led us to investigate.

The earliest reference we were able to find, was a picture of him in Pennant's *Account of London*, published in 1791. This shows him with wings, a cloak, and the inscription across his chest, arms, and tummy 'This Boy is the Son of the late Fire of London Occasion'd by the Sin of Gluttony 1666.' Part of the cloak remains, but no trace of the wings, or of the inscription, can be found today; according to another reference, the wings were present in 1816, painted yellow. The present day figure differs in yet another detail from the print in Pennant's book; if we accept the detail of that drawing, and believe that this is the same Golden Boy, we must try to explain this. We suggest that perhaps the Victorians preferred the fig-leaf.

The district around the east end of Cock Lane used to be known as Pye Corner, and until 1910 there stood at the corner, a public house, called 'The Fortune of War.' The Golden Boy used to stand on the wall of this pub, facing the Hospital. There is a water-colour by Appleton, dated 1890, in the writing (gramophone) room, College Hall, which shows 'The Fortune of War' and the Boy. The pub had an infamous reputation, for it was the house of call for those resurrectionists who supplied Bart's surgeons with subjects for dissection. It was pulled down in 1910, and on the 8th June of that year, in the City Surveyor's Report, it was 'Ordered that in the new lease of the premises in Giltspur Street on which the sign was originally exhibited, Mr. Comptroller do insert a clause requiring the lessee to re-erect and preserve the figure, and re-gild it every five years.' Such a covenant, expiring in 2009, was put in the lease to Foster Estates Ltd., the present owners of the site;

when the offices were built the Boy was placed in his present position. During the war he was removed to the Central Criminal Court, for safety; he was re-gilded and restored to his old position early in 1946.



*The Golden Boy in 1791*

In 1949, the City Authorities took over the responsibility of his upkeep, and they now pay for his five yearly gilding.

The origin of the Golden Boy is still shrouded in mystery. In the *Vade Mecum for Maltworms*, which was written about

why the figure of a small boy was chosen. A small boy wanted a piece of cake, but his mother would not let him have any; in a fit of temper he set fire to his mother's house in Pudding Lane (where the Fire began), and ran away. He was pursued and



THE GOLDEN BOY

V. MAJOR

1715, 'The Fortune of War' is mentioned as a well-known tavern, but nothing is said about the Boy. A naked boy was often used as a trade-sign by clothiers, undertakers and coachbuilders, and it is known that such tradesmen lived in the neighbourhood at the time of the Great Fire. Originally he may have been such a sign, the inscription being added later. However, the inscription does say that the Boy was put up to commemorate the end of the fire at Pye Corner, and there is an ingenious legend which explains

eventually caught at Pye Corner; as punishment he was thrown into the flames. Needless to say no evidence could be found to support this heartless story.

There is little doubt that the Great Fire began near Pudding Lane and came as far as Pye Corner. On these two facts, a Nonconformist Divine, preaching at an anniversary of the catastrophe, based his sermon. "The Calamity could not have been occasioned by the sin of blasphemy, for in that case it would have begun in

Billingsgate; nor lewdness, for then Drury Lane would have been first on fire; nor lying, for then the flame had reached the City from Westminster Hall. No, my beloved, it was occasioned by the sin of gluttony, for it began at Pudding Lane and

ended at Pye Corner.' (Burn's *Tradesmen's Tokens*).

We would like to thank the staff of the Guildhall Library and Art Gallery for their help, and for permission to reproduce the drawing.

G.D.S. AND D.T.

## RAHERE AND THE MISSING BOOK

OUR KNOWLEDGE of the foundation of St. Bartholomew's Hospital and of the Priory of St. Bartholomew is largely based upon a manuscript preserved in the British Museum, the *Liber fundacionis ecclesie Sancti Bartholomei Londoniarum*. The manuscript was written about the year 1400 and contains two versions of the same work: a Latin original and a Middle English translation. The former is itself a transcription of a work composed in about 1180 by a canon of the Priory who, though not directly acquainted with Rahere, says that he talked with those who remembered him.

After describing Rahere's journey to Rome, his vision and the difficulties which beset the foundation of the Priory, the canon sets down a number of miracles and miraculous cures associated with Rahere and the Priory, of which the following, chapter XIV of book I, is an example. The Middle English version given here should present no difficulties to those familiar with Chaucer's *Canterbury Tales* (Chaucer died in 1400). The meaning of unfamiliar words will become obvious if they are read aloud. "This nat unprofitably byfore tastid, lette us draw nere to the narracion of myracles."

### OF THE ANTHYPHONER

A CERTEYN MAN toke a way a boke from this place, that we callith an antiphonere, the whiche was necessarie to them that schulde syngre ynne the church, in that specialy that ther was nat at that tyme grete plente of bokys, in the place. Whan it was sowghte besily and not i fownde, it was tellid to Rayer the priour what was done of thee boke and he toke this harme with a softe herte paciently. At nyghtys tyme, whan as he was ynne his chambre to take his reste the glorious apostle of God, Bartholomew spake to hym and seyid, "sey Rayer, what is that, of whoeys loste, me presente, thus ye playne." And he seied "syr thy clerkis hadde a profitable boke to them, in the whiche to the honoure of God and of the, in the holy temple of thy glorie they were wownte to syngre; and now yf it be hidde yn any place, or stolyn a way, they know nat." "In the mornnyng eerly commaunde thyn hors to be redy, and hastily entre the cite and whan thou cummyste yn to the Jewes Strete, spare thy sporys, lose thy brydyll lette thyn hors to my governaunce, and yn to what howse thy hors willfully putte yn his fote, know welle of me, ther thy boke schall be fownde. Dowte no thyng, prudently and constawntly inquire." No more this i seid yn a moment he disparisshid. Rayer yn the mornnyng slyd owte of his bedde, and diligently all that was commaunde hym he exccutid, and with the enemyes of pees he spake pesibly; and the boke that he sowghte he fownde, and tok hit and broght hit hoome.

## A HISTORICAL SURVEY OF MEDICAL ETHICS

(Continued)

by ROBERT FORBES

Let us take a concrete case of the conflict between the law and professional etiquette. A doctor may become aware that another practitioner has committed an act against a patient professionally assessed as wrongful. The community, through its legislature or statutes or judges or guardians, may demand that he speak and denounce what he has seen in order that the crime may not go unpunished, while professional etiquette bids him preserve silence. The law may, on certain occasions, insist on his divulging the information he has acquired, but in so doing he should avoid securing any commercial advantage over his brother practitioner or laying any accusation or counter-charge which would bring the profession into disrepute.

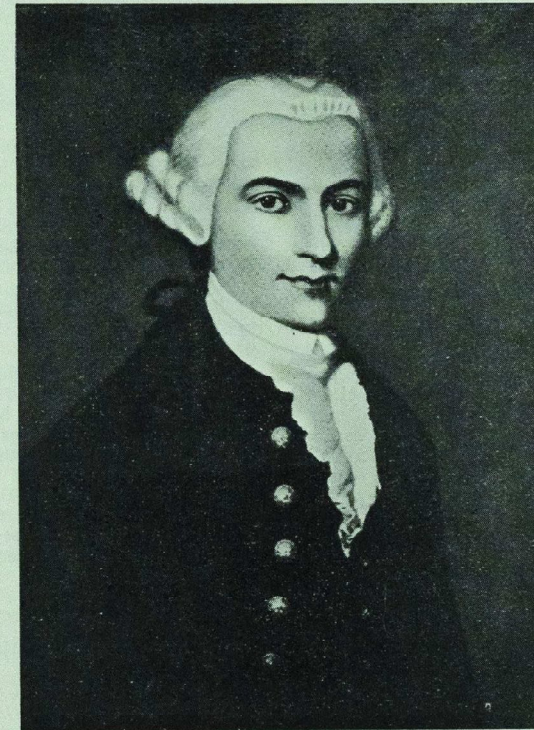
Professional secrecy is one of the most striking principles which underlie Percival's *Code* and also previous codes of ethics. It is a well-settled principle of modern medical ethics that a physician should hold inviolate the confidence of his patient which he had to obtain for a proper understanding of the case, and that he should not, by reason of superior special knowledge, give countenance to suggestions of a scandalous nature, especially about women.

The sad and cruel consequences of a failure to observe this last rule are exemplified in the celebrated case of Lady Flora Hastings, a lady-in-waiting at Queen Victoria's Court. In 1839 Lady Flora was on duty at Court performing the functions of a lady-in-waiting upon the Sovereign when her appearance suggested to some of her associates that she might be with child. One of them reported her suspicions to Sir James Clark, the Court physician, who at once fell in with the insinuation, and, after catechizing her, intimated that she "must be privately married, or at least ought to be so." This Lady Flora indignantly denied, and, to vindicate her character, demanded a consultation. Lord Melbourne reluctantly permitted a medical examination to be made, which at once established her chastity. Sir

James Clark and Sir Charles Clarke, the consultant, certified that:

"There are no grounds for believing that pregnancy does exist, or ever has existed." Lady Flora survived this humiliating ordeal only a few months. Sir James Clark, the Court physician, should have been more alert and circumspect, and by the observance of that prudence and delicacy which should ever characterize the physician in dealing with such conditions, he could have saved the lady and her friends much anguish and distress.

Another illustration of the consequences which may result from a doctor's tactless remarks is to be found in the noted case of *Kitson v. Playfair and wife* in 1896. In this case Dr. Playfair told his wife that Mrs. Kitson had had a recent miscarriage, although she had been away from her husband considerably more than a year, and the verdict given strengthens and fortifies the great doctrine of the preservation of the confidence of patients. Mrs. Kitson was the wife of Mrs. Playfair's brother. Mr. Kitson was not prosperous, and his brother gave him an annual allowance of £500, which, as a result of Dr. Playfair's unfortunate and damaging statement to his wife, was discontinued. At the trial the weight of expert testimony was that a placenta might be retained *in utero* for more than a year after a miscarriage. The damage was laid at £5,000, but the jury awarded the unprecedented amount of £12,000. Upon application for a new trial this amount was reduced by agreement to £9,200. In any case, the defendant was mulcted in heavier damages than the plaintiffs had tried to obtain in the first instance. The reason for this is probably to be sought in the strong British prejudice against tattling about womankind. The Mordaunt case in 1870, made the Prince of Wales less unpopular, because it was held that the evidence he gave in the witness-box was the only evidence which a man of the world could give in the circumstances. The slanders which drove Lady Flora Hastings and the wife of Sir Travers Twiss from Queen Victoria's Court, and even the statements made against the actress Adelaide



Thomas Percival

Neilson, which also came to a legal test, were not regarded with favour by the English people. Women may gossip among themselves and malign other women, but a spy or he-gossip is usually regarded as a cad. A physician, at all events, should be neither spy nor he-gossip.

Returning once more to Percival, he recognized the effect of legislation and the progress of civilization upon the conduct and duty of the physician. He lamented, as we do to-day, the passing of the family doctor. Team work, clinics, hospitals, and statutory functions of local authorities have all worked in the same direction. Medicine is becoming more and more recognized as a profession catering for the people rather than for

individual ambition. Its aim, the prevention of disease, is its own end, as by preventing illness the doctor is removing his means of gaining a livelihood. Although the ideal of the prevention of disease is assuming greater importance, it is difficult for the practitioner wholly to support a process which involves the loss of his status as a curative practitioner, and he must therefore retain to a certain extent a financial interest in the ills of humanity. Nevertheless it is his duty so to conduct his practice that the conflict between his ideals and his material needs is reduced to a minimum, and he will find inspiration and guidance in the high ethical traditions which he has inherited from his predecessors reaching back to Hippocrates.



CENTRAL ETHICAL COMMITTEE OF  
THE BRITISH MEDICAL ASSOCIATION

When the British Medical Association was founded in 1832 it had for one of its objects "the maintenance of the honour and respectability of the profession." A little later in its history it established a Committee known as "a Committee on medical ethics" but now known as the Central Ethical Committee.

The actual circumstance that brought about the establishment of the original Committee derived from the action of a Branch in expelling a President Elect, on account of unprofessional conduct in consulting with an unqualified person.

The Central Ethical Committee reports to the Council of the Association and to the Representative Body on its work, and on ethical pronouncements relating to differing aspects of medical practice. Questions are addressed to the Committee by members and organisations seeking guidance to avoid criticism of acting unethically.

The Central Ethical Committee considers complaints by one member against another on the propriety of his alleged professional behaviour in stated circumstances. It affords a full opportunity to the complainant and the respondent to present their opposing points of view and evidence. Witnesses are allowed to attend to support the protagonists. In the ultimate the Committee makes a pronouncement on whether or not the respondent has been guilty of an ethical offence, and, if so, may censure or recommend the Council to expel the Member from the Association.

Over the years a large number of decisions have been promulgated and published to the profession. These deal with professional secrecy, covering unqualified persons, irregular medical certification, dangerous drugs regulations, rules pertaining to consultation, self-advertisement, appearance in a broadcasting programme, patenting in the medical field, dichotomy and a host of other matters too numerous to mention.

The Members of the Committee are drawn from a cross-section of the profession. They are practitioners who have engaged in the hurly burly of medical practice and are familiar with its temptations and difficulties. Those who appear before this body "on trial" can rest assured that they will be judged by

a Committee with personnel of the highest integrity who approach their duties in a quasi judicial manner, anxious at all times to maintain the honour and interests of the profession and to smooth out difficulties arising often from a failure to see the other person's point of view.

There are in addition Ethical Committees attached to each division or branch of the Association where local disputes are examined as in a Court of first instance. Dissatisfied participants have the option of appealing to the Central Ethical Committee. Occasionally when feeling runs high in a local area, the division elects, as it can, to have the matter adjudicated by the Central Ethical Committee and so remove all suspicion of bias or undue influence.

As evolution plays an important part in other branches of medical work, so, in ethics, the evolutionary process can be seen in operation. Professional opinions and customs change, consequently the ethical code must change. New situations call for a reorientation of ideas, or a departure from standards appropriate to earlier years. The Central Ethical Committee does not hesitate to re-adjust itself to modern conditions when re-adjustment is indicated.

THE GENERAL MEDICAL COUNCIL

In 1858 the first Medical Act was placed on the Statute Book, whereby was established the General Medical Council charged with the responsibility of (1) keeping a Medical Register, (2) supervising the standards of instruction in medical schools, (3) preparing and issuing the British Pharmacopoeia and what is more pertinent to our consideration (4) maintaining discipline in the profession.

The General Medical Council is a body that can be regarded as protecting the interests of the public rather than those of the profession. From time to time it has made pronouncements on matters of an ethical order such as professional advertisement, the issue of medical certificates, notifications and medical reports, unqualified practice and the covering of unqualified or unregistered assistants, the contravention of the Regulations pertaining to dangerous drugs, canvassing for patients, the keeping of an open shop and association with unqualified women practising as midwives.

Some of these pronouncements are drawn together in a series of warning notices issued by the Council to members of the profession.

Under the Medical Acts (there have been many) the Council is authorised to erase the name of a practitioner who is convicted of a felony or misdemeanour in England, or of a crime or offence in Scotland or Northern Ireland. In addition it may receive a statutory declaration from a member of the public (medical or lay) alleging that a registered medical practitioner has acted in a manner calculated to be indicative of "infamous conduct in a professional respect." In these circumstances the Council, through its Penal Cases Committee, gives initial consideration to the facts alleged to determine whether there is a prima facie case to go to a hearing. If it decides affirmatively, the case is then sent to the Disciplinary Committee, consisting of nine or eighteen persons at the discretion of the President, who sits as the Chairman with a legal Assessor. This Committee affords to the contending parties a full opportunity to present the case for and against the charge. The Disciplinary Committee has power of subpoena and it administers the oath to witnesses.

The only penalty that the Committee can impose is that of erasure of the name of the offending practitioner from the Medical Register. An appeal from this decision can be received and heard by the Judicial Committee of the Privy Council. It often, however, suspends judgment on a case and requires the offender to appear before it after an interval of six months or a year to furnish reports on his conduct in the meantime. This particularly applies to persons who have been convicted of drunkenness whilst in charge of a car, and some other minor offences unworthy of the full penalty.

When a practitioner's name is erased from the Medical Register, he may further suffer the penalty of the withdrawal of his medical qualifications, according to the powers possessed by the Licensing Authority who gave him these qualifications. As an unregistered medical practitioner, he suffers certain dis-

abilities by withdrawal of legal authority to discharge certain medical duties. After a period of time the practitioner whose name has been erased may apply to the Council for its reinstatement in the Register.

There is a close liaison between the British Medical Association and the General Medical Council, and indeed so close that a complaint cannot in practice be lodged by the British Medical Association to the General Medical Council concerning a practitioner. Were a complaint lodged, it might result in the compulsory withdrawal from the hearing of that case of a large number of the members of the Disciplinary Committee owing to their membership of the Association acting as complainant.

The medical defence organisations frequently appear through their solicitors and counsel before the Disciplinary Committee alleging and seeking to prove misconduct on the part of a practitioner or defending a practitioner against whom such an allegation is preferred.

There is a constant confusion between the name of the British Medical Association and that of the General Medical Council and, even now, highly educated people and many press representatives are not fully aware of the wide difference of purpose, constitution and organisation applicable to these bodies.

There is a parallel that can be drawn between the British Constitution and medical ethics. In the former as in the latter there is a great deal that is unwritten though accepted by use and custom from time immemorial as being part and parcel of a code of conduct that must be observed in the affairs of men in their social and business relationships with one another. This is a *lex non scripta*. Some dicta concerning ethical behaviour have been reduced to ethical rules just as certain accepted forms of practice and obligations have been incorporated in Acts of Parliament and Statutory regulations. There is much that remains outside the ethical rules where principles have to be applied to learn the path to be followed and where conscience is the final arbiter.

*The first part of this article has appeared in the British Medical Journal and is reprinted by kind permission of the editor.*

*The illustration was supplied by the Wellcome Historical Museum. The original is a painting in the possession of the Manchester Philosophical Society.*

## A CASE OF HYPERPARATHYROIDISM

by P. J. SCOTT AND C. B. S. WOOD

*The earliest symptoms rarely lead to diagnosis. They may be recognised in retrospect as an accompaniment of hypercalcaemia, and include muscular weakness, nausea, anorexia, constipation, and bone pain.\**

A MARRIED WOMAN of 35 presented herself in Out-patients in April, 1955, complaining of low back pain. She dated her symptoms from a miscarriage in the eighth week of pregnancy one year previously. She had one daughter of 16, and these were her only two pregnancies.

In 1949 she had been admitted to the Royal Free Hospital with right-sided renal colic, and had spontaneously passed a ureteric calculus.

Following her miscarriage in the spring of 1954, she began to have aching pain in the lower back, brought on by walking and relieved by rest, and which was more severe two days before her menstrual periods. When severe the pain would pass down both legs and round into both groins. Salicylates and codeine gave her little relief. The pains became progressively worse, and by Christmas 1954, eight months after her miscarriage, she could hardly sit down, walk, or indeed move her legs at all during bad attacks, and she gave up her job.

Since the summer of 1954 she had had swelling of her ankles, brought on by exercise, and relieved by rest, and had been having to get up two or three times at night to pass her water. She was not short of breath and had no other urinary symptoms.

In January, 1955, she was seen at another London teaching hospital complaining of pain in her right lower chest, abdomen and groin—unlike her previous renal colic. She was found to have some tenderness in the right hypochondrium and right iliac fossa. Her haemoglobin was 61 per cent, and a catheter specimen of urine showed a trace of albumin, occasional leucocytes and red cells, and hyaline and granular casts. Chest X-ray and I.V.P. revealed no abnormality. The urine was examined by smear, culture and guinea-pig inoculation for tuberculous infection, all with negative results. Her E.S.R. was 8 mms per hour.

In March, eleven months after her miscarriage, she had a constant pain in her back

and lower limbs, made worse by exercise but no longer relieved by rest, and began to have similar pains in both her shoulders and her left elbow. The pain was little affected by salicylates, and kept her awake at night.

In April she was seen at this Hospital, complaining of pain as described, with consequent difficulty in walking, sitting and sleeping, ankle swelling on exercise, and nocturia. She admitted to occasional mild spasmodic dysmenorrhoea, to occasionally noticing a slight swelling in the front of her neck, and said that she had always been constipated and taken laxatives. She had no other urinary, cardiovascular, or other symptoms, and had not been losing weight. She was noted to have difficulty in flexing the hips, carious teeth, and a palpable, diffusely enlarged thyroid gland. Her haemoglobin was 84 per cent, W.B.C. 8,000, and W.R. negative. It was thought that she might have pelvic inflammatory disease with secondary arthritis, and she was referred to the Gynaecological Clinic, where no abnormality was found, but a gonococcal complement fixation test was suggested. This was done and proved negative.

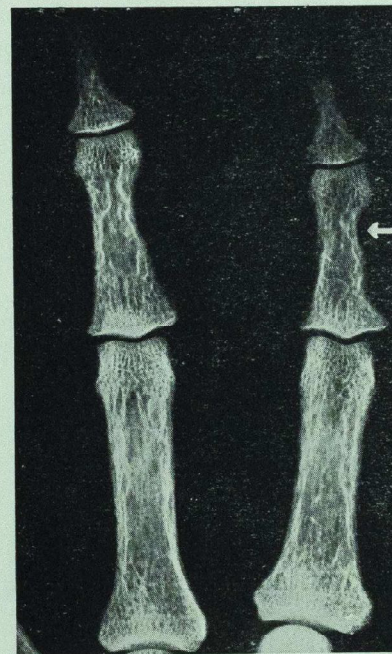
X-rays of her hips and lumbar spine showed some degree of osteoporosis of the pelvis and femora. Subsequent X-rays of the spine, skull, and hands showed widespread osteoporosis and multiple fractures of the ribs; the changes in the skull and hands being practically diagnostic of hyperparathyroidism. There was also very characteristic subperiosteal resorption of bone and typical lace-like osteoporosis in the phalanges of the hands.

She was admitted to Garrod Ward, and it is interesting to note that at this time she located the pain in her lumbar region, hips, knees, ankles, shoulders and left elbow, and it was even possible to elicit a history of redness and swelling of the affected joints. She also said that her bones seemed tender, and she admitted to nocturia and constipation. She had no symptoms of thyrotoxicosis.

On examination, springing of her pelvis and the lower parts of her legs caused pain, and a soft, smooth, diffuse enlargement of both lobes and the isthmus of her thyroid was found; but no other physical signs.

The mean value of six estimations of her serum calcium was 14 mgms per cent and of

operation was carried out. This revealed on the posterior aspect of the lower part of the right lobe of the thyroid gland a small tumour three quarters of an inch in diameter, which was removed. Histological section showed a well-circumscribed adenoma of the parathyroid with no evidence of carcinomatous



*X-ray of fingers showing subperiosteal resorption of bone (arrow) and lace-like osteoporosis in the phalanges.*

the serum phosphorus 2 mgms per cent. The serum alkaline phosphatase was 54.5 K-A units. The 24-hour urinary excretion of calcium was 460 mgms (normal maximum, 300 mgms) and the more easily performed Sulkowitch test gave a thick turbidity with the urine as compared with tapwater, indicating excessive calcium excretion.

After a two-week course of calcium and calciferol to improve her calcium balance as much as possible, she was transferred to Lawrence Ward, and an exploratory neck

change. Section of a nodular portion of the left upper lobe of the thyroid, removed at the same time, showed normal thyroid tissue with little evidence of cellular hyperplasia.

Post-operatively the serum calcium fell to 8 mgms per cent and she developed a positive Chvostek's sign, and paraesthesiae of her hands and forearms. She was discharged on calcium gluconate and calciferol.

This case is presented as an illustration of the difficulty in the early diagnosis of the condition. At the present time 60 per cent

of patients with proved primary hyperparathyroid disease show no bony disease, but present with nephrolithiasis. Primary hyperparathyroidism probably accounts for as much as 5 per cent of all nephrolithiasis.<sup>1</sup>

In this case the bone changes were picked up by skilled radiology and revealed the diagnosis, which was later confirmed by the biochemical changes; but in many cases the severity of the bone disease bears no relation to the severity of the chemical lesion.<sup>2</sup> This is well illustrated by another case—a woman of 57 from whom a parathyroid adenoma was removed this year at another hospital. She presented with renal colic and calculi, and had had a renal calculus removed for renal colic 20 years ago after her only pregnancy. Her serum calcium before operation was 13.4 mgms per cent, and her 24-hour excretion, 326 mgms, with a normal serum alkaline phosphatase. Extensive radiography, including her skull and hands, revealed no significant bone changes, and her only symptom attributable to hypercalcaemia was mild constipation.

In conclusion, a little more stress might be laid upon the significance of renal symptoms,

not only in diagnosis, but also in prognosis. One authority estimates an incidence of nephrocalcinosis of 80 per cent of all cases of hyperparathyroidism<sup>3</sup>, and another quotes one fatal and one severe case of progressive renal disease even following parathyroidectomy<sup>4</sup>.

#### ACKNOWLEDGMENT

We are very grateful to Professor Sir James Paterson Ross and Dr. Graham Hayward, who treated this patient, for encouraging us to write this account, and for much kindly guidance in its preparation.

#### REFERENCES

- \* Thorn, Forsham and Goldfein, *Harrison's Principles of Internal Medicine*. 2nd Edition, H. K. Lewis, London, 1954, p. 628.
- <sup>1</sup> Croidman, *Surgery, Gynaecology and Obstetrics*, 100, 1955, 689.
- <sup>2</sup> Albright, Sulkowitch and Bloomberg, *American Journal of Medical Science*, 193, 1937, 800.
- <sup>3</sup> Black, B. M., *Hyperparathyroidism*, American Lecture Series Publication No. 173, Springfield, Ill., 1953.

#### Births

CONNELL.—On August 19, to Marjorie (*née* Gilham) and Dr. Philip H. Connell, a brother for Michael.

Dews. On July 28, to Edmund and Dr. Lore Dews (*née* Feldberg), a daughter (Diana Caroline).

GREY-TURNER.—On August 31, to Liliastom (née Tomlinson) and Dr. Elston Grey-Turner, a son.

LEVIN.—On August 21, to Alice (*née* Rudinger) and Dr. Arthur Levin, a daughter.

MASKELL.—On August 4, to Rosalind (*née* Rewcastle) and Dr. John Maskell, a son (Giles Francis).

STEEL.—On August 25, to Rosamund (*née* Sapwell) and Dr. Peter Steel, a daughter.

THOMSON.—On June 3, to Dora and Dr. W. McL. Thomson of Premaydene, Tasmania, a daughter (Piona Mary).

#### Engagements

MURLEY-MACDONALD. The engagement is announced between Mr. A. H. G. Murley, F.R.C.S. and Miss A. T. Macdonald, B.A.

NYE-MAHALSKI. The engagement is announced between Mr. E. R. Nye and Miss P. A. Mahalski.

STURDY-GILLIBRAND. The engagement is announced between Dr. D. C. Sturdy and Miss S. C. Gillibrand.

#### Deaths

GRIFFIN. — On July 28 at Bourne Crest, Farnham, Surrey, Walter Bristow Griffin, F.R.C.S. Qualified 1907.

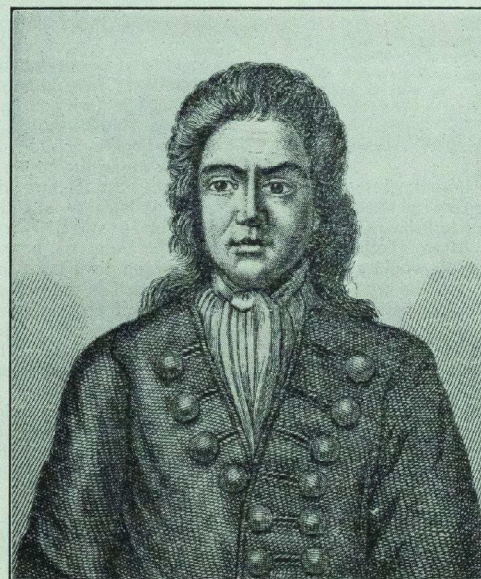
MARTIN-JONES.—On July 24 at Salisbury, J. D. Martin-Jones, M.R.C.S., L.R.C.P., aged 48. Qualified 1934.

## A FAMOUS PATIENT

### NICHOLAS HART—THE GREAT SLEEPER

NICHOLAS HART became the subject of general notice and conversation, from the circumstance of a lethargic fit, that seized him on the 5th of August, 1711, to the 11th of the same month. His friends, after having tried every means in their power to rouse him

him, by confederate knaves, as an object of charity and commiseration. In his speculation, Mr. Hart entirely succeeded; and, it seems, from the symptoms of his periodical sleeping fit, faithfully detailed by a gentleman of Lincoln's Inn\*, that Hart slept in order to



Nicholas Hart

from the dormant state he lay in, had him conveyed to St. Bartholomew's Hospital, where he remained during the above period, without taking the least refreshment of any kind whatever, excepting sleep; though several experiments were made on his person to promote resuscitation.

It appears, however, there was a greater portion of art than nature in his unnatural slumber; and that he had purposely taken narcotic drugs, to produce the effect desired, namely, to procure money to be raised for

be maintained in ease and comfort when he awoke, and that he gained more by his rest than others by their industry; and, in short, wealth flowed so fast upon him, that he obtained sufficient to support others, besides saving his own provisions, while he carried on his profitable farce! What use Hart put the money to he had thus raised we are not informed; but Mr. Addison, in noticing the circumstance, says, "Nicholas Hart, who slept last year in St. Bartholomew's Hospital, intends to sleep this year at the Cock and

Bottle, in Little Britain," probably glancing at a similar attempt to raise contributions on the credulous part of the community.

\*The symptoms this gentleman observed in Hart were, that

"On the first of the month he grew dull,  
On the second appeared drowsy,  
On the third fell a yawning,  
On the fourth began to nod,  
On the fifth dropped asleep,  
On the sixth was heard to snore,  
On the seventh turned himself in his bed,  
On the eighth recovered his former posture,  
On the ninth fell a stretching,  
On the tenth about midnight awaked,  
On the eleventh in the morning, called for a little small beer."

The same gentleman observes, "I believe it a very extraordinary circumstance for a man to gain his livelihood by sleeping, and that rest should procure a man sustenance, as well as industry; yet so it is, that Nicholas Hart got last year enough to support himself for a twelvemonth;" and adds, "I am informed that he has had this year a very comfortable nap."

The experiments to promote resuscitation were probably of a similar kind to those used by M. Brady, Physician to Prince Charles of Lorraine, on Elizabeth Alton, another extraordinary sleeper; though it would appear, if the following account is to be trusted, that in her case the underlying pathology was something more than the love of gold.

A woman, named Elizabeth Alton, of a healthy strong constitution, who had been servant to the curate of St. Guilain, near the town of Mons, about the beginning of 1738, when she was about thirty-six years of age, grew extremely restless and melancholy. In the month of August, in the same year, she fell into a sleep which held four days, notwithstanding all possible endeavours to awake her. At length she awaked naturally,

but became more restless and uneasy than before; for six or seven days, however, she resumed her usual employments, until she fell asleep again, which continued eighteen hours. From that time to the year 1753, which is fifteen years, she fell asleep daily about three o'clock in the morning, without waking until about eight or nine at night. In 1754, indeed, her sleep returned to the natural periods, for four months, and, in 1748, a tertian ague prevented her sleeping for three weeks.

On February 20, 1755, M. Brady, with a surgeon, went to see her. About five o'clock in the evening, they found her pulse extremely regular; on taking hold of her arm it was so rigid, that it was not bent without much trouble. They then attempted to lift up her head, but her neck and back were as stiff as her arms. He hallooed in her ear as loud as his voice could reach; he thrust a needle into her flesh up to the bone; he put a piece of rag to her nose flaming with spirits of wine, and let it burn some time, yet all without being able to disturb her in the least. At length, in about six hours and a half, her limbs began to relax; in eight hours she turned herself in the bed, and then suddenly raised herself up, sat down by the fire, ate heartily, and began to spin.

At other times, they whipped her till the blood came; they rubbed her back with honey, and then exposed it to the stings of bees; they thrust nails under her finger-nails; and it seems these triers of experiments consulted more the gratifying of their own curiosity than the recovery of the unhappy object of the malady.

(From "Memoirs of Remarkable Persons")

## SO TO SPEAK...

**They stop at nothing these days**

CHIEF ASSISTANT: "Tell me, madam, have you been treated here before?"

OLD DEAR: "Oh! yes, doctor. I had my tonsils removed by the T.N.T. specialist."

## SPORTS NEWS

### CRICKET

#### 1st XI RESULTS:

**Cup Match:** v. U.C.H. June 2 at Chislehurst. U.C.H. 153 out; Bart's 127 out (Nichols 48). Lost.

v. **Horlicks C.C.** June 12 at Slough. Horlicks 155—8 dec. (Batterham 3 for 10); Bart's 52 out. Lost.

v. **Old Roans C.C.** June 19 at Chislehurst. Old Roans 201—7 dec. (Bloomer 6 for 69); Bart's 197—8 (Nichols 75, Marks 44). Drawn.

v. **Hornsey C.C.** July 2 at Hornsey. Hornsey 146—6 dec.; Bart's 106 out (Batterham 51). Lost.

v. **Past.** July 3 at Chislehurst. Past 173 (A. Clapham 41 n.o., Nichols 5 for 52); Present 166 (Bloomer 53). Lost.

v. **Incogniti C.C.** July 9 at Chislehurst. Bart's 167—9 dec. (Nicholson 39); Incogniti 168—6 (McKenzie 5 for 57). Lost.

v. **Hampstead C.C.** July 10 at Chislehurst. Bart's 115; Hampstead 117—3. Lost.

v. **R.N.V.R.** July 24 at Old Paulines' Ground. R.N.V.R. 149 (Bloomer 5 for 52); Bart's 110. Lost.

#### THE SUSSEX TOUR

v. **Hurstpierpoint C.C.** July 31. Hurstpierpoint 93 (Nichols 5 for 25); Bart's 94—8 (McKenzie 30 n.o.). Won.

v. **St. Andrew's, Burgess Hill.** August 1. St. Andrew's 235—8 dec.; Bart's 199 (Downham 44). Lost.

v. **Rottingdeane C.C.** August 2. Rottingdeane 220—9 dec.; Bart's 54 out. Lost.

v. **Littlehampton C.C.** August 3. Littlehampton 95 (Nichols 4 for 6); Bart's 97—5. Won.

v. **Barcombe C.C.** August 4. Barcombe 191; Bart's 125. Lost.

v. **Keymer and Hassocks C.C.** August 5. Bart's 213—8 dec. (Nichols 52 n.o., Nicholson 43); Keymer and Hassocks 121 (Nichols 4—22). Won.

#### THE CUP MATCH

The Cup Match was played at Chislehurst on Thursday, June 2. Bart's were without two regular members of the team—their Captain, I. R. Nicholson; and D. Rosborough. U.C.H. won the toss and elected to bat. After an early success by Garrod, both he and McKenzie settled down to some accurate bowling; scoring was slow. The second wicket put on 37, but it was the third wicket partnership of 66 which laid the foundations of U.C.H.'s innings. After lunch the last five U.C.H. wickets fell for the addition of only 48, thanks to some fine bowling by Bloomer, Nichols and McKenzie. Thus at 4 o'clock, Bart's were set to get 154 runs to win. The two U.C.H. bowlers bowled unchanged and

proved to be too much for most of the Bart's batsmen, only Nichols, Bower and Batterham offering any serious resistance. Nevertheless the game remained in the balance until the last wicket fell, 16 runs short of the U.C.H. total.

CUP TEAM: A. C. S. Bloomer (Capt.), G. B. Gillett, A. P. Marks, D. W. Downham, J. C. McKenzie, J. Nichols, H. Bower, J. Owens, A. Garrod, J. Batterham, R. Bonner Morgan.

#### Leading Averages

BATTING:	Not Highest			
	Inn.	out	Score	Runs Av.
J. Nichols	19	2	75	459 27.00
H. Bower	18	0	78	357 19.83

#### BOWLING:

	Overs Mdns. Runs Wkts. Av.			
J. C. McKenzie	188	47	506	36 14.25
J. Nichols	208.4	41	581	38 15.26

#### Analysis of Results

Played 22. Won 6. Lost 13. Drawn 3.

### TENNIS

The tennis season to date has proved rather disappointing. In previous years many matches had to be cancelled because of rain; however, despite this year's fine weather, a number of matches were not played. Some were cancelled because of travelling difficulties during the rail strike; but the majority were cancelled, invariably at the last moment, by the opposing teams who found that they were unable to raise a team. It is incredible that institutions with two hundred students are unable to find six people willing to play tennis; however, such is the case, for six of our 1st VI matches were cancelled for that reason.

Results this season show that although Bart's are able to raise two teams consistently throughout the season, they are not always capable of providing a winning side.

**1st VI results:** Matches played 10; won 4, lost 5, drawn 1. Matches cancelled, 8.

In fairness to the players it must be noted that invariably the matches were closely fought, the result being undecided until the last game. Of the individual matches played, that against Hampstead West Heath L.T.C. springs to mind as an enjoyable social and sporting contest; so does that against the Roehampton Club, when we played on the courts used for the preliminary rounds of Wimbledon.

The 2nd VI had a more successful season although, again, this was spoilt by cancellation of matches.

**2nd VI Results:** Matches played 4, won 3, lost 0, drawn 1. Matches cancelled, 4. (A few matches are still to be played.)

## FENCING

The results of the fencing matches for the latter part of the season are as follows:

v. Westminster Hospital. 4 F. Fights 8-8. Won on hits 50-51.

This is the first time since the Club was formed that a second team match has been fought. A very enjoyable evening was spent, though the lack of an experienced president prolonged the length of the match. Spurred on by this relative success a beginners' fixture was arranged with the Middlesex Hospital; unfortunately this had to be cancelled due, indirectly, to the railway strike.

v. London School of Economics. 4 F. Fights 8-8. Won on hits 50-59.

This match, the first round of the de Beaumont Trophy, was keenly fought throughout and the finish was very close.

v. St. Thomas's Hospital. 4 F. Lost 14-2.

St. Thomas's won in a leisurely style due to their undoubted superiority and our lack of training. This match was the second round of the de Beaumont Trophy, which St. Thomas's went on to win.

Several members of the Club went to Chelsea Town Hall in June for the Couble Memorial Cup individual sabre competition. The Hungarians, who are perhaps the leading exponents of sabre fencing, were very much in evidence and succeeded in taking five of the first seven places.

It is hoped that anyone new to Bart's who is interested in fencing will come to the Annual General Meeting or to one of the training afternoons (Details are given on the Notice Board). Previous experience is definitely not essential, but novices are warned that they cannot expect to execute the more spectacular movements *ab ovo*.

## HOCKEY

At the Annual General Meeting of the Club the following Officers were elected for the year 1955-56:—

President: Prof. Sir James Paterson Ross.  
Vice-Presidents: Professor A. Wormall, Dr. G. Ellis, Mr. P. H. Jayes, C. B. T. Grant, Esq.  
Captain: R. P. Doherty.  
Secretary: I. R. Nichols.

Match Secretary: D. R. Dunkerley.  
Financial Secretary: C. S. Goodwin.  
Preclinical Reps.: D. S. Wright, J. A. Garrod.

The resignation of Dr. Cunningham from Vice-Presidency, due to his appointment at the Royal College of Surgeons, was accepted with regret. The Club Committee wish to thank Professor Cunningham for his sustained enthusiasm and the help which he gave to the Club whilst in office.

In the coming season a full fixture list has been arranged for both 1st and 2nd XI's, and in addition a team has been entered for the Bournemouth six-a-side tournament on September 24. The 1st XI will go on tour to Cambridge from November 4-7.

Prospective members are asked to get in touch with one of the committee members. New players from among the pre-clinical students will be particularly welcome.

## Six-a-Side Tournament at Bournemouth

A team was entered for the Bournemouth Tournament on the 24th September. The team, despite rigorous training, achieved no greater success than that of last year as far as results show. It was defeated by Stoats 1-2 in the first round, and lost to Bournemouth, 1-2, in the Plate competition.

However, it was encouraging to see that the team had grasped some of the special skills of six-a-side hockey. In the match against Stoats, luck and a penalty Bully went against the Hospital. Batterham scored our only goal from a well angled shot; but apart from this finish was lacking. In the game against Bournemouth Batterham put the Hospital ahead; but the Hospital tired and mistakes in defence cost two goals. With two years of six-a-side hockey behind them, there is hope that Bart's will do better next year.

TEAM: J. B. Nichols, C. S. Goodwin, C. B. T. Grant, E. J. Batterham, D. R. Dunkerley, A. S. Tabor.

## RUGBY

## 1st XV Fixtures for 1955-56

Sept. 21	Berkshire Wanderers	A
„ 24	Stroud	H
Oct. 1	Trojans	A
„ 8	Woodford	H
„ 15	R.M.A. Sandhurst	A
„ 19	Cambridge LX Club	A
„ 22	Old Whitgiftians	A
„ 29	U.S. Chatham	A
Nov. 5	Penzance	A
„ 7	Devonport Services	A
„ 9	Paignton	A
„ 12	Rugby	H
„ 19	Old Alleynians	A
„ 26	Metropolitan Police	A
Dec. 3	Esher	A
„ 10	Saracens	H
„ 17	Old Cranleighans	H
„ 31	Middlesex Hospital	A
Jan. 7	Old Rutlishians	A
„ 14	Taunton	A
„ 18	London University	H
„ 21	Cheltenham	A
„ 28	Oxford Greyhounds	A
Feb. 4	Old Merchant Taylors	A
„ 11	Old Paulines (a.m.)	A
„ 18	Streatham	A
„ 25	Old Haberdashers	H
Mar. 3	Old Millhillians	H
„ 10	Loughboro' College	H
„ 17	Aldershot Services	H
„ 24	Harlequin Wanderers	A

## HOSPITAL APPOINTMENTS

## Medical Unit

## Director.

Dr. E. F. Scowen from 1.10.55  
(vice Professor R. V. Christie)

## Harvey and Luke Wards

## Physician

Dr. R. Bodley Scott from 1.10.55  
(vice Dr. E. F. Scowen)

## Dr. Bourne's Firm

## Acting Assistant Physician

Dr. J. M. S. Knott (Casualty Physician).  
Temporary Acting Assistant Physician in addition to his duties as Casualty Physician.

## Chief Assistant

Dr. J. P. D. Thomas from 1.10.55 (vice Kok).

## Junior Registrar

Dr. G. C. R. Morris from 1.10.55 (vice Dossetor).

## Surgical Professorial Unit

## Assistant Surgeon

Mr. G. W. Taylor from 1.7.55 (succeeds Mr. Kinmonth).

## Mr. Hosford's Firm

## Chief Assistant

Mr. N. A. Green from 1.10.55 (vice Robinson).

## Mr. Corbett's Firm

## Chief Assistant

Mr. R. M. T. Walker-Brash from 1.6.55.  
Junior Registrar  
Mr. R. V. Fiddian from 1.9.55 (vice Philip)

## Orthopaedic Department

## Chief Assistant

Mr. J. N. Aston from 17.10.55 (vice Shephard).

## Pathology Department

## Senior House Officer

Mr. R. G. Huntsman from 1.7.55.  
Senior House Officer  
Mr. B. S. Jones from 1.10.55 (vice Rees).

## Anaesthetics Department

## Senior House Officer

Mr. T. M. Young from 1.9.55.  
Senior House Officer  
Mr. J. P. N. Hicks from 1.9.55.

## Radiotherapy Department

## Senior House Officer

Mr. H. Horwitz from 1.10.55.

## RECORD REVIEWS

## HAYDN

Symphony No. 88 in G major (Letter V)  
Op. 56, No. 2.

Symphony No. 101 in D major (The Clock)  
Op. 95, No. 2.

The Vienna Philharmonic Orchestra conducted by  
Karl Münchinger. L.P., 12in. LXT 5040.

Some uncomplimentary things have been said about this recording, and so when I came to listen to it for the first time, I expected something rather poor. However, although this is certainly not an outstanding recording, I did not think it was as bad as all that.

I liked the First Movement of No. 88; there

is plenty of life and bite about it; the Second Movement, however, is rather disappointing. It is not intense enough, and towards the end appears to drag. Mr. Münchinger tries to make the Minuet of the Third Movement grand and pompous; the result is rather heavy, but amends are made in the last movement, which just bubbles with good humour.

The "tick-tock" of the "clock" in the Slow Movement of No. 101 is played delightfully; the bassoon and strings give that air of unhurried precision and regularity. The Minuet is again rather ponderous, lightened a little by a delicately played Trio. The First and Last Movements are adequate.

## HANDEL

## Concerti Grossi. Opus 6.

No. 5 in D. major. No. 6 in G. minor.

No. 7 in B Flat major. No. 8 in C. minor.

The Boyd Neel String Orchestra conducted by  
Boyd Neel. Harpsichord: Thurston Dart.  
L.P.: 12in. LXT 5042.

The twelve Concerti Grossi from Opus 6 are available on three L.P. 12in. records. This, the second in the series, carries numbers 5-8.

Immediately one begins to listen to this recording one is aware that Dr. Boyd Neel and his Orchestra are in complete command. Every note is played with masterly precision, yet flexibility remains; this, with good recording makes a superb performance. Balance is excellent; in the fugues the part playing is remarkably clear, each entry being easily heard; and throughout, the harpsi-

chord can only just be heard, sufficient to give the required percussive flavour  
A highly recommended recording.

**RAWICZ AND LANDAUER, Volume 1. The music of Johann Strauss arranged by Rawicz and Landauer. L.P., 12in. L.K. 4094.**

Although these arrangements by Rawicz and Landauer are reminiscent of the Music Hall, the Strauss melodies are unspoiled; actually, the occasional use of the arpeggio accompaniment by the second piano is most effective.

Throughout, these two artists play perfectly together, changes in time causing no difficulty. I was also impressed by their delicate playing in the quieter passages, and the way that they get the buoyant rhythm in the waltzes, by giving the lift on the second and third beats of the bar.

However, after forty minutes of Strauss, I was beginning to wish that they would play something by somebody else.

## EXAMINATION RESULTS

## UNIVERSITY OF LONDON

Special First Examination  
for Medical Degrees  
June, 1955

## Pass

Hartley, J. A.	King, D. E. L.
James, S. E.	Renn, G. W. T.
Kennedy, K. C.	Robson, J. R.
Kilroy, A. W.	Tuftt, I. J.

The following have qualified for  
exemption from the First Medical

Barraclough,	Davies, R. R.
G. P. M.	Geach, A. R.
Bartlett, J. J. D.	Morrison, J. D.
Benedikz, J. E. G.	Theobald, G. M.
Bratton, L. W.	Thomas, A. H.
Brown, M. D.	Thomas, L. R.
Cassell, P. G.	Watkins, A. V.
Darmady, J. M.	Weaver, P. C.

Special Second Examination  
for Medical Degrees  
June-July, 1955

## Pass

Bannerman-Lloyd, F.	O'Keeffe, C. J. M.
Cawley, M. I. D.	Phillips, R. M.
Davies, D. J. C.	Price, D. J.
Gould, A. M.	Richards, H. M.
Law, H. M. I.	Waters, W. E.
Neely, J. A. C.	

First Examination  
June, 1955

## Pharmacology

Bloomer, A. C. S.	Millard, F. J. C.
Langham, G. D.	

Final Examination  
July, 1955

## Pathology

Dawrant, A. G.	Lytton, A.
Lloyd, D. B.	Nash, D. J. R. F.

## Medicine

Canning, W. C.	Menage, J. A.
----------------	---------------

## Surgery

Austin, S.	Gray, A. J.
Black, D. H.	Lytton, A.

## Midwifery

Batterham, F. I.	Greenwood, R. A.
Black, D. H.	Lytton, A.
Farrar, J. F.	Menage, J. A.

The following have completed the  
examination for the Diplomas

## M.R.C.S., L.R.C.P.

Black, D. H.	Gray, A. J.
--------------	-------------

## BOOK REVIEWS

## COMMON SKIN DISEASES

By A. C. ROXBURGH, M.A., M.D.(Cantab.),  
F.R.C.P.(Lond.). H. K. Lewis & Co.,  
Ltd., London. 1955, pp. xxxi + 515.  
8 colour plates: 214 illustrations.

THE AUTHOR dedicated every edition of this book to his clinical clerks, and it was only a day or so after he had made the final corrections to the proofs of this edition that we learned with great sorrow of his sudden death. Roxburgh's text book has served many generations of clinical clerks since it was first published in 1932, and they have carried it with them and used it gratefully when they have left the Hospital and gone into practice not only in England but in many places in the world. This volume is a worthy successor to its predecessors.

The particular appeal of the work is that it is essentially practical; it embodies a certain amount of theory, but this is always applied to practical ends. As an example one may quote from p. 463 where, after discussing the nature and use of extracts made from the plant *Ammi majus*, the author writes: "This treatment cures about 15 per cent, improves another 15 per cent of cases, and relapses may occur even in these, so it is not of much practical use at present." It is seldom that one finds such a direct and informative statement which tells the reader, without any quibbling, exactly what he wants to know. In other parts of the book information is given as succinctly.

Besides small insertions through the book to bring it up to date, the principal change is the addition of paragraphs which deal with the following: the latest antibiotics, cortisone and ACTH, the L.E. phenomenon and the L.E. cell, Bisgaard's treatment of varicose ulcer, the use of isoniazid in lupus vulgaris and of mepacrin in lupus erythematosus, keratoacanthoma, malignant melanoma, dermatitis due to detergents, ocular lesions in rosacea and recent work on the histology of pemphigus, pemphigoid and dermatitis herpetiformis and on phrynoderma and dysidrosis.

The scope embraces all dermatological subjects which the general practitioner is likely to require. The book is excellently produced, and the illustrations, the majority

Continued overleaf

The Bacterium at  
the Breakfast Table

"Eat up your nice flannel," the clothes-moth is credited with saying to her child, "or you won't get any mink."

Bacteria have no mothers. They merely split into two, and it would puzzle even a Freudian to discern a mother-child relationship between the halves. This method of reproduction, besides sparing them many complexes, enables them to eat whatever they like. Nature, however, is a universal mother, and one of the old school; she sees to it that they eat the right things, or else.

I need hardly remind you that the bacteria which cause disease are very fond of battenning on the likes of you and me. And what is it, you may well ask, that they find so delicious?

Well, one of the things, which it seems we keep always on the menu, is known to biochemists by the insufferable name of . . .

If only we had space for the rest of this instructive medical essay, which appeared originally in *The Times*, you could read it here. What we have got, however, is a collection of these diverting articles from the same celebrated pen. Would you like a copy of "The Prosings of Podalirius"? Just drop us a card at the address below.

## VITAMINS LIMITED

DEPT. (G.6)

Upper Mall, London, W.6

## Makers of

BEHAX	VITAVEL SYRUP	VITASPRIN
BECOVITE	BEFORTISS	PREGNAVITE
FERTILOL CREAM	CHOLINVEL	ETC.

from photographs taken by the author, are remarkable. The index shows the same high standard as the text. Undoubtedly an 11th edition will be required, and whoever undertakes this task will find it difficult to improve in any way on the standards set by Dr. Roxburgh; he will do well if he can maintain the work at its present high level.

R. M. B. MACKENNA.

**MODERN TRENDS IN GASTRO-ENTEROLOGY.** Edited by F. Avery Jones. Butterworths Ltd.

Dr. Avery Jones has certainly achieved his aim in the production of this work, and recent progress in the field of gastro-enterology has been skilfully presented against a background of established knowledge. Although the Editor makes no claim that the book is completely comprehensive, there is in fact very little in this branch of medicine which has not received adequate mention. The 45 well-known contributors are to be congratulated on the stimulating and lucid manner in which they have presented their subject, and the reader cannot fail to be impressed either by the advances of recent years or by the scope for further research in the future. In a work of such a uniformly high standard, it may be considered invidious to mention any section specifically, but of particular interest are the chapters on diaphragmatic hernia, fat absorption and steatorrhoea, and the relationship between the alimentary tract and the cardio-

vascular system in disease.

Criticism of a few minor points is all that is possible. Dr. K. D. Keefe might have mentioned the occasional acute abdominal emergency produced by leakage from or rupture of an arteriosclerotic abdominal aneurysm, and Mr. R. T. Payne could have included treatment with Hexamethonium compounds as a cause of xerostomia. Mr. R. Delsey, in his section on hiatus hernia, is rather scornful of medical treatment but he is, at the same time, unable to be dogmatic about the results of surgery. Mr. G. H. Wooller gives very scanty details of the medical treatment of cardiospasm and Mr. Ivor Lewis mentions the pre-operative use of Digitalis in patients undergoing surgical operations in close proximity to the heart. Quinidine would probably be a more rational drug to use in such cases. Dr. W. T. Cooke is surely in error in stating that an M.C.H.C. below 28% is the indication for giving Iron to an anaemic patient—a figure below 32% is usually taken to mean Iron deficiency.

These criticisms apart, the book deserves nothing but praise. Each section has a comprehensive bibliography and the technical production is in keeping with the high standard associated with the name of Butterworth. Dr. Avery Jones is to be congratulated both on his choice of collaborators and their subjects. As he points out in his introduction, gastro-enterology is not yet an established speciality in this country, but this work has surely brought us nearer to the day when that state of affairs will no longer obtain.

R. C. KING

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LIX

NOVEMBER 1955

No. 11

## EDITORIAL

*As my poor father used to say  
In 1893,  
Once people start on all this art  
Good-bye, moralitee!  
And what my father used to say  
Is good enough for me.*

OVER A THOUSAND people visited the Bart's Art Exhibition, held in the Great Hall this October. On show were nearly two hundred works of art, including oil-paintings, water-colours, pottery and sculpture, contributed by sixty members of the Medical, Nursing and Lay Staff of the Hospital, both past and present. The Exhibition, like its three predecessors, was a great success and the organizing committee must seriously consider the possibility of holding one regularly every two or three years.

The Exhibition was opened by Lady Kelly, wife of Sir Gerald Kelly, ex-president of the Royal Academy. Lady Kelly admitted that she had always been rather frightened of doctors and nurses; they had an air of knowing something about her she didn't know herself. Many of the reporters covering the preview evidently shared this fear and were obviously disappointed to find that the frequently macabre and dramatic happenings of a doctor's life were not reflected in his paintings. As the *Daily Mail* commented: "The exhibition was a reminder that doctors and nurses are really quite normal people."

Some of the exhibits have been selected for criticism by our art correspondent, whose report, together with photographs, appears on page 346. Our own favourite among the paintings was Miss Rhoda Biffin's *Girls Skipping*; while Lady Kelly embarrassed the exhibition secretary, Mr. John Chalstrey, who was showing her round, by praising his unusual still life.

Nowadays, when the names of Modigliani and Picasso, introduced, ever so casually, into the tea-time conversations of suburbia,

can no longer be relied on to quicken the pulse and raise the eyebrows; it is difficult to imagine the opposition faced by the organizers of that first exhibition in 1938. The opinions of *l'homme moyen sensuel* rarely find their way into the correspondence columns; but judging by the reckless accusations of obscenity that were hurled at Gill's harmless design for the *Journal* cover, the following letter must have been fairly representative. (*S.B.H.J.*, 46, 1938, p. 312).

"With mingled shame and disgust I observed the most pornographic exhibition of my life. I have always suspected that no true medical student, imbued with the great tradition of healing, could find time to do anything else, with the exception of the requisite amount of exercise necessary to sufficiently obtain *mens sana in corpore sano* . . . in my student days we all played Rugby football, and it must be a sign of these degenerate days that despite the purchase of the new ground these young "men" seem to find outlets for their energies of which we should have been ignorant at their age in my day, and of which we should have scorned to be aware. I hope the authorities will discourage an activity which thus lowers the prestige and honour of Rahere's Hospital."

Old Bart's men need have no fear; their Alma Mater has successfully withstood the corrupting influences of five art exhibitions. The English Channel still separates Smithfield from Montmartre; the jugs on the refectory tables still contain just plain water. As for Rugby Football, that traditional spare-time activity of the medical student, we can present an encouraging report: the

## BOOKS — NEW and VALUABLE

### Biochemistry for Medical Students

By W. V. Thorpe, M.A., Ph.D.  
New (Sixth) Edition 48 Illustrations. 27s. 6d.

### A Short Textbook of Midwifery

By G. F. Gibberd M.B., M.S., F.R.C.S., F.R.C.O.G.  
New (Sixth) Edition, 199 Illustrations. 30s.

### A Short Textbook of Surgery

By C. F. W. Illingworth C.B.E., Ch.M., F.R.C.S. (Edin.).  
New (Sixth) Edition 13 Plates and 227 Text-figures. 37s. 6d.

### Forensic Medicine

#### A Textbook for Students and Practitioners

By Sir Sydney Smith, C.B.E., M.D., F.R.C.P., LL.D., F.R.S. (Edin.), and F. S. Fiddes, O.B.E., M.D.  
New (Tenth) Edition. 173 Illustrations. 40s.

### Textbook of Gynaecology

By Wilfred Shaw, M.A., M.D., F.R.C.S., F.R.C.O.G.  
Sixth Edition. 4 Plates and 304 Text-figures. 27s. 6d.

### The Essentials of Materia Medica, Pharmacology and Therapeutics

By R. H. Micks, M.D., F.R.C.P.I.  
Sixth Edition. 24s.

Also by Professor R. H. Micks

**Approach to Clinical Medicine** 8s. 6d.

### Human Physiology

By F. R. Winton, D.Sc., M.D., and L. E. Bayliss, Ph.D.  
New (Fourth) Edition. 236 Illustrations. 32s.

### Diseases of Infancy and Childhood

By Wilfrid Sheldon, C.V.O., M.D., F.R.C.P.  
New (Seventh) Edition. With 18 plates (3 in Colour) and 25 Text-figures. 50s.

### Clinical Endocrinology

#### For Practitioners and Students

By Laurence Martin, M.D., F.R.C.P. and Martin Hynes, M.D., M.R.C.P.  
New (Second) Edition. 39 Illustrations. 20s.

### Essentials of Orthopaedics

By Philip Wiles, M.S., F.R.C.S., F.A.C.S.  
New (Second) Edition. 7 Coloured Plates and 393 Text-figures. 55s.

### An Introduction to Functional Histology

By G. E. Bourne, D.Sc., D.Phil.  
98 Illustrations. 21s.

### Synopsis of Regional Anatomy

By T. B. Johnston, C.B.E., M.D.  
Seventh Edition 20 Plates and 17 Text-figures. 22s. 6d.

### An Approach to Clinical Surgery

By G. H. C. Ovens, O.B.E., M.B., B.S., F.R.C.S.  
118 Illustrations. 22s. 6d.

J. A. CHURCHILL LTD., 104 GLOUCESTER PLACE, LONDON W.1

game is played by well over a quarter of the students, a greater proportion, in fact, than in the pre-war years.

The echoes of Victorian prudery are dying away, and there can now only be a few who will say that painting is an unworthy pastime for the medical student.

#### Hospital Physicians' Society

The Hospital Physicians' Association held its Annual General and Scientific Meeting at Bart's on September 30th and October 1st.



*Professor Rotblat welcomes the Mayor of Moscow, Mr. Yasnov, during his visit to the Hospital. Sir George Aylwen (Treasurer) stands on the Professor's left, Sir Denys Lowson and Sir Frederick Wells on the right.*

The Society was formed in 1943 for the discussion and exchange of views of the special problems of hospital physics. One of its principal founding members was Professor F. L. Hopwood, late Professor of Physics of the Medical College. The Association has grown from a mere thirty members on the last occasion the meeting was held at Bart's, 10 years ago, to well over 200 members at the present time. At both this early meeting and the present one Bart's could claim a national lead in high energy X-ray machines. Ten years ago the 1 MeV Van de Graaff machine led the field, and to-day the 15 MeV Linear Accelerator is the highest energy

machine yet built for radiotherapy and radiobiological research in this country.

At the Scientific Meeting Professor Rotblat read a paper on the development of the accelerator for radiobiological research. Papers by Mr. G. S. Innes and Dr. G. W. Dolphin dealt with the special methods of dosimetry required for high energy X-rays and electrons. Dr. J. W. Boag described spectroscopic measurements on the free radicals produced by electron irradiation and Professor Wormall described the effects of irradiation on some enzymes and blood

complements. A lively discussion was continued over tea in the Great Hall.

These papers were followed by the Annual General Meeting. After dinner films were shown, including Dr. McDonald's entertaining and interesting high speed photography of the falling cat, when physicists turned their minds from the problems of X-rays and electrons to those of the inertia and angular momentum of the tail-less, blindfolded falling cat.

On the following day demonstrations were given of the research being carried out in the Physics Departments of the Medical College and of the Hospital.

#### Russians Visit Bart's

The visit of a party of Russians to the Hospital is, we believe, without precedent; for the Hospital to be visited by two parties of Russians within a few weeks is remarkable and must surely go unequalled.

A deputation from the Moscow City Soviet, including the Mayor of Moscow (correctly known as the Chairman of the Moscow City Soviet Executive Committee), which has been in London at the invitation of the Lord Mayor, visited the Physics Department in Charterhouse, where the complexities of the Linear Accelerator were explained by Professor Rotblat (see photograph on opposite page and *The Linear Accelerator at Bart's, S.B.H.J.*, July, 1955, pp. 218-22).

Bart's was also one of the hospitals and research establishments on the itinerary of the six eminent members of the Russian medical profession who have spent three weeks in this country as the guests of the British Medical Association.

Despite the political impasse reached at the latest Geneva conference, we hope that the British and Russian medical professions will continue in their efforts to re-establish the co-operation that existed during the war.

#### The Student Tuberculosis Foundation

It is estimated that nine or ten medical students out of every thousand contract tuberculosis requiring sanatorium treatment every year. In 1950 the *British Students' Tuberculosis Foundation* was established and sponsored by several national organizations, including the British Medical Association and the British Medical Students Association.

The aims of the Foundation as laid down in the trust deed, are "to give assistance to any and every kind of students who are suffering from tuberculosis" and in particular "to establish sanatoria and other curative centres, wherein students may continue their studies while under medical supervision."

In 1952 a rehabilitation unit for men, with 16 beds, was set up at Pinewood Hospital near Wokingham in Berkshire and arrangements have been made recently to admit students during the active phase of treatment. Tutors from London and Reading universities as well as from the R.M.A. Sandhurst visit Pinewood each week or fortnight, depending on the particular needs of their students.

It has, however, always been the intention of the Foundation to establish a permanent main centre for both men and women students, and negotiations with the Ministry of Health have been continuing for some time for the purchase of Mottingham Hall, a mansion in the grounds of Grove Park Sanatorium in South London. Mottingham Hall would be an ideal centre; not the least of its advantages being proximity to London. Students would be admitted to Grove Park Sanatorium for active treatment and then transferred to the nearby permanent centre at Mottingham Hall for convalescence and study under the guidance of tutors from London University.

Since 1951 over £30,000 has been raised for the Foundation, largely by the students and teaching staffs of universities and colleges in this country. (The result of the recent appeal at Bart's can be found on page 335.)

#### Cambridge-Bart's Sherry Party

The Cambridge Graduates Club held its annual sherry party in the Library on October 21. Mr. Kenneth Walker, the Chairman, welcomed the newcomers who had just come down from the University and hoped that they would enjoy their time at Bart's. He said the Hospital was a kindly old mother, rather prim in his day, but now much less proper than she used to be. The occasion had been a particularly interesting one for him, as he had, for the first time, met an entirely new species—the Cambridge-Bart's lady graduate.

The party was a success, and of the hundred and sixty guests fully eighty were still enjoying the sherry, the conversation and the canapés at eight o'clock.

Social occasions in the Hospital are regrettably few and far between, and it was therefore disappointing to note that many Cambridge students in their second and third clinical years did not attend. Their presence would have helped bridge the rather austere gap between the senior members and the new arrivals.

#### Board of Governors

The Minister of Health, Mr. Iain Macleod, has made the following re-appointment to the Board of Governors:

Professor A. Wormall.



### The Vicarage Club

On a Sunday late in August there took place at Chislehurst a contest at cricket between two teams, one representing the Chief Assistants and the other the Vicarage Club. The latter has been recently formed with the object of preserving the spirit of the defunct, and greatly lamented, Vicarage, among a number of those who have taken a more or less active part in Hospital sport.

The thirteen men forming the Vicarage XI were a very mixed bag of cricketers. There were those who had, so to speak, been born with a silver bat between their lips; and some whose unco-ordinated movements of a vaguely sweeping character, proclaimed them to be, like ducks, more at home on the water. These gentlemen were thoughtfully directed to field in positions where they were unlikely to suffer the indignity of having to avoid a catch. A similar state of affairs obtained in the Chief Assistants XI, brought up to strength by Edwin Gawne and a young McIlroy. Dr. Picton Thomas' XI undoubtedly had its giants, but then it also had its Ronnie King.

The Chief Assistants batted first and despite a hat-trick by a wing three-quarter scored a total of 108 all out. Their task was made easier by the insistence of the fielding side that each of its members should be given the opportunity to bowl [sic]. After tea the Vicarage XI went in and by playing their "rabbits" early, as cannon fodder to the Top Floor Tysons, they were able to snatch victory in a last wicket stand.

The party later broke up with the promise of a further contest at some future date.

### The Journal

We are always pleased to publish news of Bart's men, whether this be personal, such as the announcement of an engagement, or of more general interest, such as the conferment of an honour. At the present time other publications provide our main source of this information. We are, therefore, unable to publish more than a small proportion of the news that must really be available, and this only after a considerable delay.

We invite your co-operation in seeing that the *Journal* is kept well supplied with information. All that is required is a postcard sent direct to the Editor, giving details of the appointment, examination result or whatsoever. No charge is made.

### THE LIGHTER SIDE

"If you're not too busy doctor, I should be grateful if you would call and see my baby boy. The Hospital doctor says he would look like an acorn after his operation; but to me he looks more like a horse-chestnut."

I feel like quoting my anaesthetist in the Minor Ops. theatre, who invariably said on such occasions "There's a divinity that shapes our ends, rough-hew them how we will."

\* \* \*

Dr. Langford of Hereford writes:

"A patient came into my Surgery last week who had, when previously seen, been treated for a boil. He had evidently been told it was *furunculosis*. His opening remark to me was, 'Do you remember doctor, when I had them *five uncles* on my bottom?' . . ."

### NOTICES

#### Pot-Pourri

This year's Pot-pourri, which includes the best of the Ward Shows, will be held at the Cripplegate Theatre on Wednesday and Thursday, December 28 and 29 at 8 p.m., and on Friday, December 30, at 5.30 p.m.

Tickets, price 7s. 6d., 5s., 3s. 6d. and 2s., can be obtained from Bert Cambridge, Williamson Laboratories, St. B.H.

\* \* \*

#### Medical College

FINAL F.R.C.S. — MAY 1956

A course will be held for this examination on Tuesday and Thursday evenings at 6.30 p.m. starting on Thursday, February 23 and ending on Tuesday, April 24. There will be a break for Easter. The course will consist of 16 clinical tutorial classes with short cases, followed by lecture-demonstrations on selected subjects. The course is not comprehensive. The class will be limited to 24 members.

Fee: Twenty guineas, or to Bart's men fifteen guineas.

Application to the Sub-Dean, St. B.H. Medical College, E.C.1.

## LETTERS TO THE EDITOR

### RESULT OF T.B. APPEAL

Sir,—As a result of the appeal on behalf of the British Student Tuberculosis Foundation we received a total £114 made up as follows:

Collection (students and teaching staff) .....	£23
Letter of appeal in the <i>Journal</i> .....	£32
Raffle .....	£58

In addition the Medical College has very generously contributed a further £114, bringing the total to £228.

We consider this to be a most satisfactory result and should like to thank all those who helped with the collection, publicity, and other arrangements. We should also like to thank the many old Bart's men who responded to the letter of appeal in the May issue of the *Journal*.

Finally, we thank the Dean for his advice and assistance and the Medical College for their most generous support.

Yours sincerely,

JOHN NICHOLSON,  
(Senior Secretary, Students Union).

GEOFFREY DAWRANT,  
(Chairman, appeal sub-committee).

### ESCHATOLOGY

Sir,—The great importance and interest of the questions raised by Mr. Parker may perhaps excuse a few more lines upon this subject.

1.—The conception of Limbo is reached "by a process of elimination, since the punishment of an immortal but innocent soul in Hell is inconsistent with the belief in a God of infinite mercy." This elimination, if it has occurred at all, is of very recent date. For instance, this doctrine of the eternal torture of those unavoidably ignorant of Christian theology sustained the wonderful courage of missionaries such as Robert Moffat, Livingstone's father-in-law (see his *Matabele Journals*\*). Is not this doctrine, expressed in the Athanasian Creed, still the official teaching of the Church?

2.—" . . . 'Limbus Patrum' where the just who died before the coming of Christ were detained." Where are the just who died after that event?

3.—"Others maintain that when Christ spoke to the good thief on the cross: 'Today thou shalt be with me in Paradise' . . . He was referring to Limbo . . ." If the place to which Jesus promised to convey the thief "today" was Limbo, this benefit was a poor affair indeed, for the thief was going there in any case, to await the Last Judgement, and moreover, would be accompanied by his unrepentant companion. However this may be, millions of readers of the Bible have been entranced by the delightful picture of this miserable, tortured man, conveyed by Jesus himself, his fellow-sufferer, to

the immediate joys of Heaven, which is what the vast majority of people understand by "Paradise."

If the same place can be called (1) "Paradise" in the Bible, (2) "Hell" in the Apostles' Creed, and (3) "Limbo" in modern teaching, confusion could hardly be greater. Cannot the Church give us definitions of Hell, Hades, Paradise, Heaven, and Limbo?

\* *Matabele Journals* (1829-1860) Vol. 1. Government Archives of South Africa, 1945.

E. L. KENNAWAY.

Chelsea.

### SIR ANTHONY BOWLBY

Sir,—I was peculiarly in Vick's article on Sir Anthony Bowlby as I was Bowlby's first House Surgeon and can vouch for all that he said. He had one delightful trait which Vick wouldn't know about. Whenever we rang him up about an emergency abdominal he would say, "Put him in the theatre," and he would operate without further examination. He naturally gave one a great uplift, but one can remember many anxious moments and also satanic sighs of relief when a whiff of gas came from the peritoneum! Of course, it was a great deal easier in those days as most of the cases had been "sat on" for days; some of our staff "sat on" them a bit longer. The mortality was appalling compared with today.

My son tells me that Girling Ball, whose House Surgeon he was, had the same idea. Ball was one of my Dressers and later House Surgeon to Bowlby.

Yours faithfully,

V. GODSALVE WARD.

The Tiled House,  
West Byfleet, Surrey.

### "SO TO SPEAK"

Sir,—It is possible that the excited nurse in your September issue (p. 293) may have been correct in her supposition that the ward round was to be concerned with subarachnoid haemorrhoids.

An uncommon cause of meningeal haemorrhage is an angiomatous malformation of the brain or, much more rarely, of the spinal cord. An example of the latter was described by Dr. Julius Gaupp in 1888 as "Hämorrhoiden de Pia mater spinalis."\*

\* Gaupp, J. (1888) *Beitr. path. Anat.* 2, 516.

Yours faithfully,

JOHN POTTER.

The Radcliffe Infirmary,  
Oxford.

## THE DEVELOPMENT OF THERAPEUTIC DIETETICS

by Miss M. E. FURNIVAL (*Chief Dietitian*)

DIETETICS has been defined as the "interpretation and application of the scientific principles of nutrition in health and disease" (*Brit. Med. J.* 1945). Food has been used as a therapeutic agent since time immemorial. The writings of Hippocrates, Celsus and Galen include dogmatic statements on the foods proper to various conditions. The humoral theory dominated practices in the food intake of the sick for many centuries. The "principles of nutrition" had, indeed, no firm scientific foundation until systematic studies of organic chemistry and physiology began in the mid-19th century. By 1880, analyses of the protein, fat, carbohydrate and caloric contents of many foods had been made by methods established by Voit and Rubner. Since the turn of the century there has been a vast increase in nutritional knowledge. The assessment of protein requirements, the character of the vitamins and their action and the elucidation of the role of the amino acids typify only some of the information made available through constantly improving biochemical and microbiological research methods.

As in so many fields, the impact of war stimulated dietetic research. The submarine blockade of World War I emphasized the precarious nutritional position of this country, while Germany and her allies suffered even more devastation nutritionally from our counter-blockade. The relief work undertaken among the children of Vienna in 1919-1922, for example, resulted in conclusive proof of the anti-rachitic action of Vitamin D.

The discovery of insulin, also in 1922, opened a wider field for therapeutic dietetics. As the therapeutic possibilities of further dietetic regimes unfolded in the 1920's it became increasingly obvious that suitably trained personnel could do much to relieve the doctor of the necessity of supervising the day-to-day details of the various diets. At that time there were no training facilities for dietitians in this country. Towards the end of the decade Rockefeller Fellowships were

made available to three nursing sisters and two non-nursing candidates for study in the United States. One of these candidates was Miss Abrahams, the first dietitian at St. Bartholomew's Hospital. These women set up training establishments in various hospitals on their return to this country. At the outset, a science graduate, after three months intensive cookery, was required to undergo six months practical experience in one of these centres to qualify as a dietitian. Within a few years it became apparent that a wider theoretical background was desirable. In 1935 the University of London opened the first postgraduate course in dietetics. In the next year the British Dietetic Association was founded, its primary objective being the supervision of training courses.

The present training of a dietitian occupies from 4½ to 5 years. The initial qualification required is either a B.Sc. degree or an Institutional Management diploma. Entry may also be gained by those possessing State Registration in Nursing, a Domestic Science Teacher's diploma or Associate Membership of the Hotel and Catering Institute. Further theoretical training is then given for six or twelve months prior to the final six months practical hospital experience. The theoretical training of a dietitian includes courses in chemistry, physiology, biochemistry, hygiene, bacteriology, nutrition and the principles of diet in disease. On the administrative side she will be taught economics, accounting and business affairs as a background to her knowledge of cookery, institutional administration and staff management. During the period of practical experience the student learns to apply her theoretical knowledge while, at the same time, gaining experience in co-operating with hospital staff and learning to work with the patients. At this time also she must learn, both literally and metaphorically, to find her way about the hospital and acquire some insight into its complex social structure. All training courses are recognised and supervised by the British Dietetic Association and

satisfactory qualification is marked by admission to full membership. A dietitian works at all times under the orders of the doctor concerned and is responsible to him for carrying out the treatment he specifies.

### DIETETICS AT ST. BARTHOLOMEW'S HOSPITAL

The concern of the Governors for the feeding of the patients treated in the Hospital is apparent throughout the records of their Court. In the Middle Ages, and, indeed, until much later, bread formed the basis of the diet. As the result of an increase in the price of the loaf in 1550 the following injunction was recorded:

"Wheras it apperythe to the Commyssyoners of thys howse that the Halpeny loffe (now beyng very small) is to lyttell for ii men at a mele. Therfor it is agreed that from hensforth every ii persons shall have at every mele a halpeny loffe and half a loff which is iii farrthynges in brede to ii parsones at a mele. Which iii farrthynges in brede wait at the day large xvi oz. So it is agreed that every person shall have in brede at every mele viii oz."

By 1656 the allowance had risen to "10 oz. of the Bakers best wheaton bread" and a reprimand was issued to the baker who supplied bread half cooked.

The importance of adequate food in aiding recovery was recognised in 1652.

"Patients which have their diet allowance in money have their sores and diseases enlarged and their cures retarded by their illdisposing thereof, some spending it at ale houses, others upon trash, more unwholesome than the house diet, and others out (of) a covetous disposition abridge themselves of those things which are necessary . . . because they would save the money . . . therefore it is ordered that no patient shall be permitted to receive any diet money but shall be satisfied with the house allowance in victuals, except such of the doctors patients as are feverish or otherwise diseased so that they cannot eat the house allowance without prejudice to their cures, and also such of the chirurgions patients as are dismembered. And it is further ordered that such sick persons shall not dispose their money themselves but shall receive broths and caudles or other things suitable for their condition from the sister and the diet money to be paid by the steward to the sister to discharge her disbursements in providing such provisions."

"The dyett of the Matrone of the howse" first referred to in 1553 as given "to such as be very feble that they cannot recyve the dyett of the howse" was defined in 1680 as "one pint of broth and a chop of mutton

diet in leiw of the ordinary diet". In 1694 a "Milk dyett" was given as an alternative to the "Beefe and Mutton dyett", such patients only to receive in addition "the usuall allowance of Bread and beere every day and Ale Caudle on Sundays", i.e. 10 oz. of Bread, 3 pints of beer and 1 pint of caudle.

On 27th April, 1687 the daily allowances for the house diet were entered in the records of the court.

### DYETT

<i>Sunday</i>	10 oz. wheaton bread 6 oz. of Beeffe boyled without bones 1 pinte and a halfe of Beeffe broth 1 pinte of Ale Cawdell 3 pints of 6s. Beere
<i>Monday</i>	10 oz. of wheaton bread 1 pinte of Milke Pottage 6 oz. of beeffe 1 pinte and halfe of Beeffe broth 3 pints of Beere
<i>Tuesday</i>	10 oz. of wheaton Bread Halfe a puond of Boyled Mutton 3 pints of Mutton broth 3 pints of Beere
<i>Wednesday</i>	10 oz. of Bread 4 oz. of Cheese 2 oz. of butter 1 pint of Milke pottage 3 pints of Beere
<i>Thursday</i>	10 oz. of bread 6 oz. of Beeffe 1 pint and a halfe of Beeffe broth 1 pint of rice milke 3 pints of Beere
<i>Fryday</i>	10 oz. of bread 1 pint of Sugar sopps 2 oz. of cheese 1 oz. of butter 1 pint of water gruell 3 pints of Beere
<i>Saturday</i>	the same as Wednesday

Old and new cheese to be provided for the Patients And fresh butter from the first day of May to the first of October.

Small Beere allowed the Patients on Tuesdays and Frydays to make possett drinke.

Apparently it had recently been ordered that all patients should be fed from the kitchen, for in August of 1687 the "Cooke" petitioned the Governors "to be allowed a person to helpe her dresse the Poores Dyett (the Labour being above double what was Formerly) by reason that all Patients are by a late order putt into the Kitchen Dyett". The patient assigned to assist the cook was paid ninepence a week "over and above a patients allowance." In February 1729 it

was "Ordered that the Account of the Poores Dyett of this Hospital be printed and fixed in the Wards".

The terms *Dieta Carnis* and *Dieta Dimidia* passed into the Hospital vocabulary and have only recently been superseded by the nomenclature full and light diet. Until 1928 when the Special Diet Kitchen was established by Miss Abrahams, any diet required by a patient and not met from the Main Kitchen had to be improvised by the Sister. The following ten years saw the evolution of most of the common dietary regimes in vogue today. The doctor's prescription for specific nutrients was translated in the Diet Kitchen into food that the patient could and would eat. Bran biscuits and raw liver cocktail were provided for the stringent early regimes of the diabetic and pernicious anaemia cases. The importance of restricting the potassium intake in Addison's disease had recently been recognised and vegetables were chopped small, boiled in three changes of water and served with large quantities of salt. The book on *Modern Dietary Treatment*, published by Miss Abrahams and Miss Widdowson in 1937 became a standard text in many Dietetic Departments. The dietetic treatment of outpatients was part of the work of the Department from its inception. It was recognised that in many cases the duration of a patient's stay in hospital could be shortened by teaching him to carry out his diet at home. Doctors also came to consider that some types of treatment could effectively be maintained without admission to hospital, provided that they could refer the patient for dietary instruction and supervision in Surgery.

Today the Dietetic Department is responsible for feeding from 25-30 per cent of the patients in the Hospital. The kitchen is open for from 10-14 hours a day, serving four main meals and supplying where necessary the ingredients for mid-morning and bed-time feeds. Any therapeutic diet required is "boarded" initially by the physician or surgeon concerned or his house officer. The order is transmitted to the Diet Kitchen by the Sister, either immediately by telephone, or by the written order received each morning at 9 a.m., from which the daily service list of diets is compiled. Any "new" patient is visited as soon as possible by the dietitian assigned to the ward, who explains the diet to him and enquires as to any foods he may

dislike. In the majority of cases an individual diet sheet is calculated and posted in the ward kitchen. Such a patient is then visited periodically during the time he remains on a diet. When it is known that a patient is to continue dietary treatment after his discharge, instruction is started as soon as possible in order that he may obtain the maximum help. This is particularly important for a diabetic admitted for initial stabilisation, since the dietitian is then able to accustom the patient gradually to a new way of thinking about his food and, where necessary, to discuss with the wife or mother what modifications should be made in the home cooking methods. The dietitian must be prepared to teach dietetics at all times. Formal lectures are given to nurses and medical students during their training, but they may gain much practical information by asking questions about specific cases receiving diets on the wards or as outpatients.

Modification is now the keynote of all modern therapeutic dietetics. A "special diet" is no longer a mysterious concoction emanating from the hands of an alchemist disguised as a dietitian. In common with all other catering establishments the food supplied from the Diet Kitchen is based on a weekly menu. Suitably modified variations on each dish are then arranged for the different types of diet, and another dish is only substituted when the main ingredient of the first is radically unsuited to the requirements of the diet concerned. Superimposed on this is the necessity of catering for the individual preferences of "Mr. or Mrs. Buggins" who "can't abide carrots, dearie, fair turns me stummick they do." In all some twenty therapeutic diets are listed in the Hospital Diet Book. These are, however, only the most usual types and may be required in various combinations. The diet of the diabetic, who is also a gastric; or the patient requiring reducing, who suffers concurrently from diverticulitis or an hiatus hernia, may need some thought; but does not present quite the problems involved in finding breakfast for the patient on a salt-free, low-fat, high-protein, high-carbohydrate diet, who does not like fish and may not be given very many eggs.

The Department works in close co-operation with the ward and laboratory concerned when balance diets are required for metabolic studies. When the scope and purpose

of the study has been decided, a diet acceptable to the patient is arranged and the intake of the nutrient in question calculated from food tables. Statistical investigations have shown that a 7-day balance period provides information which is more reliable than similar facts from a 5-day period, but as effective as those from a 10-day period (Brewer, W. D.). A duplicate food intake is homogenised for check analysis by the laboratory and any food rejected by the patient is also collected, homogenised by high-speed blender and sent for analysis. Twenty-four hour saves of urine and stools are made by the ward.

In an average week some 60 outpatients are referred for dietetic advice. The majority of these require gastric, reducing or diabetic diets. The patient is referred with a "green card" on which the doctor specifies the diagnosis, the diet required and whether he wishes the case to be followed up. A brief history is then taken by the dietitian to learn something of the patient's social background, his cooking facilities, his work and what meals he may eat away from home. With this information in mind the dietitian discusses with the patient how best he can meet the dietary requirements of his case and prepares an individual diet sheet. If, as often happens, the relative who will do the cooking is available, the means whereby the diet can best be fitted into the family food pattern are also considered. An offer of help with any future cooking difficulties is always made. The patient ordered a reducing diet who is to continue in attendance at the Hospital is, if at all possible, seen at frequent intervals for a weight check. These brief interviews also provide an opportunity for the patient to ask questions and receive moral encouragement or the requisite degree of persuasion. The diabetic patient who con-

tinues to attend a clinic regularly soon acquires the status of an old friend in the Department. Such a patient will often "drop in" to discuss the carbohydrate value of seasonal foods. The dietitian must be prepared to advise on the numerous proprietary products on sale as suitable for diabetics. Commercial information of this type is kept up to date by frequent interviews with medical representatives of the relevant firms. These channels can also be used to suggest specific products for which a therapeutic need has become apparent. It was, for example, in this way that a sodium-free milk substitute was made available in this country.

The effective development of therapeutic dietetics in England has taken place largely in the last 25 years. The dietitian's role as the practical interpreter of the doctor's prescription for a patient's food has many facets. The work is very rewarding and may well become more so if the present trend towards the integral treatment of the patient fulfills its promise.

#### ACKNOWLEDGMENT

I should like to thank Miss M. V. Stokes, the Assistant Archivist, for her help in preparing the extracts quoted from the records of the Courts of the Governors.

#### REFERENCES

1. Abrahams M., Widdowson E. M. *Modern Dietetics*. Ed. Mottram V. H. and Graham, Cox, London, 1937.
2. Brewer W. D. Personal communication.
3. *Brit. Med. J.* (1945) *ii*, p.617.
4. Hollingsworth D. F. *The British Dietetic Association*, London, 1946, (unpublished).
5. Hutchinson R. *The History of Dietetics*, reproduced in *Food and the Principles of Dietetics*, Ed. Mottram V. H. and Graham, G. Arnold, London, 1944.

## SO TO SPEAK . . .

We always wondered

"You believe that two and two make five because your biochemistry is upset."

—Psychiatric Out-Patients.

## POSTMAN'S PARK

*It was a saying of Lord Chatham, that the parks were the lungs of London.*

—William Windham.

OPPOSITE the South-east Gate of the Hospital, tucked away between St. Botolph's Church and the Headquarters building of the General Post Office, lies Postman's Park. Hidden by the surrounding buildings from the outside world, a green valley encircled by dark mountains of bricks, it has an air of peace and tranquillity which is hard to find in this busy city. Here, from May to September, weather permitting, open-air religious meetings are held on Monday lunch-times. And throughout the summer many people take advantage of its quietness; office workers eat their mid-day sandwiches, young men come a-courting, and more aged business men take their constitutional strolls. In the shade of the trees they can rest awhile and forget their daily drudgery.

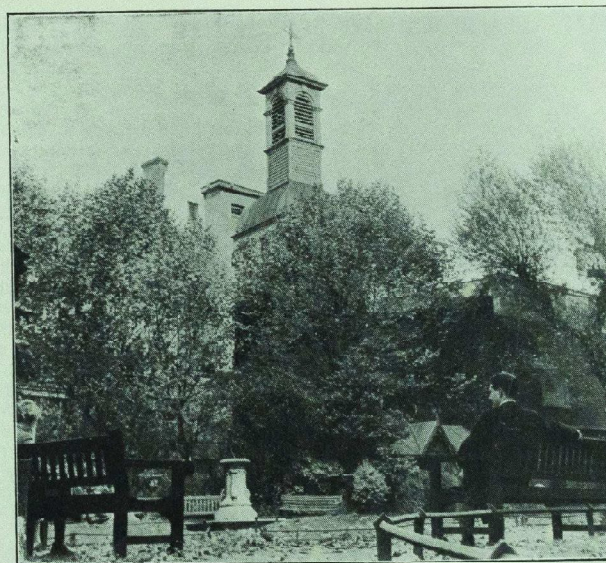
Some inhabitants of this garden are no longer troubled by the worries of this world; for the northern part of the park was once a Burial Ground; in fact, it was the combined Churchyards of St. Botolph's, Aldersgate; Christ Church, Newgate; and St. Leonard's in Foster Lane. In 1880 the three Parish Councils decided to transform their churchyard into a garden; the decision by St. Botolph's is recorded by an inscription around the pedestal base of the sundial: 'This ancient Burial Ground was converted into a garden by the vote of the Parish Vestry and with the concurrence of the vicar.' A similar inscription is engraved on a stone tablet placed in one of the brick pillars at the St. Martins-le-Grand entrance by the Christ Church authorities: 'This Burial Ground was laid out by order of the Vestry, Sept. 10th, 1883.' The tombstones were removed, and they can be seen today, weather beaten and crumbling with age, propped up against the surrounding walls.

In the 1890's the Post Office purchased the land to the south of St. Botolph's, as far as Angel Street, for the site of their proposed Headquarters Building. Part of this land, a strip adjoining the Garden, was given to the Church Authorities. A little more ground was bought by public subscription, and, with these additions, the Garden was replanned and opened to the

public by the Lord Mayor and the Bishop of London in 1900. To help towards its maintenance, the Post Office makes an annual payment to the Trustees of the London Parochial Charities; with this association and its close proximity to the Post Office, it is not surprising that it has become known affectionately as Postman's Park.

The Park is dominated by a large statue of Sir Robert Peel, which looms out from the shadow of the trees, and appears rather sinister when first seen from the West Gate. Less awe-inspiring and far more picturesque, are the Sundial in the centre, and the Fountain at the eastern end. The fountain trickles rather dejectedly into its circular pond, trying hard to aerate the water for the chief inhabitant, an enormous fish. He (or she) may once have boasted a golden colour, but now, having attained an incredible size, has become black with age; to keep him company there are two or three recognisable gold fish. However, few visitors notice this monster and his attendants lurking in the dark water, they are more often attracted by the rows of white glazed tiles along the western wall beneath the loggia.

These tiles, just over two rows, running along the length of the wall, are made of glazed Doulton ware; on them are set down for remembrance the courageous deeds of men and women who lost their lives saving others. They were the idea of the artist G. F. Watts, who wanted to put on permanent record those acts of supreme self-sacrifice, which, once published in the daily newspapers are read and then forgotten. Watts, therefore, searched the daily publications of his time, and selected the first names to be recorded. When he died, a carved wooden memorial was placed against one of the loggia pillars; in its centre there is a statuette of an old man holding a scroll which bears the single word 'Heroes.' His work was carried on by his wife and more names were added from time to time, the last being put up in 1928. After the death of Mrs. Watts, the maintenance of the memorial was taken over by the Churchwardens of St. Botolph's.



*Autumn in the Park.*

In all, fifty-three heroic actions are recorded. Many of them are attempts to save others from drowning, being run over by trains, or being burnt to death. The following is an example:

SARAH SMITH (Pantomime Artist)  
at Princes Theatre  
died of terrible injuries received  
when attempting in her inflammable dress  
to extinguish the flames which had  
enveloped her companion  
January 24, 1863

These tragic events are all simply and touchingly told; perhaps this is the most pathetic:

SOLOMON GALAMAN  
Aged 11. Died of injuries  
Sept. 6, 1901 after saving  
his little brother from  
being run over in  
Commercial Street  
"Mother I saved him but  
I could not save myself"

The Medical Profession is not neglected; for among the names are those of two surgeons and one physician. The cause of the physician's death reminds us that the risks of practising medicine are greatly decreased today:

SAMUEL RABBETH  
Medical Officer  
of the Royal Free Hospital  
who tried to save a child  
suffering from Diphtheria  
at the cost of his own life  
October 26, 1884

It is a pity that no more have been added, for men and women have not ceased to voluntarily give up their lives, trying to save others in danger. Perhaps, one day, someone will carry on the good work of Mr. and Mrs. Watts.

REF.: *Post Office Magazine*, February 1952. Postman's Park by W. Maillard.

G.D.S.

## SOME ASPECTS OF MEDICINE IN CANADA

by GEOFFREY FFRENCH

AFTER seven years in Canada I believe that I am now capable of answering the question I have so often been asked by visitors and newly arrived doctors, as to how I find Canadian Medicine. Frankly, I have often wondered just what was meant by that question and I have generally fished around awhile to find out what has been in the questioner's mind. One gets pretty used to answering questions on how one likes things when you come to Canada and you naturally have to be careful that you don't upset people's feelings by speaking what might be in your heart. Contrast is so great, both in the way of life and in the practice of a profession, that one is often overcome by nostalgic longing in the early years of residence in Canada. I think that one point should be clarified at the outset: in my opinion, the casual visitor and the person coming as an immigrant gain very different impressions of life on this side of the water.

Early in your immigrant career, be you a labourer, professional or business man, the need to obtain living accommodation and adequate transportation requires the necessary minimum of cash. Ordinarily in Britain, if faced with a similar situation, you would make use of your bank and other useful contacts to obtain backing for a reasonable loan; as a newcomer to Canada you cannot do that if you are without friends, and this knowledge can be very demoralising, particularly as the need to obtain "Credit" is paramount in this country. By "Credit" is meant that you have proved yourself in the eyes of a reputable financial house capable of accepting a loan of money, or goods without immediate payment, and have repaid the amount within the time required. You are often then given a certificate stating you are credit-worthy. Obviously you have got to start somewhere and this is the difficulty. It reminds me very much of the situation in Britain after the war when one wanted to purchase beer by the bottle in the off-licence shops; you always had to hand in an equivalent empty before being supplied with the full bottle,

and it was not always easy to come by an empty beer bottle to start the chain reaction!

The moral of all this is, that it is most unwise to come to Canada with the idea of setting up in practice as a principal from the start, no matter how far up the ladder of professional success back in Britain. Far better to accept a salaried post either within or outside your chosen line for a period; you may not necessarily save money, but if you are wise you will early begin the attempt to achieve a good "credit rating," particularly with the bank. But remember a very important fact that I and many others have found; this "credit rating" may be only local and if you move any distance it may be of little value.

With regard to salaried posts, a word of warning: too often when reading the advertisement columns in the *B.M.J.* and *Lancet* one sees assistantships, etc., in Canada being offered for four, five and six thousand dollars a year. This may sound a tidy sum if changed into sterling, but no account will have been taken of the very high cost of living in Canada, which varies across the country. Before accepting such positions always contact the authorities in London of the different Provinces and obtain their advice as to how far such a salary would go in relation to your own family. Rents are enormous over here and take up a sizeable piece of the income.

We have wandered somewhat from the answer to the original question about what I think of Canadian Medicine. First of all, in my opinion, you don't have to *think* too much about Canadian Medicine: for the facts of recent history speak for themselves. Some of the foremost names in Medicine have been Canadians, Osler, Banting, Collip, Penfield, to name but four; and although not more than a hundred years old, organised Canadian Medicine has given itself a wealth of tradition in this short time. There are, across the country, medical centres which compare with those better known in the United States, and certainly

some of the work they do is of the highest standard, both in clinical and experimental medicine. But what you want to know is what goes on in the smaller towns and cities, the standard of knowledge of the doctors, the quality of nursing, public health services, social and medical insurance and many other pertinent facts. I am afraid that I am not qualified to give you a critical analysis of these, and what information I do give is a purely personal impression, with all the defects which that implies.

### THE DOCTORS

The quality of the student material entering the medical schools in Canada today compares in every way with that of the students entering British universities to take a degree in Medicine. I have had experience both at Dalhousie University, a smaller school in Halifax, Nova Scotia, and at Toronto University. Most students have taken a three-year course for an Arts degree before entry. However, the standard required for this arts degree does not parallel those in Britain and I would say that the knowledge held by the new medical students in both countries is similar in quality and quantity. The system of obtaining the degree is somewhat different: in Canada the weeding out of unsatisfactory students is done at an early stage and those remaining, provided they satisfy their teachers at terminal and other lesser examinations, will go on to write their finals; the favourable result of which is a foregone conclusion for 95 per cent. of them. In this way I would say that a great deal of the nervous strain of the student year is removed. The student year is greatly broken up by the long summer vacation of four months, during which time the majority of students take on a job, often earning enough to keep them at school the rest of the year. In the remainder of the year the teaching continues with only a few days break at Christmas. This apparently causes no severe strain on the students and they have become adapted to the seasonal work, which is a characteristic of most parts of Canada.

Clinical teaching of the undergraduate appears to follow the lines of that in Britain, but it is in the interning or house-jobs that a slight yet significant difference lies. The Canadian intern is far more articulate than

his British counterpart and this is stimulated by the method of ward-rounds held once weekly and attended by all the staff, in and out-patient, of the respective medical departments. At these rounds the junior interns present the cases, discuss the significance of findings, review recent literature and generally take an active part in the proceedings: this is undoubtedly a very important part of their education. In my own hospital in Toronto, St. Michaels, one of the three teaching hospitals of the university, we have had three British interns during the last year; one a Dublin graduate of twelve years, the second a Guy's man who had just completed three years in the R.C.A.F. Medical Service and the third a recent graduate from the University College of the West Indies: all of them remarked on the education value of these open rounds.

I would say, to generalise, that the recently graduated young Canadian doctor differs little from his British colleague except that he appears more sure of himself. One could criticise of course, noting perhaps a certain lack of appreciation of the value of history taking and the value of physical signs, the sometimes poor recording of charts and undue emphasis on the value of laboratory procedures. As far as I know, some of the teachers are very much aware of these faults and attempt to steer the middle course.

Most of the Canadian provinces require an immigrant doctor to obtain the Licence of the Medical Council of Canada. This is an examination taken by all Canadian medical students at the end of their course, and is in most universities the only final examination taken. The British doctor, even of some years post-qualification, should have no difficulty in passing provided he works for it for at least four months at the books, adopts a reasonably humble approach in the written papers and more especially so in the vivas, refusing to become rattled when the examiner has some fun at his expense. In my own case, when I took the L.M.C.C. two years ago, the surgical examiner, a well-known Toronto surgeon, asked me from what university I had graduated. I replied, "Cambridge, Sir", and with a puzzled look on his face he asked me, "just exactly where is that, at Oxford?" I was naturally somewhat peeved, but kept my counsel, realising the importance of suffering fools gladly on occasion. It was only afterwards that I discovered my examiner was a Fellow of the

Royal College of Surgeons of England and one presumes that he really did know the whereabouts of Cambridge!

The British tradition of medicine still permeates the minds of Canadian doctors, particularly in the authoritative ethical views expounded. Naturally, the influence of the great neighbour south of the border is constantly felt and many good modifications have been introduced and accepted. Sometimes, particularly at large hospital ward rounds, one has the impression that the patient as a person is of little importance and that it is the disease that is being studied; this has been commented upon by both Canadian doctors themselves in the medical Press and by post-graduate students from countries other than Britain. It certainly is a sad reflection when the patient doesn't even get a "good morning" when he comes in to be examined. However, this is not universal.

#### GENERAL PRACTICE

General Practice has the reputation, both within and without the profession, of being a pretty lucrative occupation. I think that this is true; but you have to get out and keep out, to earn the money. Besides the ordinary routine small illnesses that go to make up the G.P.'s income, there are two other good sources: firstly, industrial work, whether it is for attendance by the hour or part-time or on Workmen's Compensation Act treatment; and secondly, Obstetrics, known colloquially as O-B. There is very little domiciliary midwifery in the more developed areas of Canada and none in most large towns or cities: similarly, there are no midwives either inside or outside of maternity hospitals. All the deliveries are done by the doctors, mostly G.P.'s, and the fees range from \$60.00 upwards for antenatal, delivery and post-natal care. To us coming from Britain, it does seem odd that there are no midwives and it certainly makes having a family an expensive habit. One result of this is that up to half the beds in a hospital may be for normal deliveries and this takes a considerable portion of the already inadequate nursing staff away from their true vocation of nursing sick people. However, this is leading to controversial subjects and had better be left for the time being. One unfortunate result of this is that when a trained British midwife comes to live in

Canada, she cannot work at her vocation and does not have any status as a nurse!

#### THE NURSE

I would say that the standard of nursing care as I know it when I left England has generally not been reached in Canada. These are provocative words but they are not said with any malicious intent. Coming from Bart's one has learnt to appreciate fully the care and service that is given in our great hospitals in Britain; one's standard for criticism is therefore high. Nevertheless, I do not believe that the Canadian nurse knows as much about practical nursing, either in the care of the patient or the maintenance of the bed; she does little cleansing work of any sort apart from instruments, and much of the practical nursing is done by nurses' aides, both men and women, many of whom are immigrants. On the other hand, the recently graduated nurse has a considerable theoretical knowledge of procedures usually considered in Britain not part of a nurse's job. One has to be very careful in one's approach and never, *never* tell a nurse, however junior, to do anything; rather you have to suggest that it would be a good thing if she did. There is apparently a great deal of "face" to be maintained and this leads to the delegation of menial tasks. I realise I might sound critical when I read through what I have just written, but it's not because I have any personal dislike of the nursing profession in Canada; quite the opposite, they are delightful with beautifully manicured nails and hair-dos and exuding charm and poise!

It is often noted by British immigrants when chatting among themselves, how dissatisfied they (the immigrants) appear. This happens anywhere, and who doesn't love a grouse? A quick answer to this is, "Why did you come then?" "To see what it was like, of course," is the obvious reply, and then the argument goes on as to no two countries being exactly the same and what can you expect etc. etc., and, finally, "If you are used to better things why don't you go back and enjoy them?" Well, there is no doubt that those of us in Bart's have been brought up with a very high standard of nursing care at our elbow, and the only thing we can do about our situation here is to preach and practise what we know *sotto voce* and so discreetly! I look back with some

thankfulness to those early days as a dresser on the late Mr. J. E. H. Robert's firm and the simple nursing and bed-making instruction given under Sister Fleet's watchful eye.

Nevertheless, what the eye doesn't see the heart doesn't grieve about, and if the patients appear to be satisfied, they know no better.

#### SPECIALIST QUALIFICATIONS

The obtaining of specialist recognition in Canada requires a minimum period of four years post-graduate training for the specialty. If fellowship is sought (either FRCPC or FRCS(C)) then a further year of study in the basic sciences is required before becoming eligible to write the examination. Doctor immigrants from Britain and France may submit evidence of holding specialist diplomas from their respective countries and may or may not be excused from the written paper (in the Certification only), but will have to sit the viva and clinical. The basic specialist qualification is the Certification of the Royal College of Physicians and Surgeons of Canada. Certification is given in all the recognised specialties and will have to be obtained by any British specialist coming over here and wishing to continue to specialise. He will be very wise to write this examination as early as possible, sometimes even before the licence to practise if the dates of examination decree it—as in my own case. I was qualified as a specialist in Internal Medicine before I was allowed to practise medicine! When the Certification has been obtained, he may consider trying for the Fellowship in Medicine or Surgery, but only if he has the requisite study time.

I think I have talked enough for the time being. I will always try to answer queries from Bart's men considering coming to Canada, and I hereby suggest to the Editor of this always interesting *Journal* that he should compile a regional register of Bart's men in Canada, who would give similar assistance. I know that there are numbers in Alberta, perhaps because Alberta does not require the Licence examination, but has direct reciprocity with Britain!

It was a great pleasure to meet again some of our colleagues from Bart's at the recent combined B.M.A. — C.M.A. Meeting in Toronto, and many of us over here look forward to making a return visit to Edinburgh in 1959.

## PICTURES FROM AN EXHIBITION

"No, they're not in the catalogue, Hogarth did them."

"Didn't he take his models from actual members of the Staff?"

\* \* \*

"Gibbs became a Governor in 1728 and designed the new buildings, each separate—"

"Sherry at this hour is so debauched, may I have another glass?"

"You can photograph Lady Kelly in five minutes time."

"But I'm a Governor my boy."

—as a fire precaution. The Great Hall was completed in 1732—

"As I have lost the place in my notes, I declare the Exhibition open."

"What's that? I don't like it!"

"The best Coronation picture I've seen."

"Wife of the Ex-P.R.A., not the Ambassador to Moscow."

"Yes, an eminent old Bart's man."

"Of course, three months off term is a bad time to pose."

"Are there any paintings by a psychiatrist?"

"A Mobile, we opened the window, but it still won't."

"'Cabbages and Gloriosa,' at first we hung it on its side and I still think it looks much better that way."

—and the Hospital still owes £20 for it.

"I'm doing three months S.O.P's. and I have a man every week."

"He was colour-blind you know."

"Recognized it straight away, I was in Les Baux last year."

"A sort of symbolic fish."

"A shilling!"

"Anyhow, there's a free tea in the Nurse's Home."

—Does that answer your question?"

C. F. A.

## THE ART EXHIBITION

Great Hall, October 6—14

The Fifth Art Exhibition was opened by Lady Kelly in the Great Hall of the Hospital on the 6th October.

The range of work submitted was extremely varied. Ambitious Coronation and crowd pictures vied with those of landscape and still life on their common backcloth of chocolate coloured hessian, mounted on stands loaned by the Royal Academy of Arts. In addition there were surgical and botanical drawings, pottery and sculpture. The exhibition was fortunate in having four forceful and authoritative pieces in the latter class from a contributor of the stature of Beth Jukes, A.R.B.S., A.R.C.A.

Perhaps outstanding was the work of Miss Rhoda Biffen, who exhibited delicate and accomplished etchings, and a masterly still life (No. 13) in which the interplay of local and attracted colour was so well evaluated.

Dr. Henry Wilson showed three broad and satisfying watercolours (Nos. 57, 58, 59) of

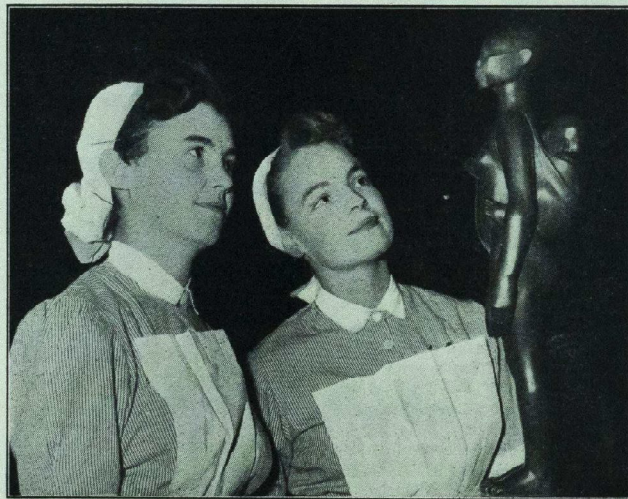
which *Walkern Mill* was of great assurance and surely owed something to one, in particular, of the classical watercolourists.

The three charming paintings (Nos. 3, 4, 5), submitted by Sir Harold Gillies, in oils were all of delicacy and refinement.

Dr. B. N. Brooke's *Cabbage and Gloriosa* (No. 145) was a very well painted still life study, in which the attractive quality of the paint was used to the full in conveying the movement of the leaves. He also submitted a forceful study of Tony Daniels, both pictures reminded the viewer of the distinguished work of Robert Buhler.

Dr. R. Morshead's in *Canonbury Square* (No. 75) has produced a study that has almost the quality of an architectural drawing, enlivened by the addition of morning light.

Dr. W. G. Scott-Brown shows *Les Baux en Provence* (No. 85), a very firm and assured watercolour, and, although one hesitates to



Nurses Campbell and Franklin admire 'African Mother,' a wood-carving by former nurse Beth Jukes.



Sir Harold Gillies awaits Lady Kelly's opinion of his painting, 'Prasa da Roche, Portugal.'

attempt to trace influences in subject, colour and approach something of the former master who worked in this Department of France is evident.

*Flowers* (No. 33) was a decorative study and, in arrangement and colour, evocative of the work of Henri Rousseau.

Nos. 110/16 represented a memorial exhibition of the drawings of Dr. H. G. Adamson—some were in monochrome and all were most sensitively executed.

Mr. J. S. Malpas, whether painting in France or in England, has come under a bold French influence, and showed us (No. 28) *Watermill, Dorking*, through the eyes of an émigré.

Mr. L. J. Chalstrey in *Still Life* (No. 53), contributed a clever study of a difficult subject.

Mr. Geoffrey Sparrow sent a most forceful and professional aquatint in *Tommy's Stables* (No. 77) and two watercolours.

M. E. Russell submitted two studies in poster paint *Boy Fishing* (No. 15) and *Clowns Dressing Room* (No. 17) in which the subjects are very effectively treated, as if by a lithographic technique.

Dr. F. T. Burkiitt showed Nos. 89/92, some delicate and beautiful botanical drawings which might have been prepared for Curtis' *Botanica*—of which *Convolvulus Sepium* was noteworthy.

Mr. H. B. Stallard contributed some remarkable drawings of eye surgery, which were quite astonishing in the delicacy and fastidiousness of their draughtmanship.

Finally there was D. F. Craggs' forceful *The Hand and Shears*, last seen in the parlour of that Inn in Cloth Fair.

Altogether a very interesting and successful exhibition on which the Organising Committee and contributors are to be congratulated.

J. G.



Miss Rhoda Biffin and Miss Elizabeth Rowswell discuss Miss Biffin's painting, 'Girls Skipping.'

### THE EXHIBITORS

The Physicians, Surgeons and General Practitioners exhibiting works included:

E. A. J. Alment, A. P. Bentall, D. H. Bergel, Geoffrey Bourne, B. N. Brooke, J. Bunting, F. T. Burkitt, Hugh Campbell, C. J. Champ, J. C. T. Church, J. H. Coulson, D. F. Craggs, W. V. Cruden, A. B. Fearnley, J. D. O. Fearnley, K. J. Franklin, Sir Harold Gillies, J. S. Malpas, R. Morshead, W. G. Scott-Brown, M. Skoblo, G. Sparrow, H. B. Stallard, J. L. Struthers, Henry Wilson, R. Ogier Ward, and the late Dr. H. G. Adamson.

The students and members of the Nursing and lay Staffs exhibiting works included:

M. J. Ball, B. N. Ballantine, Miss Rhoda Biffin (Slade D.F.A.), P. G. Burles, J. H. Clark, Miss Sylvia Dennison, Miss M. Desbottes, L. J. Chastrey, N. H. Gale, Miss W. E. Hector, Miss Sheila E. James, Robert E. Jones, Miss Beryl Flitton, M. Hall-Smith, F. H. Kendall, M. A. Newton, D. O'Sullivan, R. Pracy, I. Poulson, Miss E. Rowswell, Miss M. E. Russell, J. A. Tait, I. Simpson, I. Stuart, C. M. Theobald, A. C. Watson, M. E. Williamson, and Miss Beth Jukes (A.R.B.S., A.R.C.A.).

#### Births

- BARNES.—On Sept. 14, at the British Military Hospital, Kinrara, Malaya, to Elizabeth (*née* Kerr) and Major J. Barnes, R.A.M.C., a daughter.
- BOYCE.—On Sept. 21, at St. Bartholomew's Hospital, to Jeanette (*née* Grimwood) and Dr. E. A. Boyce, a son.
- COLDREY.—On Sept. 17, at Brighton, to Iris and Dr. P. A. Coldrey, a daughter (Christine).
- DOWNEY.—On Sept. 24, at Harpenden, to Rosemary and Dr. M. F. Downey, a daughter.
- EVANS.—On Sept. 9, at Guildford, to Margaret (*née* Meikle) and Dr. C. M. W. Evans, a daughter.
- EVANS.—On Sept. 12, at Sheffield, to Shiela (*née* Hirst) and Dr. J. W. G. Evans, a daughter.
- GELDART.—On Sept. 2, at East Sheen, to Margaret (*née* Lahee) and Dr. E. Geldart, a son, (John Richard).
- HOUGHTON.—On Sept. 6, at Worcester, to Jean (*née* Swift) and Paul Houghton, F.R.C.S., a son.
- KATZ.—On Sept. 11, to Wendy (Dr. Green-grass) and Alexander Katz, F.R.C.S., a son, (Anthony David Trevor).

- SUGDEN.—On Sept. 27, at University College Hospital, to Freda (*née* Bades) and Dr. G. P. Sugden, a son (Simon Geoffrey).
- TIMMINS.—On Sept. 16, to Lorna (*née* Davey) and Dr. W. L. Timmins, a daughter (Lorna Louise).
- WINSTON.—On Sept. 23, at Johannesburg, to Ida (*née* Weil) and Dr. Frank Winston, a son.

#### Engagements

- CLEMENTS—WORSLEY. The engagement is announced between Dr. R. D. Clements and Miss P. D. Worsley.
- LODGE—STAINES. The engagement is announced between Dr. A. B. Lodge and Miss J. R. Staines.
- WHITE—EDWARDS. The engagement is announced between Dr. W. T. White and Flying Officer I. Edwards, P.M.R.A.F.N.S.

#### Marriages

- LAVY—WARD. On September 3, Dr. G. A. D. Lavy to Miss P. Ward.
- MORETON—COVENTRY. On September 24, Adrian Leonard Moreton, M.S., F.R.C.S., to Margaret Camilla Coventry.

#### Deaths

- BURROWS.—On September 29, Harold Burrows, C.B.E., Ph.D., F.R.C.S., aged 80. Qualified 1899.
- CARMODY.—On September 28, Ernest Patrick Carmody, M.B.E., L.R.C.P., M.R.C.S., aged 73. Qualified 1908.

#### Change of Address

- CHILTON.—Dr. N. Chilton c/o the East India Club, St. James's Square, London, S.W.1.
- DOSSETOR.—Dr. J. B. Dossetor to 8, Buckland Crescent, Swiss Cottage, London, N.W.3.
- HARRIS.—Dr. H. Elwin Harris to The Mount, Halse, Taunton.
- KNIGHT.—Surg. Lt. R. J. Knight to Apple-tree Cottage, Staplecross, Robertsbridge, Sussex.
- STANLEY.—Mr. E. G. Stanley to Wycollar, Salcombe, South Devon.
- HERINGTON.—Dr. Cecil E. E. Herington to 56, Grafton Road, Selsey, Chichester.
- SAVIDGE.—Dr. R. S. Savidge to Birchdene, Pinfold Lane, Whitefield, Lancs.



## STUDENTS UNION

### COUNCIL MEETING

A meeting of the Council was held on Wednesday, September 28, with Professor Rotblat in the Chair. The following is a résumé of the more important business.

1. It was agreed that the efforts to obtain longer library hours at Charterhouse should be maintained.

2. It was agreed that a full delegation of three members should be sent to the Annual General Meeting of the British Medical Students Association at St. Andrews.

3. The Secretary of the Finance Committee, Mr. Gordon Burles, informed the Council that the Medical College were at present considering the problem of the Foxbury Athletic Ground (see the finance report).

4. The Secretary of the Students' Union, said that the arrangements for next year's Hospital Ball were well in hand. It would be held at the Hyde Park Hotel and a double ticket would cost £3.

5. It was agreed that a committee should be elected to supervise the Pot-pourri. A band had already been booked for the Pot-pourri party, which would be held on December 30.

### FINANCE COMMITTEE

At the meeting of the Finance Committee on October 18, the allocation of club grants for the following year was made (see below). The large expenditure on capital grants is due to the Union's decision to utilize the £769, accruing from the liquidation of the Catering Co., in building up the clubs fully with equipment.

It was decided that £21 13s. 6d. should be set aside for the delegation travelling to the B.M.S.A. conference at St. Andrew's.

The Medical College informed the Secretary that they were prepared to assist the Students' Union with the Foxbury expenses by a further £350 a year until 1957, when they would take over the whole. This decision of the College Executive Committee is most

welcome; for the upkeep of the ground was absorbing a progressively larger proportion of the Union's funds each year. In fact during the last two years the grants to many clubs had to be cut below the level necessary for the maintenance of their equipment. And while overhead expenses have risen, the income of the Students' Union has fallen, because fewer students are now entering the College.

The residue of the Students' Union income available for distribution among the clubs is £923, which together with the £350 makes a total of £1,273. The minimum sum required for maintenance grants is £1,477 10s. The difference will be made good by sale of Stock. This the Union can well afford to do as the financial future is now assured. The Secretary concluded by pointing out that the finances of the Union were now on a firm footing, the first time for a considerable number of years.

#### Maintenance Grants 1955-6

	£	s.		£	s.
Christian Union	20	0	Golf	34	0
Men's Tennis	32	10	Sailing	50	0
Women's Tennis	18	0	Cricket	163	5
Table Tennis	6	15	Chess	5	0
Women's Hockey	60	0	Rifle	29	10
Athletic Club	34	0	Squash	22	0
Sports Day	48	0	Boat	208	10
Natural History	5	0	Fencing	57	0
Abernethian	40	0	Boxing	25	0
Physiological	4	0	Soccer	86	0
Music Society	3	0	Rugby	405	0
Photographic	1	0	Drama	10	0
Men's Hockey	110	0s.			
Total of grants awarded	£1,477 10s.				

#### Capital Grants 1955-6

	£	s.		£	s.
Fencing	4	10	Chess	12	0
Men's Hockey	22	0	Rifle	25	0
Athletic	25	15	Rugby	152	2
Cricket	16	0	Music	20	0
Photographic	7	10	Boat	265	0
Total of grants awarded	£549 17s.				

## ROTUNDA '55

by 'MEDICAL DAVY'

THE DUBLIN Lying-in Hospital for Poor Women was founded by Doctor Bartholomew Mosse, son of the Reverend Thomas Mosse, Rector of Maryborough. The hospital opened its doors on the 15th March, 1745. Ten beds were available.

It was soon obvious that Mosse's venture did not meet the demands of Dublin mothers for medical help and the energetic Doctor therefore prepared further plans. On the 8th December, 1757, a new fifty-bed hospital was opened on the present site, at the junction of Great Britain Street with Sackville Street (now Parnell Street and O'Connell Street, respectively).

Today, the Rotunda Hospital contains 209 beds: 117 maternity, 32 gynaecological, and 60 for sick or premature infants. Each year 4,000 women are delivered in the Hospital, some 750 gynaecological operations done, and the extern department delivers approximately 1,500 women in their own homes.

The finances of the Rotunda have always done credit to free enterprise. From the beginning, the hospital has not despised the support to be drawn from public entertainments. Coffee stalls and concerts, balls, bowling greens, breakfasts and banquets and, above all, lotteries have contributed to the development of a Dublin maternity service. A levy on sedan chairs and a Royalty from licensed coaches have also helped and, in those merry days, even the Chapel was a paying concern. Much later, Oscar Wilde was to say, *The best way to get on . . . is to feed people, amuse people, or shock people.* We may be sure that the Rotunda has never shocked people, but it has certainly kept them fed and amused. The Rotunda Gardens—forerunner of Battersea—were followed by the building of the Round Rooms, completed in 1767 and from which the Hospital derives its name. Here, the Rotunda Cinema now points the relationship between business and pleasure, and every night is a Saturday night.

The Royal Charter of 1756 decreed the Rotunda Hospital to be a teaching centre. Systematic teaching began in 1766, during the mastership of William Collum. At first this was restricted to intern work, but later

came the development of an extern service. By 1856 this aspect of the hospital's work was firmly established. A hint of wider recognition came with the registration of the first American student, in 1798. With the arrival of the first Englishman, in 1808, the final seal of approval might be said to have been given. There followed, steadily and in due course, an increase in the number of students and an improvement in their living conditions.

The Rotunda now offers both undergraduate and post-graduate courses of training, resident and non-resident, in obstetrics gynaecology and paediatrics. The facilities which are available include:—

1. Experience of normal intern and extern midwifery.
2. Lectures and practical instruction in obstetrics, gynaecology, pathology, paediatrics, and ante-natal and post-natal care.
3. Attendance at gynaecological operations and abnormal cases of labour.

Just as important as all of these, is the opportunity to meet medical students from several other Universities and post-graduate students from all over the World.

On entering Hospital, the new student is naturally keen to join a group and get some experience on the District. Before he can do this, he must first deliver ten cases under supervision in the Labour Ward and then pass a viva voce test by the Clinic Clerk; this is one examination for which no syllabus is issued. Since students attend the Labour Ward for single cases, by turns, it normally takes one or two weeks to qualify for a District group.

District is covered by both nurses groups and student groups, supported by the Doctors when necessary. Nurses work in pairs and attend normal cases of labour within two miles of the Hospital; each student has to attend one nurses' case, so that he may learn something of nursing management.

Undergraduates work in threes, the most experienced being designated group leader. The number of groups varies from three or four to eight or nine. If a smaller number

of groups means less peace of mind it also means more experience. The group on call must set out within five minutes of receiving a request for assistance. As students attend all calls they have experience of abortions as well as normal labours. Another valuable aspect is that patients in labour are apt to be attended from the first stage, or even before this if the mother is an optimist, rather than when the head is crowning. Frivolous requests do, of course, filter through. Late one evening a group was called out to a house some miles away, only to find that the patient was anxious to get up immediately instead of next day, so had rung the Hospital to find out. A system which is rigid enough to eliminate this sort of thing would run the risk of neglecting a genuine plea for help.

Students may be away on a call for a considerable time, varying from two to twenty hours. On one occasion a weary group leader was seen to move the mother over and lie down comfortably beside her, thus providing a symbolic 'couvade,' as it were. On an even better occasion, an American student got the mother out of bed and ordered her to walk up and down the room, while he relaxed in her place. Most unfortunately at that moment, High Authority chose to visit the young doctors to ensure that all was well. It was not, and the ensuing explosion provided much valuable conversation.

When attending a miscarriage it is necessary to call in one of the Clinic Clerks who, assisted by a postgraduate, deals with the situation in the appropriate way. Products of conception are baptised immediately, in the presence of the mother and her relations; this being one of the rules of the Hospital. All patients are visited for the next seven to ten days and, on discharge, they are given an appointment to attend a follow-up clinic. District visits sometimes take up a substantial part of the day, and even with a car, it is possible to be away for three or four hours. This may make it difficult to attend classes regularly but, in the event, these visits are important in safeguarding the health of the patients and are another aspect of medical apprenticeship.

The hospital grounds provide some opportunities for recreation, including a croquet lawn and two tennis courts. Close to the lawn stand several mysterious granite pedestals, mocking Stonehenge. These were

erected by Mosse and, according to legend, were to have carried the busts of Apollo, Venus, Faunus, and Lord Sudeley. Although the contract was never completed the pedestals remain as a challenge to curiosity.

## EXAMINATION RESULTS

### CONJOINT BOARD

#### First Examination, September 1955

##### Pharmacology

Kiely, M. G.	Butler, A. C.
Winstock, D.	Rosborough, D.

#### Final Examination, September 1955

##### Pathology

Bloomer, A. C. S.	Winstock, D.
Millard, F. J. C.	Rothwell-Jackson,
Kiely, M. G.	R. L.
Menage, J. A.	

##### Medicine

Farrar, J. F.	Buckle, R. M.
Mellows, J. W.	Jewell, G. J.
Phillips, B. S.	Nwachukwu, P. O.
	Rothwell-Jackson,
	R. L.

##### Surgery

Buckle, R. M.	Arthur, T. I. F.
Ellis, C. D'A.	Canning, W. C.
Nwachukwu, P. O.	Greenwood, R. A.

##### Midwifery

Nash, D. J. R. F.	Buckle, R. M.
Phillips, B. S.	Nwachukwu, P. O.

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

Farrar, J. F.	Buckle, R. M.
Nwachukwu, P. O.	Ellis, C. D'A.
	Canning, W. C.

## SPORTS NEWS

### RUGBY

1st XV v. Berkshire Wanderers. Won 6-5.

1st XV v. Stroud. Lost 0-18.

Although the Hospital were not at full strength this was a poor game. The Hospital kicked off into a slight breeze and during 15 minutes of intense play had no share of the ball. From a scrimmage on the Hospital line Stroud heeled quickly and the fly-half dropped a neat goal. This seemed to put a new life into the Hospital side and until half-time they played a better game. However, the loose play was bad and the line-outs and tight scrummaging seemed ineffective against a bustling Stroud pack, who were always on the ball. When Bart's did heel the ball the movement petered out in midfield due to bad passing and handling. Fortunately the defence of the Hospital backs was good, with Badley reinforcing the centre.

For the second half the play was scrappy with Stroud failing to exploit their greater share of the ball. However, they added three tries after some good running, all of which were converted. At this stage L. Thomas, who had been covering and tackling well, went off with an injured shoulder. Once again Tallack, who had throughout the game played with fire and determination, got some life from the pack and Bart's prevented Stroud from adding to their score.

1st XV v. Trojans. Won 8-3.

On a rock hard ground at Southampton Trojans kicked off into the sun. Bart's were soon pressing strongly and it became obvious that they were the better of two average sides. The forwards, though better than in previous games, did not possess the required standard of fitness and determination. It was, however, against the run of the play that Trojans scored an easy penalty goal just before half time.

In the second half Trojans began strongly, but as time passed Bart's gained an increasing ascendancy and set up a steady pressure. The first try came when Creightmore broke partially from a loose Maul and passed the ball to Lloyd, who tore between two defenders with great resolution and ran 25 yards to score. Badley failed with the kick. Pressure on the Trojans line now mounted as Bart's warmed to the attack but each time they failed to score through mistakes. Finally, Laurent made a grand corkscrew run to score near the posts, Badley converted. In the remaining ten minutes Bart's were well on top. Main honours of the day go to Gawne who played his usual superb game, and Laurent, who has now developed into a first team player of some merit.

TEAM: B. W. D. Badley, D. A. Lammiman, J. Neely, J. Plant, J. Laurent, R. R. Davies, C. A. C. Charlton, B. Lofts, W. Costley, D. B. Lloyd, J. S. T. Tallack (Capt.), J. Creightmore, M. Whitehouse, E. F. Gawne, J. C. McKenzie.

1st XV v. Woodford. Won 16-8.

After a quiet start in ideal conditions, Woodford soon took the initiative and after twenty minutes opened the scoring with a penalty goal. The play then became more even and there was no further score before half time.

After the change over Bart's had the advantage of the slope and soon began to press. After 15 minutes Whitehouse broke away and passed to Tallack who scored, Badley kicked the goal and a few minutes later put over a penalty kick. Bart's were now strongly on the attack and Gawne soon broke away and passed to Laurent who ran hard down the wing for a good try. Five minutes later Tallack broke from the forwards and McKenzie scored. Bart's continued to press, but against the general run of the play Woodford scored another goal.

The game was notable for the improvement in forward play. Lloyd and Lofts were more comfortable at prop and Carr, in his first match for Bart's, hooked very well. Gawne and Badley were also outstanding.

TEAM: B. W. D. Badley, D. A. Lammiman, L. Plant, R. M. Phillips, J. Laurent, R. Rees Davies, C. A. C. Charlton, B. Lofts, C. Carr, D. B. Lloyd, J. S. T. Tallack (Capt.), J. W. B. Palmer, M. Whitehouse, E. F. D. Gawne, J. C. McKenzie.

1st XV v. R.M.A. Sandhurst. Lost 6-17.

1st XV v. Cambridge University LX Club. Lost 3-6.

### HOCKEY

1st XI v. City of London College. Won 5-2.

The greatest surprise of this first game of the season was the way in which an experimental forward line outdistanced their opponents and seized every chance that came its way. After ten minutes of inconsequential play, Anderson, at centre forward, scored with a quickly taken shot from the edge of the circle. A mistake in defence permitted an equalizing goal soon afterwards; but with a second goal by Anderson Bart's led at half time.

After a somewhat shaky start to the second half, during which only Nichols inspired confidence, the opponents' weakness on the left side of the field allowed Anderson to score two more goals. The second of these resulted from an intelligent reverse stick pass by Tabor, who then scored himself with a speculative flick. The opponents' second goal came from a sudden breakaway. Despite a disturbing last ten minutes, in which Nichols appeared to be defending entirely on his own, no further goals were scored.

TEAM: Doherty, Nichols, Ford, Batterham, Ross, Grant, Tabor, Roles, Anderson, Dunkerley, Blake.

**1st XI v. R.N.C. Greenwich.** Won 3-1.

Bart's started in a scrappy fashion and were soon a goal down, but the speed of the forwards and fast tackling by the defence began to take the play into the opponents' half. Anderson scored first, and then Batterham drove in a delightful shot from a short corner.

In the second half, with the team settling down, the speed of the Bart's forwards and halves proved too much for a tiring defence, and only weak finishing and over-eagerness prevented a much higher score. Dunkerley scored the third goal after an unfamiliar bout of close passing by the centre forward and inners.

TEAM: As above, with Reiss, Nicholson and Tait in place of Ford, Ross and Grant.

**1st XI v. Burnt Ash.** Drew 2-2.

A very fast start by the opponents gave Bart's little chance to settle down, and a mis-kick by the goalkeeper seized on by the Burnt Ash forward put us one down. Gradually the Bart's forwards began to get more of the ball and after a number of near misses Dunkerley scored with a fast shot from an acute angle. Soon after half time Roles scored off a rebound after several unsuccessful shots. After this some of the fire left the forwards, who were repeatedly off side, and the defence was tested severely. The calm play of Nichols was invaluable. Ten minutes before the end of the game Burnt Ash equalized when one of their forwards found himself completely unmarked on the edge of the circle, and though Bart's then produced their best play of the match, they could not score.

TEAM: R. P. Doherty, J. B. Nichols, B. B. Reiss, J. R. Nicholson, E. J. Batterham, H. B. Ross, A. S. Tabor, N. S. Roles, A. S. Anderson, D. R. Dunkerley, H. V. Blake.

**2nd XI v. Burnt Ash III.** Lost 0-3.

TEAM: H. Bower, C. J. C. Grant, J. A. Garrod, D. S. Wright, K. White, W. Pagan, A. P. Marks, R. McNeill, J. R. Nicholson, D. Harrison, P. G. Cassell.

**2nd XI v. R.N.C. Greenwich II.** Drew 2-2.

TEAM: Bower, Grant, Garrod, White, Wright, Pagan, Cassell, Almeyda, McNeill, O'Keiffe, Harrison.

In the Hospitals Cup Bart's have a bye in the first round and meet the London in the next, as last year. The game will be played by December 18th. We hope to publish the exact date later.

**CRICKET****Annual General Meeting**

The following officers were elected for the coming year:

President: Mr. J. E. A. O'Connell.  
Vice-Presidents: Prof. Sir J. Paterson Ross, Dr. N. C. Oswald, Dr. E. F. Scowen, Mr. J. Howkins, Prof. A. Wormall.  
Captain: J. B. Nichols, Vice-Capt.: A. P. Marks.  
Secretary: H. Bower. Treasurer: J. C. Owen.  
Committee: J. R. Nicholson.

**ROWING****Annual General Meeting**

The following officers were elected:

President: Prof. L. P. Garrod

Vice-Presidents:

Dr. M. Donaldson, Dr. A. W. Spence, Prof. A. Wormall, Mr. J. H. M. Ward, Dr. R. C. King, Mr. O. S. Tubbs, Prof. K. J. Franklin, Dr. J. H. Coulson, Dr. E. F. Scowen, Dr. A. G. S. Bailey,

Dr. J. C. M. Currie.

Captain: C. C. H. Dale.

Secretary: G. D. Stainsby.

Treasurer: D. A. Chamberlain.

Committee:

M. R. Burfoot, G. M. Besser, A. R. Geach.

The Boat Club Dance will be held in College Hall on December 14. There will be Cabaret, Buffet and Bar.

Tickets: 15s. (double).

The United Hospitals Winter Regatta for small boats and junior oarsmen will be held from the London Rowing Club on Wednesday, November 23.

**FOOTBALL****1st XI v. London Hospital.** Drew 0-0.

In the first match of the season Bart's did well to draw with a team that included ten members of last year's winning Hospital Cup side. This undoubted success was due to better defence, in which A. Whitworth, a former Cambridge Blue, was outstanding.

Play was even throughout the game, both sides unfortunately losing a player through injury—in the Bart's team it was Jumper who broke a talus. The forwards lacked cohesion and never really looked like scoring. Had they achieved this, it would have been an excellent curtain-raiser for the season.

TEAM: Kingsley, Kennedy, Jumper, Hackett, Whitworth, Clarke, Plumtree, Pilkington, Johnson, Arden, Jailler.

**1st XI v. Caledonians.** Won 4-0.

A slightly changed forward line showed more bite in this match and Bart's were unlucky to score only four goals. Plumtree opened with a hard volley and Pilkington followed with two more goals. The latter spoiled his hat-trick by shooting straight at the advancing goalkeeper with no one else to beat. In the second-half Pemberton scored from a twenty yard free kick to bring our total to 4. Many chances were wasted through wild passes; but when the team have settled down a little more we can expect better results. The outlook for the season looks most promising. The new goalkeeper Kingsley, did well to keep out a number of testing shots and should be an asset to the side.  
TEAM: Kingsley, Kennedy, Clarke, Hackett, Whitworth, Pemberton, Plumtree, Pilkington, Arden, Johnson, Ballantine.

**RECENT PAPERS BY BART'S MEN**

- ABRAHAM, Sir ADOLPHE. My most interesting case. VI. Malingering or malignancy. *Practitioner*, 175, July, 1955, pp. 96-7.
- ANDREASON, A. T. Cross-circulation. *Brit. med. Bull.*, 11, iii, 1955, pp. 233-5.
- \*BADENOCH, A. W. Acute retention of urine. *Brit. med. J.*, July 2, 1955, pp. 36-8.
- \*BALLANTYNE, K. I. W., and JACKSON, I. Ear, nose and throat surgery. *Anaesthesia*, 10, July, 1955, pp. 279-84.
- \*BETT, W. R. Moreton Stillé (1822-1855). *Med. Press*, 234, Aug. 17, 1955, p. 168.
- \*NAPT. Fourth Commonwealth Health and Tuberculosis Conference. *NAPT Bull.*, Aug., 1955, pp. 125-30; *Nature*, Aug. 6, 1955, p. 245.
- \*Anatole Chauferd (1855-1932). *Med. Press*, 235, Aug. 24, 1955, p. 192.
- \*Stephen Paget, F.R.C.S. (1855-1926). *Health Horizon*, Summer, 1955, pp. 40-44.
- \*Guillaume Mauquest de la Motte (1655-1737). *Med. Press*, 233, June 29, 1955, p. 613.
- \*Sir John Bland-Sutton (1855-1936). *Middx. Hosp. J.*, 55, June, 1955, pp. 66-71.
- \*Onward from Galen; a current causerie. Johann Georg Gmelin. *Chem. & Drugg.*, June 4, 1955, p. 163.
- \*Archibald Arnott (1771-1855). Napoleon's physician. Hermann Nothnagel (1841-1905). Lunsford Pitts Yandell (1805-1878). *Med. Press*, July 6, 1955, pp. 20-21.
- \*Zachariah Williams (1677-1755), physician, inventor, poor brother pensioner. *Med. Press*, 234, July 13, 1955, p. 45.
- \*Tuberculosis problems in the Commonwealth. *Nursing Mirror*, July 8, 1955, p. 101.
- \*Two great American surgeons. Samuel David Gross (1805-1884); John Blair Deaver (1855-1931). *Med. Press*, 234, July 20, 1955, p. 80.
- \*Albert Mathieu (1855-1917) and Mathieu's disease. Emil Berger (1855-1926) and Berger's sign. *Med. Press*, Aug. 3, 1955, pp. 127-8.
- \*James Parkinson. *Med. Press*, Aug. 10, 1955, p. 148.
- \*Anthonius Mathyson (1805-1878), inventor of the plaster of paris bandage. *Med. Press*, Sept. 7, 1955, p. 237.
- \*Gustav Gaertner (1855-1937), clinician and inventor. *Med. Press*, Sept. 28, 1955, p. 308.
- \*BLACKBURN, GUY. Ruptured visceral diagnosis and treatment. *Med. Press*, 234, Aug. 17, 1955, pp. 155-158.
- \*BOULTON, T. B. Oral chlorpromazine hydrochloride. *Anaesthesia*, 10, July, 1955, pp. 233-46.
- \*CAVE, A. J. E. Sir Arthur Keith, anatomist and anthropologist. *Conquest*, 43, 1955, pp. 10-12.
- \*J. C. Brash and —. Sir Arthur Keith: in memoriam. *J. Anat.*, 89, July, 1955, pp. 403-10.
- \*CUNNINGHAM, G. J. Studies in lung structure by low-voltage radiography. *Amer. J. Clin. Path.*, 25, March, 1955, pp. 253-60.
- \*CURETON, R. J. R. Malignant change in bronchiectasis. *Thorax*, 10, June, 1955, pp. 131-6.
- DUFF, R. S. Effect of adrenaline and noradrenaline on blood vessels of the hand before and after sympathectomy. *J. Physiol.*, 129, i, 1955, pp. 53-64.
- FARRAR, D. A. T. Otitis externa. *Med. Press*, 234, July 13, 1955, pp. 29-31.
- \*FRANKLIN, K. J. Experimental findings of possible relevance to hypotheses about "toxaemia of pregnancy." *Conf. et rapp. Cong. Internat. Gynec. et d'Obstet.*, 1, 1954.
- \*Adult medical education: a preclinical scientist's point of view. *Brit. med. J.*, Aug. 27, 1955, pp. 507-9.
- GARROD, L. P. Present position of the chemotherapy of bacterial infections. *Brit. med. J.*, Sept. 24, 1955, pp. 756-8.
- GARROD, O. (and others). Metabolic effects of 9 $\alpha$ -fluorohydrocortisone and of cortisone in adrenal insufficiency. *Brit. med. J.*, Aug. 20, 1955, pp. 367-70.
- (and others). The action of cortisone and desoxycorticosterone acetate on glomerular filtration rate and sodium and water exchange in the adrenalectomized dog. *J. Clin. Invest.*, 34, June, 1955, pp. 761-76.
- \*GOULD, J., (and B. S. Cooper). The treatment of the psychiatric and toxic aspects of influenza by parenteral vitamins. *Med. Press*, 234, Aug. 10, 1955, pp. 138-145.
- HALE, J. F., McDONALD, D. A., and WOMERSLEY, J. R. Velocity profiles of oscillating arterial flow, with some calculations of viscous drag and the Reynolds number. *J. Physiol.*, 128, 1955, pp. 629-640.
- , TAYLOR, M. G., and WOMERSLEY, J. R. The counter chronometer method for recording pulse-wave velocity. *J. Physiol.*, 129, i, 1955, pp. 27-8P.
- \*HANKEY, G. T. Pain of temporomandibular origin. *Long. Hosp. Gaz.*, 58, June, 1955.
- \*HARPER, K. A. KEMP. Radiology of the pancreas. *Modern trends in diagnostic radiology*, pp. 218-238.
- The radiological manifestations of diffuse systematic sclerosis. *Proc. Roy. Soc. Med.*, 46, July, 1955, pp. 507-522.
- HARRISON, R. J. The contribution of comparative anatomy to medicine. *Med. Press*, 234, Sept. 7, 1955.
- HAYNES, W. S. Hospital treatment of pulmonary tuberculosis in Africans. *Tubercle*, June, 1955, pp. 175-8, 181.
- Immunity to tuberculosis in East Africans. *East African Med. J.*, May, 1955.
- \*HAYWARD, G. W. Pulmonary oedema. *Brit. med. J.*, June 4, 1955, p. 1361.
- , and KNOTT, J. M. S. The effect of exercise on lung distensibility and respiratory work in mitral stenosis. *Brit. Heart J.*, 17, July, 1955, pp. 303-312.
- HEWER, C. Langton. Anaesthetic rooms. *Brit. med. J.*, July 23, 1955, p. 257.

- HEATHFIELD, K. W. G. Peripheral neuritis. *Med. Illus.*, 9, Aug., 1955, pp. 496-500.
- HODGSON-JONES, I. S. Acrodermatitis enteropathica. *Brit. J. Derm.*, 67, June, 1955, pp. 223-4.
- \*HOWELL, TREVOR H. Old folk who fall. *Practitioner*, 175, July, 1955, pp. 56-8.
- HUBBLE, D. V. The continuing education of the consultant. *Brit. med. J.*, Aug. 27, 1955, pp. 505-7.
- HUNTER, RICHARD, A., see MACALPINE, IDA, and —.
- JACKSON, I., see BALLANTINE, R. I. W., and —.
- \*JOKES, A. M., (and others). The function of kidneys autotransplanted to the iliac vessels. *Ann. Roy. Coll. Surg. Engl.*, 16, May, 1955, pp. 324-36.
- \*—, (W. J. Dempster and —). Emotional antidiuresis in the autotransplanted kidney. *J. Physiol.*, 128, i, 1955, pp. 122-30.
- \*JONES, F. AVERY, (E. Murland and —). The dietary control of obesity. *Practitioner*, 175, July, 1955, pp. 13-15.
- KEELE, K. D. Leonardo da Vinci on vision. *Proc. Roy. Soc. Med.*, 48, May, 1955, pp. 384-90.
- \*KENNAWAY, SIR EKNEST. Some problems in the study of cancer in man. *Brit. med. J.*, May 7, 1955, pp. 1107-1110.
- \*—, The identification of a carcinogenic compound in coal-tar. *Brit. med. J.*, Sept. 24, 1955, pp. 749-52.
- \*KINMONTH, J. B. Experience of the stripping operation for varicose veins. *Proc. Roy. Soc. Med.*, 48, June, 1955, pp. 442-3.
- KNOTT, J. M. S., see HAYWARD, G. W. and —.
- LEHMANN, H., (and others). A third example of haemoglobin D. *Trans. Roy. Soc. Trop. Med. & Hyg.*, 49, iv, pp. 399-400.
- \*MACALPINE, IDA, and HUNTER, RICHARD A. The importance of the concept of transference for present day theories of mental disease. *Acta Psychother. psychosom. et orthopaed.* Supp. 3, 1955, pp. 515-21.
- MCDONALD, D. A., see HALE, J. F., and others.
- McMENEMEY, W. H. A note on James Parkinson as a reformer of the lunacy acts. *Proc. Roy. Soc. Med.*, 48, Aug. 1955, pp. 393-4.
- \*MACKENNA, R. M. B. The art of dermatology. *Brit. med. J.*, Aug. 20, 1955, pp. 449-52.
- MAINGOT, R. Congenital atresia of the bile ducts. *Brit. med. J.*, May 21, 1955, pp. 1256-8.
- \*NYE, E. R. The flies of the London area. II. *Culicidae*: sub-family *Culicinae* (mosquitoes). *Lond. Naturalist* for 1954, pp. 114-126.
- PHILIPS, SEYMOUR. The eye signs in thyrotoxicosis. *Med. World*, 83, Sept., 1955, pp. 209-13.
- \*ROBERTS, G. FULTON, (and others). Acquired haemolytic anaemia occurring in young piglets. *Sang*, 26, i, 1955, pp. 24-30.
- ROBINSON, J. O. Carcinoma of the bladder treated by total cystectomy with the formation of an ileocolic bladder. *Proc. Roy. Soc. Med.*, 48, July, 1955, p. 538.
- \*RUSSELL, BRIAN. Occupational dermatitis in dentists. *Brit. dent. J.*, 98, May 17, 1955, pp. 348-52.
- \*—, A valuation of hydrocortisone ointment. *Lancet*, May 21, 1955, pp. 1038-43.
- \*SARMA, VISHNU, (S. Abraham and —). A case of annular spontaneous detachment of the cervix in an elderly primipara. *J. Ind. Med. Prof.*, 11, June, 1955.
- SCOTT, R. BODLEY. The treatment of acute leukaemia. *Brit. med. J.*, July 9, 1955, pp. 75-7.
- , The doctor in contemporary literature. *Brit. med. J.*, Aug. 13, 1955, pp. 341-3.
- \*SHEPARD, E. Deposit of calcium salts at the wrist: report of two cases. *J. Bone & Jt. Surg.*, 37B, Aug., 1955, pp. 453-5.
- SIMMONDS, F. A. H., (W. Pagel and —). Chemotherapy and cavity wall: histological observations. *Tubercle*, 36, Jan., 1955, pp. 2-15.
- TAYLOR, M. G., see HALE, J. F., and others.
- \*TIDSWELL, T. H. Penicillin anaphylactoid shock successfully treated with adrenaline. *Brit. med. J.*, Sept. 17, 1955, pp. 721-2.
- TUBBS, O. S. Surgical treatment in coarctation. *Brit. med. Bull.*, 11, Sept., 1955, pp. 197-9.
- , Surgical treatment of persistent ductus arteriosus. *Brit. med. Bull.*, 11, Sept., 1955, pp. 200-202.
- \*WALLIS, R. W. E. Metabolic rate changes following thyroid destruction by AT<sup>211</sup> and I<sup>131</sup> in the rat. *Proc. Soc. exper. Biol.*, 89, 1955, pp. 220-22.
- WEBER, F. PARKES. A note on so-called lymphatic tuberculosis. *Med. Press*, Aug. 3, 1955, pp. 119-20.
- \*WOODCOCK, W. H. Management and breeding of a new laboratory species *Meriones libycus*. *J. Animal Tech. Assoc.*, 6, 1.
- WOMERSLEY, J. R. see HALE, J. F., and others.

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

## BOOK REVIEWS

*Any fool may write a most valuable book by chance, if he will only tell us what he heard and saw with veracity.*

—Thomas Gray.

**B.C.C. and VOLE VACCINATION**, by K. Neville Irvine. Publ. N.A.P.T. Pp. 96. Colour plates 10. Price 12s. 6d.

This is an excellent little book. Though only pocket size, it covers the whole field of immunisation against tuberculosis. It is written in a lucid readable style, and is amply illustrated with useful photographs and drawings.

The main theoretical points, including safety and efficacy and the indications for the two vaccines and their comparative merits, are well discussed, with interesting examples from the world-wide experience of B.C.G. It is also highly practical, and gives exact details of the technique of all the diagnostic tests and vaccination methods in clear detail.

It only takes an hour or so to read, and I think this a reasonable investment of time for an interested student. The harassed crammer, near Finals, can get a rapid bird's eye view of the subject from the half-minute summaries which the author has thoughtfully provided at the end of each chapter.

For anyone who is going to use either of these vaccines, or to advise on their use, it is a guide of the utmost practical value.

J. H. COULSON.

**SKIN DISEASES** by Reginald T. Brain, Duckworth's Modern Health Series. 8s. 6d.

Like the rest of the Modern Health Series, this book is not a textbook, nor is it a substitute for one from the student's point of view. Its object is to give a general background of information to satisfy the natural curiosity of patients about their diseases. Too often in the past the demand for this kind of work has been satisfied in a catch-penny manner, incomplete and misleading where not actively harmful. This book, however, is both accurate and authoritative. It contains a remarkable amount of information, and a large number of false beliefs and old wives' tales are effectively disposed of.

One of the most frequent and justifiable criticisms levelled at the medical profession is that we are secretive and do not explain to patients the nature of their ailments; this may sometimes be because we find it difficult to translate our concepts, so wrapped up in jargon, into simple straightforward language intelligible to patients. This little book can be read with benefit by any student, doctor or nurse, for it contains many ideas and examples of how one can explain in simple language the nature, workings and disorders of the skin.

I. S. HODGSON-JONES.

*Continued overleaf*

**MATERIA MEDICA FOR NURSES** (Third Ed.) by W. Gordon Sears. Edward Arnold (Publishers Ltd.), 9s.

With the increasing number of new drugs, many with several names, a textbook has become a necessity and Dr. Gordon Sears' is well known to all nurses. This new edition is comprehensive and up-to-date and contains an adequate account of all drugs likely to be met in practice today, besides some useful conversion tables. The price is most reasonable for such a store of information.

Dr. Gordon Sears has not consistently used the approved name for the drugs he describes and gives no indication which are proprietary names. "Sulfasuxidine" appears as the name of choice for "Succinylsulphathiazol." There appears no obvious reason why the dosage table should be written in Latin. A nurse who wanted to know the dose of folic acid might not think of looking under "acidum folicum." The Index too is not quite worthy of the text, but the book is excellent value for the price.

W. E. HECTOR.

### THE WORLD'S GREATEST BOOKSHOP

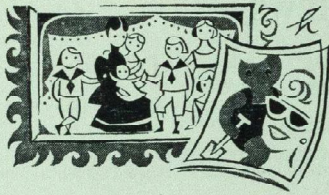
**FOYLES**  
FOR BOOKS

Bookbuyers throughout the world turn to this bookshop as a knowledgeable source of information on all their book requirements. And from generation to generation they praise and recommend Foyles — and buy their books here.

*Foyles have departments for Gramophone Records, Stationery, Music, Handicraft Tools and Materials, Magazine Subscriptions, Lending Library, Foreign Stamps.*

**119-125, CHARING CROSS ROAD, LONDON, W.C.2.**

Entrance 5660 (16 lines) • Open 9-6 (inc. Sats.)  
Two minutes from Tottenham Court Road Station



## A Chance for Child-lovers

The geneticists, those unfortunate students of heredity, are agitated by the way families in this century have shrunk in size. If any race—whether of men or of animals—is to thrive, and maintain a good stock, they say, there must be plenty of them about, so that the genes have plenty of opportunities for reshuffle. The genes are those mysterious bits of nuclear protoplasm by which hereditary characteristics are handed down from generation to generation; and of course every child gets half his genes from his father and half from his mother.

Well, the geneticists say, there must be plenty of cards in the pack if shuffling and re-dealing is to produce interesting and refreshing combinations. The smaller the pack the smaller the variety of hands you can deal.

But the hereditary pack, confound it, doesn't even remain constant. The genes in every generation show . . .

*Would you like to hear more? Unfortunately, space will not permit reproduction of the whole of this entertaining and informative essay, as it appeared originally in The Times. It is one of a collection of delightful medical musings—all from the same wise and witty pen. If you would like a copy of "The Prossings of Podalirius" just send us a card at the address below.*

### VITAMINS LIMITED

DEPT. (G.6)

Upper Mall, London, W.6

Makers of

BEMAX VITAVEL SYRUP VITASPRIN

BECOVITE BEFORTISS PREGNAVITE COMPLEVITE

FERTILOL CREAM CHOLINVEL ETC.

### SURGEON AT WAR, by Lt. Col. J. C. Watts, R.A.M.C. Allen and Unwin: 12s. 6d.

This account of Col. Watts' experiences as an army surgeon is well written and full of interest. His active campaigning started in Palestine before the last war and carried him through North Africa, Italy, Germany, Java and finally to Korea. For most of this time he was performing the initial surgery, although later he commanded the surgical division of a General Hospital.

The book is written primarily for the lay person and is full of the excitement of war; the more technical aspects are well described in simple language. The medical reader will appreciate the zest of the author and will find it difficult to put down the book until he has finished it.

A. D. M-F.

### TUBERCULOSIS, by Cedric Shaw. Modern Health Series. Duckworth and Co. Ltd. 8s. 6d.

The Modern Health Series, which was under the editorship of the late Lord Horder, is intended to give patients with chronic illnesses accurate information about their disease. Dr. Shaw's contribution is an authoritative and comprehensive account of tuberculosis which is unlikely to give any wrong impressions to the lay reader. He has reduced the technicalities of the subject to the level of the "Pelican" series, and provides an adequate glossary of medical words. There is a section of clear diagrams and x-rays, illustrating the chapters on pathology and collapse therapy. A valuable chapter answers "some common uncertainties" experienced by patients. The author believes that allergy is part of the immune response and is a strong supporter of B.C.G.

For the patient, and the reading public in general, this should be a most useful and informative book.

C. B. S. W.

### ROUND THE FOUNTAIN

The best of the humorous prose and verse published in *The St. Bartholomew's Hospital Journal* since its foundation in 1893 has been brought together in this book, now in its fifth edition.

The contents include essays by Richard Gordon (Alan Tois) and R. B. Price's *The Battle of Furunculus*, which must surely be the most famous of all humorous medical poems—it has been reprinted, not always with acknowledgment, in magazines all round the world.

If you are at a loss for a Christmas present, why not buy *Round the Fountain*? Copies may be seen and purchased in the Library and Nurses Post Office or obtained by post from The Business Manager of the Journal, St. Bartholomew's Hospital, E.C.1.

243 Pages

5/-

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LIX

DECEMBER 1955

No. 12

## EDITORIAL

THE YEAR of the Accelerator or, when that is forgotten, the year in which the Hospital crossed Little Britain. These are the tags likely to be fastened to 1955 by future generations. Retrospection is pandemic at the close of the year and we make no excuse for setting down, in no particular order, some of the year's ephemeral happenings, on most of which we have already commented.

Changes in the senior Staff have been few. Professor Christie left us to take up an appointment at McGill University, Dr. Scowen replacing him as Director of the Medical Unit. Dr. Bodley Scott is now the head of a Firm and Mr. G. W. Taylor is the Assistant Surgeon on the Unit. Dr. G. J. Cunningham moved to the Royal College of Surgeons where he is Professor of Pathology. On the nursing side, our Assistant Matron since 1939, Mrs. J. Thacker, and Miss Jupe (Sister Harvey), for many years Senior Sister, have both retired. Honours and honorary degrees are too numerous to record in detail. Lord Adrian, who was re-elected P.R.S., received his Barony, and Sir Wilfred Le Gros Clark and Sir Geoffrey Keynes, their Knight-hoods.

Lord Horder's death in August was a severe blow and his absence is, and will be, keenly felt. Another consulting physician, Dr. H. G. Adamson, the dermatologist, died in the same month. As we go to Press we learn of the death of Mr. Thomas Hayes, a former Clerk to the Governors, who retired shortly before the war.

The year 1955 has seen steady progress made on the new Physiology and Biochemistry Laboratories at Charterhouse, and the day cannot be far off when the old College Hall will be demolished. At the Hospital, a new children's ward, Kenton, has been opened. The Refectory has been pleasantly redesigned and renovation has started on the Clerk's house, which was gutted during the war. Some further work has been carried out

in the neighbourhood of the Slope: but the fibre-board partitions separating the lecture theatre from the carpenters' shop remain. There is a photograph of the Little Britain site on the following page.

View Day proceeded without a hitch, the high-lights being the newly christened Linear Accelerator at Charterhouse and the charming murals in the anaesthetic room of the new Gynae Theatre. The other events of the year, Sports Day, The Art Exhibition, Play and Pot-pourri were all uniformly successful and have been, or will be, described in the *Journal*. In sport we still do not do as well as we should. Our only major victories were won by the Sailing and Women's Hockey Clubs.

According to our records, Bart's men have published over 350 papers, articles and books during the year. The most prolific author is Dr. W. R. Bett, who specializes in medical history, while Dr. F. Parkes Weber wins the prize for the paper with the most interesting title: *Can acquired camptodactylia (Landonzy) be explained as a manifestation of an inborn lipid storage abnormality of metabolism?* We now know how Dr. Bodley Scott spends his spare time, for he has written a masterly paper on *The Doctor in Contemporary Literature (Lancet, Aug. 13, p. 341)*. It is very amusing and thoroughly recommended. We cannot resist making one quotation: "... the night sister at St. Bartholomew's was behind a screen with a recently admitted casualty and the waiting detective heard the sound of a kiss, followed by a whisper of "now rest and get well for me, soon-soon". If you wish to know the context, you must read the article. Mr. Kenneth Walker continues to extend a helping hand to the readers of *Picture Post*, and Dr. Richard Gordon, our professional humorist, and an ex-editor of this *Journal* incidentally, has published two more best sellers and written for *Punch*.

Travelling abroad has been popular this year and members of the Staff have between them visited most parts of the world. The largest contingent went to Canada, in order to attend the combined meeting of the British and Canadian Medical Associations at Toronto.

Four editorials ago we talked about some members of the Hospital who had made the Headlines. Since then we have been doing rather well on radio and television. Dr. A. J. Marshall, our Reader in Zoology, introduced a series of three programmes on the natives of central New Guinea. Drs. Lawther and Waller, who are leading experts on smog, gave a broadcast interview in which they explained the principle behind the mysterious bottles they have been supplying to out-patients. And an eminent psychiatrist lent respectability to a TV show on Hypnotism. We withhold his name in order not to compromise him with the Central Ethical Committee, but we can tell you that he wears a

monocle.

The record of Professor Rotblat, however, is so impressive that it deserves a separate paragraph. His mention in 'Beachcomber' made him distinctly one up, while a talk after the 9 o'clock news made his position virtually unassailable. To cap this he was one of the seven famous scientists to sign the nuclear declaration sponsored by Earl Russell and the late Professor Einstein. But he excelled himself at the Geneva Atoms for Peace conference where he completed three television broadcasts. His skill and charm in conducting interviews make him a serious rival to Richard Dimbleby and Wilfred Pickles. The *pièce de résistance* came in the last programme in which he demonstrated that Isotopes are Good for You by calmly quaffing a wineglass full of radio-active iodine and holding a Geiger-counter to his neck. In the not too distant future the Professor will need a Press agent to handle his publicity.

#### East Anglian Rahere Society

The East Anglian Rahere Society held a Dinner at the Royal Norfolk and Suffolk Yacht Club, Lowestoft, on the 29th October. The Chair was taken by Dr. H. R. Rogerson and Dr. Edward Cullinan was guest of honour; some twenty members were present. The health of the Hospital, coupled with the name of Dr. Cullinan, was proposed by Dr. George Day of Mundesley. Dr. Cullinan in his reply gave us some recent news of the Hospital and it was revealed that both speakers had, at one time, shared digs. Their comments upon each others behaviour provoked much mirth among the already convivial company. Although the number present was smaller than of recent years, an enjoyable evening was had by all those present.

This Dinner has become an annual function and will be held next year at Colchester. It would be helpful if anybody living in Norfolk, Suffolk or Essex who is interested, would send their address to Dr. Wilfred Knight, 10 Fonnereau Road, Ipswich, or to Mr. A. P. Bentall, 69 Newmarket Road, Norwich, if they have not already done so.

The Journal Staff wish all their readers, at home and abroad, a prosperous New Year.

\* \* \*

#### Club Days

Few of the Hospital's seventeen sports clubs have contrived to give a particular sporting event the panache of a social occasion. Sports Day is of course the best known and closely rivalling it in popularity is the Rugby Club's seven-a-side tournament. More recently the oarsmen and hockey players have joined the ranks of those who believe there is more in sport than mere exercise.

Some club functions proceed with silent and uncanny efficiency, rather in the manner of a Rolls Royce; while others are like an excursion in some Genevieve, progressing inevitably from crisis to chaos.

In the latter class falls the Boat Club's own regatta, held for the second time with St. Thomas' at the London Rowing Club. This year it was the turn of Bart's to organize the events and whereas on the previous occasion it was a shambles and not finished, this year the programme was completed. A



Dept. of Medical Photography 81228

The foundations of the new Hospital building as seen from the Children's Department. The tower and cloisters of St. Bartholomew-the-Great are in the left background. The fence at the bottom of the photograph borders Little Britain.

date had been carefully chosen with low water in the afternoon; but somehow last year's tide table was used and nobody was really surprised when the spring high tide flooded the embankment and had the river in turmoil. Small wonder then that odd things happened: two eights rowed from opposite ends of the course, each believing their opponents had scratched, and more than one oarsman discovered that he was expected to race against himself. At the end of the regatta Mrs. Hadfield presented the cups and medals, very nobly filling the sculling cups of both Hospitals with champagne before parting with them.

The Hockey Club possibly went too far in having a social occasion with no hockey; but as they invited a representative of the *Journal* to their cocktail party (other clubs please note), we can hardly say that it was anything less than a success. Among the guests were Sir James and Lady Ross, Professor Wormall, Dr. Ellis and an ex-Vice-President of the Club, Professor George Cunningham.

#### Certificate or Certification?

A General Practitioner in Kent has forwarded this dramatic letter:

Dear Sir,

So sorry to trouble you. Would you please Sir. Grant me a Certificate for the Council for a new House. Last Monday, Mr. Smith's Men Started pulling down the Houses, opposite me. That Huge Chimney fell, and terrified me, and Choked me with dust all over my Bed, it's filthy. The Bricks crashed down my Chimney and smothered me and all the Furniture. I have been ill ever since with the Colic, I have to go to the Lav nearly every ten minutes my Headache's awful, please Sir, may I have a Bottle of Medicine, and a little Ointment, please Sir, Don't come near the House or the Bricks will fall on your Head. This House is unfit for Human Habitation, Thanking you,

yours Sincerely,  
\_\_\_\_\_ (Mr.)

## NOTICES

## Journal Staff

The Publication Committee of the JOURNAL invite applications for the posts of Assistant Editor and Assistant Manager, which become vacant at the beginning of January. Those interested in a journalistic career (the Manager has an expense account) should write to the Editor as soon as possible. Previous experience, though desirable, is not essential.

\* \* \*

Princess Tsahai Memorial Hospital  
Addis Ababa, Ethiopia

RADIOLOGIST: Up to £2,058 per annum income tax free.

RADIOGRAPHER: Up to £1,284 per annum income tax free. Free accommodation and basic furniture. Excellent temperate climate, above malaria level. Satisfactory schooling to Matriculation standard. Apply to: Honorary Secretary, Princess Tsahai Memorial Hospital Council, 3. Charteris Road, Woodford Green, Essex.

\* \* \*

## Catholic Society

## LECTURES ON MEDICAL ETHICS

A series of lectures covering various aspects of medical ethics will be held on Mondays at Bourne House, 13, Devonshire Place, W.1, at 6.15 p.m., commencing on January 9. The speakers will be a moral theologian, consultants and a hospital chaplain.

\* \* \*

## Bart's Rugby Club Tie

The Committee of the Students Union have approved the application of the Rugby Club for a Club tie. The tie has a maroon background on which are Bart's crests with the letters XV in gold underneath.

The tie will be awarded to members of the Club, both past and present, who have represented any Hospital XV in twenty or more matches.

The tie will be available early in the new year and will cost 12s. 6d. (13s. post free). Applications from old Bart's men together

with some indication of their past playing record and a cheque payable to the St. Bartholomew's Hospital R.U.F.C., should be sent to the Hon. Secretary, Bart's R.U.F.C., the Abernethian Room, St. Bartholomew's Hospital.

\* \* \*

## Oxford-Bart's Club

The Club's Winter Dinner will be held at the Royal College of Surgeons on February 7. Anyone who is eligible for membership, but has not received an invitation, is requested to write to the Hon. Secretary, the Oxford-Bart's Club, the Abernethian Room, St. Bartholomew's Hospital.

## HOSPITAL APPOINTMENTS

## Dr. Spence's Firm

Chief Assistant (from 14.11.55)  
Dr. R. R. de Mowbray (vice Jenkins).  
Junior Registrar (from 1.11.55)  
Dr. G. W. H. Havard (vice Reiss).

## Dr. Bodley Scott's Firm

Junior Registrar (from 1.11.55)  
Dr. M. J. Linnett (vice Munro-Faure).

## Surgical Professional Unit

Chief Assistant (from 1.11.55)  
Mr. M. A. Birnstingl.

## Mr. Hume's Firm

Chief Assistant (from 1.10.55)  
Mr. R. B. McGrigor.

## Thoracic Department (Hill End)

Senior Registrar (from 1.11.55)  
Mr. J. G. Callanan (vice Paneth).

## Radiotherapy Department

Senior Registrar (from 1.10.55)  
Mr. R. J. M. Whittle (vice Shulman).  
Registrar (from 1.10.55)  
Mr. H. Horwitz (vice Whittle).  
Senior House Officer  
Mr. J. R. Johnson (vice Horwitz).

## LETTERS TO THE EDITOR

## TUBERCULOSIS APPEAL

To the Chairman, Tuberculosis Appeal  
Sub-Committee

Dear Mr. Dawrant,—I would like, on behalf of the British Students Tuberculosis Foundation, to express the very warm thanks and appreciation of the Foundation to the Bart's Students Union and to the College Council for their very generous gift to the Foundation, and to congratulate all concerned on the very successful result of the appeal. It is very encouraging to receive this large-hearted help, and we appreciate very much both the energy and goodwill, from the students past and present, that went into organising the appeal, and also the very practical expression of sympathetic support by the Council.

Your supporters will be glad to know that, in addition to the Pinewood Unit for men, the unit for women students, at all stages of treatment, recently opened at High Wood, Brentwood, under the supervision of Dr. F. J. Bentley, M.D., F.R.C.P., is now fully occupied and is providing tuition facilities for women students undergoing treatment and convalescence.

Our Committee has noted with interest that you hope to be able to send further contributions in future years. May we send you our warm thanks for this intention in advance, and our very best wishes to all who have contributed.

Yours sincerely,

RONALD J. STILL,  
(Hon. Treasurer).

59 Gloucester Place,  
Portman Square, W.1.

## SIR ANTHONY BOWLBY

Sir,—Mr. Reginald Vick's address to the Osler Club of London reminds me of an incident which well illustrates Sir Anthony Bowlby's lovable personality. I was one of his dressers in 1904 when the grandeur of the period was still at Bart's. Sir Anthony came to the Hospital in a landau, drawn by a fine pair of horses. Several other senior members of the staff had similar carriages, whilst some of the juniors had broughams.

Whilst home in the Rhondda Valley I was asked by an elderly collier if it was possible for me to arrange for his admission to Bart's. He had been waiting for a considerable time for a hernia operation at the Cardiff Hospital. I was astonished, as that was a time of very low wages and large families in the South Wales coalfield. However, he told me that his friends would provide the train fare. I asked my H.S., who referred me to Sir Anthony, who readily agreed, saying that he would be pleased to meet a Welsh collier. The

manager of the colliery had wisely removed him from the coalface to the stables, for he came originally from a farm in West Wales, and he was now in charge of a number of pit ponies.

On admission Sir Anthony gave him a special welcome and later was much interested in the patient's account of his old work of coal-cutter and of his care of the ponies, and told him that he had a pair of good horses which he should see before leaving the Hospital. Sir Anthony asked me to remind him, and shortly before his discharge the patient was walking round the Square with others when Sir Anthony arrived. I had warned him to be near when the carriage stopped and, to the astonishment of a large group of students, we see Sir Anthony and the old collier, who had removed his cap, walking round admiring the magnificent pair of bays. On return home he told his friends of "the wonderful kindness of a great London surgeon" and that I had chosen "the right place to learn to be a doctor".

Yours very truly,

IVOR J. DAVIES.

Aberystwyth

THE OLD GUARD COUNTER-  
ATTACKS STUDENT APATHY

Sir,—Your editorial in the October issue of the *Journal* calls for some comment. The provocative tone is unfortunate, to say the least, and I feel it displays a certain ignorance of the facts. While it cannot reasonably be denied that the Abernethian Society is no longer the eminent body it was in former times, it is disingenuous in the extreme to imply that this is the result of mismanagement by successive committees. When faced with apathy and general disinterestedness among a large proportion of the students, as has been the case in recent years, any committee is severely handicapped, however vigorous and active it may be. The editorial spectre of nepotism amongst a handful of self-seeking Oxonians is a shibboleth, and indeed has a certain air of pettiness about it.

Your editorial raises many points for discussion, too numerous to be dwelt on here. However, I would have thought that a very good case could have been made out for having occasional lectures that bear "no relation whatsoever to medical science and practice," pace the laws of the society.

Furthermore, it seems hardly relevant to compare the Abernethian Society to the Junior Osler Society, which is a small Society with a very limited membership, devoted solely to the historical aspects of medicine.

The lack of active student participation to which you refer in your editorial is not confined to the Abernethian Society, nor is it the fault of a few

individuals, sincerely trying to do their best to arouse interest in the Society. I doubt if the situation has changed in the short time since I was a student, and I would suggest that the basic fault is still the widespread lack of enthusiasm for any extra-curricular activities. Too many students are simply not interested in anything outside ward rounds and formal lectures. This is no new phenomenon, and I do not pretend to know the answer to the problem. It will certainly not be solved by editorial diatribes against those who are trying to remedy the situation.

Yours, etc.,

DUNCAN THOMAS.

Residential Staff Quarters,  
St. Bartholomew's Hospital.

### THE COMMITTEE VINDICATED

Sir,—From October, 1953, until September, 1955, the activities of the Abernethian Society have been as follows:—

Lectures on Medical Subjects ...	14
Lectures on Non-Medical Subjects ...	8
Clinical Evenings ...	3
Debates ...	2
Meetings at which Students read Papers ...	2
Visits ...	6

In addition there were a series of Discussions on Religion and Medicine, and a film show.

In the Summer of 1953 the Committee of the Abernethian Society held a series of Committee Meetings at which the Old Law, quoted in the October Editorial, was discussed. It was decided to extend the activities of the Society beyond the Old Law, and to hold Non-Medical Meetings. This decision was taken because the Committee felt that the activities of the Society should not be confined to the small group of students who would be interested in the purely Medical Meetings; provided by the Old Law. The Committee felt there was a demand for something more and that they could serve the Society best if they extended the activities so that Students had the opportunity to hear and to meet great men from all walks of life. The record shows that they did not forget the main object of the Society as laid down in the Old Law. The Minutes of these Committee Meetings are recorded in the Minute Book.

If the Editor of the *Journal* considers that the Committee of the Abernethian Society has failed in its task and was not justified in extending the Society's activities, then it is his duty to call an Extraordinary General Meeting of the Society to discuss the Committee's Policy.

The Committee of the Abernethian Society looks to the *Journal* for support and encouragement; for several months it has received nothing but misinformed criticism. It is doubtful whether this is in the best tradition of the *Journal*.

Yours, etc.,

JOHN MILLARD.

Hon. Secretary, Abernethian Society,  
1953-54.

College Hall,  
Charterhouse.

### TRADITIONS OVERBOARD

Sir,—I should like to discuss in your columns some points arising from your *tour de force* against the Abernethian Society in the October *Journal*.

The lack of original work presented before the Society by students arises rather from the conditions of medical education today than the nature of the Society itself. During the lifetime of the Abernethian Society the corpus of recognised knowledge has increased enormously. The study of this knowledge must necessarily occupy more of the student's intellectual life than in previous generations. It is therefore not surprising that his favoured extra-curricular interests should be sport, entertainment and general culture rather than the writing of papers and the presentation of cases.

In addition, even in Paget's time discoveries by students were rare, and now that research involves complicated techniques they must be more uncommon still. Papers read by students must usually be reviews or the presentation of cases, and in neither of these can the student speak with sufficient authority to lead to valuable formal discussion.

While emphasising the general limitations of paper reading by students I am sure there is still scope for a few each year, particularly if they deal with medical history. At the same time the value of hearing great men on their subjects should not be underestimated, even if it is passive. Admittedly not all the Society's past speakers have been great men, but great men have not always commanded the audience from the Society they deserve.

The Abernethian Society should serve the present day intellectual aspirations of its members rather than its own traditions.

I am Sir,

Yours faithfully,

C. B. S. WOOD.

The Abernethian Room.

\* \* \*

### Our Columnist writes:

The Editor has kindly invited me to comment very briefly on these letters. Dr. Duncan Thomas raises the cry of apathy. Neither the Editor nor myself believe in student apathy; we do believe, however, in *chacun à son goût* (see this *Journal*, Nov., p.350). In any case the attendance at the Society's meetings is remarkably large, averaging over 70 (the number of students is under 500). Mr. Millard makes much of the 'Old Law'. As far as I can ascertain from the minute book, it is still the law. He is also mistaken in thinking his committee introduced non-medical topics into the curriculum. This was done before he was born. His suggestion apropos an Extraordinary General Meeting is interesting, unfortunately the Editor cannot accept as he is not an official member of the Society (see law 3), nor, for that matter are the members of the present Committee. This is a trivial point, but it does indicate a lack of interest, as did the unconstitutional summer elections. Mr. Wood answers the criticism, though his reasoning would not, I think, have endeared him to Dr. Gee.

## ELECTROMYOGRAPHY

by K. M. BACKHOUSE

MUSCLES contract when subjected to an electrical stimulus, a fact known since Galvani's classical experiments in 1796. Although Galvani himself believed that his experiments demonstrated the liberation of 'animal electricity' by the muscles, his views were generally dismissed. That electrical charges are produced on muscular contraction was suggested by Matteucci (1842) and by du Bois-Reymond (1848) but their observations also received scant credence. Hermann (1879), therefore, can be cited as the first to demonstrate these potential changes convincingly, in eliciting measurable diphasic currents from the forearm following electrical stimulation of the upper arm nerves. Some years later Wedenski (1885) heard the effects of these potential changes in the contracting biceps brachii muscle, having inserted two electrodes into the muscle and coupled them to a telephone ear-piece.

Not until the invention, first of Lipmann's capillary electrometer (1875) and later of Einthoven's string galvanometer (1906) did instruments capable of following rapid changes in potential become available. Using these instruments, limited as they were in scope, Piper (1912), and later a Bart's man, Dr. E. D. Adrian (now Lord Adrian, P.R.S., O.M.), and his co-workers (1929), studied the action potentials produced by contracting muscles, and their pioneer work forms much of the experimental basis of electromyography.

Some 20 years ago, Dr. Denny-Brown, while still at Bart's, experimented with the possibilities of clinical electromyography; but it was not until the 1939-45 war and its associated advances in the use of valve amplifiers, that another Bart's man, Dr. Graham Weddell, and his collaborators Feinstein and Pattle (1944) working in the Anatomy School at Oxford, laid the foundations of clinical electromyography.

The modern electromyograph consists essentially of the sampling electrodes and a high gain valve amplification system feeding into a cathode ray oscilloscope, or a loud-speaker, or both. The electromyograph designed by

Multitone Ltd. for St. Bartholomew's Hospital is such an instrument, having, however, a number of additional features intended to assist the diagnostician in his work (Fig. 1).

### THE ANATOMICAL AND PHYSIOLOGICAL BASIS OF ELECTROMYOGRAPHY

Muscle fibres consist essentially of the sarcoplasm, which embodies a variable number of myofibrils (the contractile elements of the muscle), surrounded by a thin limiting membrane, the sarcolemma. As in the case of nerve fibre, this limiting membrane separates the interior of the muscle, which is maintained in a state of electrical negativity, from the positively charged exterior. The ionic balance around the sarcolemma is said to be maintained by an excess of potassium ions within the cell and a constant active transportation of sodium ions out of the cell. The result of this ionic

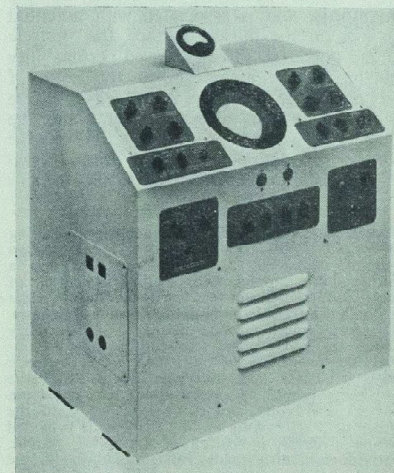


Fig. 1. The electromyograph (see footnotes).



balance is that although in the relaxed muscle a potential difference exists between the interior and the exterior of the individual muscle fibre, no potential difference exists between different points on the surface of the fibres, all points possessing a positive charge (relative to the inside of the cell). If, therefore, two electrodes are placed in the substance of a relaxed muscle mass (i.e. the electrodes are lying between the muscle fibres and therefore related to the surface only of the fibres) no potential difference exists between these electrodes, and consequently, no passage of current will be registered by a galvanometer placed between the electrodes, or by movement of the light spot on the screen of the cathode ray oscilloscope of an electromyograph.

When a muscle fibre is stimulated, a small quantity of acetyl-choline is liberated at the motor end-plate, and this substance produces a local, transient increase in the permeability of the limiting membrane of the muscle: the ionic balance is thereby broken down and ionic transference takes place across the membrane, giving rise to a potential change, the 'end-plate potential.' This process leads to an increase in the permeability of the surrounding membrane, which becomes depolarized; an excitation wave is thus generated along the length of the muscle fibre which initiates contraction of the myofibrils, and is associated with potential change on the muscle surface, the 'muscle action potential.' The increased permeability of the surface membrane at the point of passage of the excitation wave leads to a free movement of ions across the membrane, the outside of which becomes negative relative to the surrounding polarized area. If two electrodes are placed on the surface of this

The instrument is a double channel unit, having two head amplifiers with balanced input for two sets of electrodes. The amplifiers feed into a further main amplifier for audible indication of electrical activity, and into a Cossor Double Beam Cathode Ray Tube for visual indication of activity. The main amplifiers have filaments of their early stages supplied by high frequency current to prevent the possibility of hum pick up. They each have a coarse and fine gain control and the sensitivity is such as to give about 1 cm. deflection for 30 microvolts, and the noise level is of the order of 3 microvolts r.m.s. A meter is provided which gives an indication of the power output. Provision is also made for stimulation of the muscle being examined, by a built-in Stimulator, intended to give low voltage shocks via the coaxial needle, to indicate the exact location of the motor

fibre, as the excitation wave passes the first electrode, current will pass from the positively charged second electrode to the negatively charged first, which current can be measured on a galvanometer, or on the cathode ray oscilloscope of an electromyograph. After the passage of the wave, the area in contact with the first electrode will become polarized again, and so positively charged; but as the wave reaches the second electrode this will in turn become negatively charged and current will pass in the reverse direction, i.e. from the first electrode to the second. The electrical changes which will be recorded in such a passage of the excitation wave and the consequent muscular contraction will lead to a deflection in the recording instrument first in one direction and then in the other, producing the typical diphasic wave form shown in figure 2. The normal time taken for such activity in a single muscle fibre is in the region of 1 millisecond and the amplitude is about 100 microvolts.

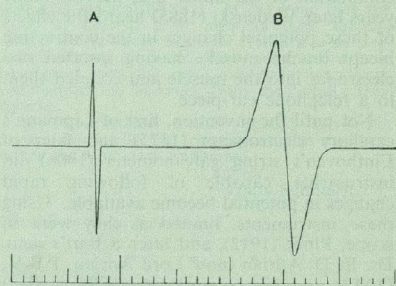


Fig. 2. Diagrams of the action potentials from (A) a single muscle fibre, (B) a motor unit. (Time scale: Small divisions=milliseconds).

Such is the picture seen under laboratory conditions when single muscle fibres are examined; but in the intact animal, muscle action is associated not with single fibre

point. A system is provided where transient phenomena will trigger off the sweep of the oscilloscope so that these phenomena may be readily detected if they exceed a certain pre-determined level (Event Trigger Switch). A balance control on each amplifier is available for use with surface contact electrodes and to balance out any hum picked up on the electrode leads. A camera unit is also provided with a separate oscilloscope with a photographic blue trace. The time-base of this oscilloscope is triggered as required by the time-base of the main unit. (Photo: Multitone Ltd.)

activity, but with motor unit activity. Each motor unit consists of anything up to 300 fibres (in a coarse muscle), contracting synchronously throughout the muscle. The clear-cut diphasic wave seen when two elec-

normal somatic muscle produces a rough potential rhythm with a frequency of about 50 per second (Piper). Voluntary movement, then, produces on the cathode ray oscilloscope, after amplification of the potentials, a

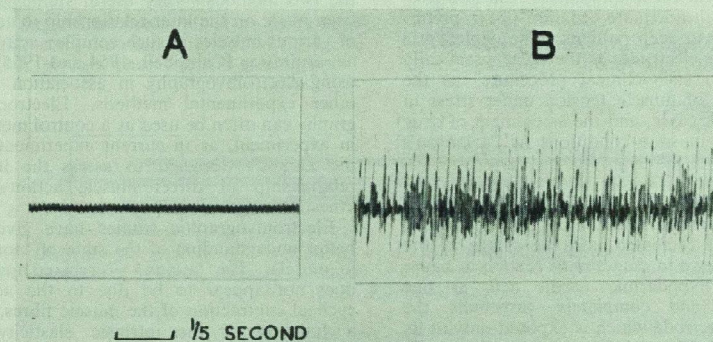


Fig. 3. Photographic records of electromyographic tracings showing (A) the 'electrically silent' picture of relaxed muscle and (B) the 'interference pattern' of fully active muscle.

trodes are placed carefully on the surface of a single fibre can hardly therefore be expected when the electrodes are placed, of necessity, rather haphazardly in the surface of the intact muscle. Nevertheless, the normal electrical activity of all the fibres of a motor unit summates smoothly to give a monophasic, diphasic or triphasic wave of up to one millivolt amplitude and between 5 and 10 milliseconds duration (Weddell, Feinstein and Pattle, 1944): the diphasic wave form is that most commonly seen. Occasionally polyphasic motor unit potentials are seen in normal muscle and the facial muscles may show quite a high proportion of such potentials (Petersen and Kugelberg, 1949). The actual amplitude and duration of the potentials recorded naturally depends to a considerable extent upon the position of the electrodes in relation to the fibres and upon the type of electrodes used.

Voluntary muscular movement is associated with the asynchronous discharge of numerous motor units; furthermore, each motor unit has its own individual firing frequency, so that a simple firing rhythm is not maintained among all the motor units in a muscle. However, maximal exertion in

series of predominantly diphasic waves of varying amplitude and frequency, dependent upon the number of motor units contracting within the range of the electrodes: weak motor unit activity produces a picture of scattered potentials, which increases in complexity until, on full activity, the screen becomes filled with a continuous but variable wave pattern, the so-called normal 'interference pattern' of electromyography (Fig. 3). When examined by loudspeaker, each individual motor unit gives a characteristic 'popping' noise, while the normal interference pattern gives a low-pitched rumble.

Two types of electrodes are in general use for electromyography in this country, namely, surface (or skin), and concentric (coaxial) needle, electrodes. Surface electrodes receive, on the skin surface, potential changes originating in the underlying muscles. When it is realised that the electrical resistance of the skin may be well above 100,000 ohms, and may vary by as great a figure, precise localization of potential changes can hardly be expected. At the best, therefore, surface electrodes can do no more than register activity somewhere in the underlying muscle mass; the potential changes received may be

from muscle groups rather than from individual muscles. For diagnostic purposes this impossibility of precise localization, and the loss of some low amplitude and high frequency potential changes, limits the clinical use of surface electrodes. They are sometimes used for children or nervous patients, but the employment of needle electrodes with adequate sedation is far preferable even in such patients. The clinical use of surface electrodes is therefore practically limited to such clinical procedures as the recording of muscle tension under stress in psychiatric cases, and the assessment of drug efficiency in such conditions as Parkinson's disease.

The type of needle electrodes most commonly used are essentially hypodermic needles with an insulated copper wire passed down and cemented into the centre of the hub as shown in diagrammatic section in figure 4. The hypodermic needle acts as one electrode and completely surrounds the second electrode which is exposed only at its point. The tip of this 'concentric needle electrode' is inserted into the muscle to be examined and the potential differences are measured between the two electrodes. All other factors being equal, the range of pick-up of potential changes by the electrodes will depend upon the distance apart of the two electrodes. The distance between the two electrodes can be reduced to a very small interval by using a small size hypodermic needle; the volume of muscle whose action potentials are to be sampled is therefore correspondingly small. Using size 20 hypodermic needles with core electrodes of 40 S.W.G. insulated copper wire, the author examined the action potentials in the second lumbrical muscle of the hand with no interference from the action potentials of the fully active, and immediately subjacent, adductor pollicis muscle (Backhouse and Catton, 1954).

#### ELECTROMYOGRAPHY IN EXPERIMENTATION

Electromyography provides an extremely useful research tool for anatomists and physiologists in their investigations of the actions of muscles, enabling them to augment or to clarify certain of the traditional statements concerning muscle function which abound in the text-books. In a study of the functions of the lumbrical muscles, Backhouse and Catton (1954) used both

electromyography and direct muscle stimulation by needle electrodes: by using the core electrode of the electromyography needle for stimulation, (the other electrode being a large surface plate) careful placement of the stimulating needle was possible, as was direct comparison of the observations from the two methods. Very useful studies have been made on the inter-relationship in action of various muscles in such complex activities as respiration (Campbell, 1954 and 1955), by using electromyography in association with other experimental methods. Electromyography can often be used as a control method in experiment, as in current experiments of the author's designed to assess the inter-relationship of direct muscle action and kinesthetic control in posture.

Electromyographic studies have given a better understanding of the state of 'tonus' in muscle. The 'tonus' of relaxed muscle does not appear to be due to the active cyclical contraction of the muscle fibres, but a function of the intrinsic elasticity of muscular tissue. The physiological hypertrophy seen following athletic training is associated with increase in the number of myofibrils in each muscle fibre, which increases the firmness in consistency of the muscle, but in no way affects the electrical picture shown on electromyography; it is in fact the opposite of the flaccidity of disused or atrophic muscle, where there is a reduction in the number of myofibrils in each muscle fibre.

#### ELECTROMYOGRAPHY IN CLINICAL WORK

##### Neuropathies

*Peripheral nerve injury* provides perhaps the most fruitful field for clinical electromyography, facilitating the assessment of both the degree of denervation and the early signs of recovery. If a nerve suffers Wallerian degeneration and degeneration of the motor end-plate, then the muscle supplied loses its power of contraction and atrophies, becoming initially 'electrically silent.' Consequent upon nerve degeneration, the muscle becomes less responsive to Faradic stimulation, Galvanic stimulation produces responses at lower amperage and a parallel change occurs in the Intensity-Duration Curve. These changes take about 2-3 weeks for their completion, and about the same time after

injury, the affected muscle fibres develop a spontaneous rapid contraction known as 'fibrillation.' Fibrillation occurs as the result of degeneration of the motor end-plate and consequent hypersensitivity of the muscle fibres to circulating acetyl-choline. Electromyography shows fibrillation potentials as characteristic high frequency, small amplitude, single fibre potentials of no more than 1 millisecond duration (Fig. 5) and the loud-speaker gives a characteristic ticking noise.

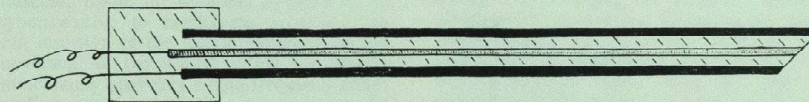


Fig. 4. Diagrammatic section of a concentric needle electrode (foreshortened). The cylindrical needle electrode is in black, the core electrode in fine stipple, and the insulating cement and butt in broken lines.

In neuropraxis, Wallerian degeneration does not occur, and hence fibrillation is not observed even though there is atrophy of the muscle from lack of nervous stimulation. If fibrillation is present, then Wallerian degeneration must have occurred in some fibres, even though other normally contracting fibres are still present; if fibrillation is not observed 3-4 weeks after injury in an electrically 'silent' muscle, then neuropraxis and not neurotmesis is the probable diagnosis.

The earliest sign of recovery is seen as a characteristic electromyographic picture, which appears before any movement can be detected or any change in response to stimulation elicited. The recovery potential is a highly polyphasic potential of some 15 milliseconds duration, easily distinguishable from the electrical activity of fibres which have escaped damage. These recovery potentials, produced by the initial lack of summation of electrical activity in the many fibres of the motor unit, are at first minute.

The picture seen in peripheral nerve injury is simply one of injury to the motor nerve: whether injury affects the anterior horn cell, the anterior nerve root or the peripheral nerve, similar results ensue. Complete damage to the nerve cell, or fibre, resulting in Wallerian degeneration leads to fibrillation in muscle fibres supplied by that nerve (neurotmesis). Damage to the nerve, which

blocks impulses but does not produce Wallerian degeneration (neuropraxis), leads to electrically silent muscle fibres. Recovery of a nerve fibre damaged by any cause is manifest by early polyphasic recovery potentials. The electromyograph can therefore afford valuable information in disease and injury of the peripheral nerves.

*Myopathic lesions.* A number of diseases of the spinal cord directly affect the anterior

horn cells: poliomyelitis, peroneal muscular atrophy, progressive muscular atrophy and infantile spinal muscular atrophy being the most important. Sometimes intramedullary tumours and syringomyelia affect the anterior horn cells indirectly. In these diseases, electromyography can often be of considerable help over and above the assessment of the extent of nerve injury and the early assessment of recovery. Particularly in progressive muscular atrophy (less often in the other diseases) the condition of fasciculation is seen. (This condition used to be called fibrillation, but with the better understanding of spontaneous muscular activity resulting from the introduction of electromyography, the term fibrillation is now applied to the fine reactions of denervation, whereas the coarse activity visible to the naked eye has been renamed fasciculation.) Fasciculation potentials are electrically indistinguishable from motor unit potentials, but occur in a muscle at rest. In many cases of progressive muscular atrophy, fibrillation potentials are found intermingled with fasciculation potentials in the resting muscle.

*Proximal Neuropathy* is a term given to lesions of the nerve roots and trunks prior to branching of the axon. Such lesions include compressions and irritations of the roots by prolapsed intervertebral discs, extramedullary neoplasms of the cord and

meninges, and the various toxic, infective, metabolic and allergic neuropathies. Spontaneous fibrillation will be found following a complete nerve lesion, but more commonly neuropraxia with an electrically silent picture is found in the severer forms of proximal neuropathy. Nerve irritation is however more common than nerve degeneration, and this leads to sustained involuntary muscle spasm in the muscles supplied by the particular

often in the facial musculature than in the spinally innervated muscles.

**Peripheral Neuropathy.** With the exception of injuries already noted, this condition is practically limited to polyneuritis. Spontaneous fibrillation may occur at rest if nerve fibres are completely damaged, but usually polyneuritis leads to a variable degree of degeneration of the nerve branches. The

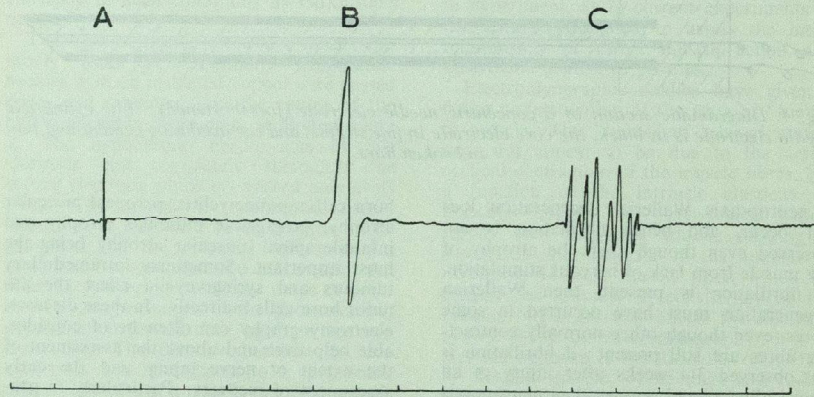


Fig. 5. Diagrammatic representation of the types of action potentials commonly found with peripheral nerve injury. (A) Fibrillation potential from a fibre having complete nerve loss, (B) Normal action potential from a motor unit whose nerve has escaped damage. (C) Polyphasic recovery potential. (Time scale: 1 division = 10 milliseconds.)

nerve roots involved, e.g., spasm of the hamstrings from a lumbar 4-5 disc lesion. This spasm can sometimes be shown clinically, but often the evidence is found on electromyographic examination only, in the form of regular sustained rhythmical discharges of normal motor unit potentials. These discharges may be potentiated by movements of the limb which irritate the particular nerve roots involved. Occasionally a type of fasciculation is seen associated with either rest or minimal activity of the muscle, in which grouped motor unit potentials are seen, though the picture is lost if any significant amount of voluntary activity supervenes. This picture is seen rather more

result is a breaking up of the motor unit to give a polyphasic action potential, though the break-up is usually less marked than that found in the myopathies.

#### Myopathies

These may briefly be considered as of two basic types, 1. diseases of the myo-neural junction, 2. diseases of the muscle tissue.

**Diseases of the Myo-neural Junction** are characterised by either rapid fatigue of the motor end-plate (myasthenia gravis) or by

delayed or incomplete recovery (myotonia congenita, dystrophia myotonica); both groups of diseases give characteristic electromyographic pictures.

Maintained voluntary contraction of the muscles in myasthenia gravis gives a decline in amplitude of the individual motor unit potentials and with fatigue the units become polyphasic. The changes are therefore of help in diagnosis though not essential thereto if the therapeutic prostigmine test is positive.

Myotonia gives a most characteristic and dramatic electromyographic picture. The muscular tissue in myotonia appears to be hypersensitive to mechanical irritation, so that insertion of the needle electrode or the movement of the needle within the muscle immediately provokes a high frequency chain oscillation which dies away in a few seconds. This electrical activity produces a noise on the loud-speaker most reminiscent of the sound of a 'dive-bomber' in action, the pitch being at first high and then falling as the oscillations die away. The individual potentials found in this condition are of small amplitude and short duration, similar to the fibrillation potentials of denervation. It would appear that in myotonia there exists some increased sensitivity of the muscle fibres to some by-product or metabolite of muscular contraction; direct stimulation of a few fibres by the needle electrode then initiates a chain of independent contractions in the muscle, irrespective of nervous stimulation. Repetition of this response leads to rapid fatigue with shortened duration of spasm and increased stimulation threshold.

**Diseases of Muscular Tissue** are primarily the myopathies or muscular dystrophies, together with such disorders as thyrotoxic myopathy and dermatomyositis. All these diseases have in common a disintegration of the motor unit potentials. There is sporadic death of muscle fibres which leads to a breakdown of the synchronous contraction of the component muscle fibres of each motor unit. The smooth summation of the individual fibre potentials into a unit potential is therefore lost and the motor unit potential becomes highly polyphasic and of low amplitude. So marked may be this change in advanced disease that only scattered individual fibres may be left which produce a fibrillary type of potential on volition: since the nerves themselves are not involved in these diseases, fibrillation is not seen at rest.

The complex low amplitude polyphasic potentials seen in the myopathies give a high frequency sound on the loud-speaker which has been likened to 'rain on a tin roof' in contrast to the low-pitched rumble of normal muscle.

#### SUMMARY

Electromyography offers a means of measuring and recording the electrical changes which occur in muscles. Given an adequate understanding of the basic anatomy and physiology of neuromuscular activity the electromyograph offers both the research worker and the clinician a useful tool for the study of muscular behaviour in health and disease. In anatomical and physiological studies of muscular activity, in the clinical diagnosis of neuromuscular disease, in the control of treatment and in the assessment of prognosis (especially peripheral nerve injury), it can prove extremely valuable.

#### REFERENCES.

- Galvani, L. (1791) *De Viribus Electricitatis in Motu Muscularis*, Bologna.
- Matteucci, C. (1842) Sur un phénomène physiologique produit par les muscles en contraction. *C.R. Acad. Sci., Paris*, 4, 797-801.
- du Bois-Reymond, E. (1848) *Untersuchungen über Thierische Electricität*, Berlin, Reimer, 2, 56.
- Herman, L. (1879) *Physiologie der Bewegungsapparate*, 1. Allgemeine Muskelphysik. *Handbuch d. Physiol.* 1, 1-260.
- Piper, H. (1912) *Electrophysiologie menschlicher Muskeln*, Berlin: Springer.
- Adrian, E.D. and Bronk, D.W. (1929) The discharge of impulses in motor nerve fibres. *J. Physiol.* 67, 119-151.
- Weddell, G., Feinstein, B. and Pattle, R.E. (1944) The electrical activity of voluntary muscle in man under normal and pathological conditions. *Brain*, 67, 178-257.
- Petersen, I. and Kugelberg, E. (1949) Duration and form of action potentials in normal human muscle. *J. Neurol. Neurosurg. Psychiat.*, 12, 124-8.
- Backhouse, K. M. and Catton, W. T. (1954) An experimental study of the functions of the lumbrical muscles in the human hand. *J. Anat., Lond.* 88, 133-141.
- Campbell, E.J.M. (1954) *The muscular control of breathing*. Ph.D. thesis, University of London.
- Campbell, E. J. M. (1955) An electromyographic examination of the role of the intercostal muscles in breathing in man. *J. Physiol.* 129, 12-26.

**REPRODUCTION IN GOLDFISH**  
OR  
**WHAT IS THE MATTER WITH LOVE-LIFE  
IN THE FOUNTAIN?**

DR. Richard B. Terry, recently of this Hospital and now at Chicago, and an authority on the ways of fish, used to deplore the cleaning of the Fountain before View Day, because this is about the time when fish spawn, and any offspring of the goldfish inhabiting the Fountain must therefore be automatically and regularly removed each year, presumably to the sorrow of their parents. Professor Garrod, having expressed this belief of Dr. Terry's in the hearing of the Clerk to the Governors, was invited to back it in the terms of the following legal agreement, which he did. The ensuing correspondence is self-explanatory.

\* \* \*

In consideration of the Governors undertaking not to clean the Fountain Pond in anticipation of View Day, 1955, nor at any other time during the said year 1955, I agree to give two goldfish to the Hospital for immersion in the said pond, provided the existing goldfish have not in the meantime bred and produced offspring not less than four in number.

March 30, 1955.

L. P. GARROD.

\* \* \*

Professor L. P. Garrod, M.D., F.R.C.P.,  
Department of Pathology,  
St. Bartholomew's Hospital,

Dear Professor Garrod,

I am sending you, herewith, a copy of your agreement for your signature which enables me to return to you the menu card which you wanted to have back. If you will sign the little Agreement over the 6d. stamp, and return it to me, all will then be in order!

There is, however, one matter which I want to mention to you. When I called over the Head Porter to tell him that I was contemplating not having the fountain cleaned out until after the piscatorial mating season, he told me that if he left the fountain uncleaned for too long, he always got complaints of the smell from the wards in the East Wing! If the fountain ever does smell, which I very much doubt, would the urge to mate on the part of the goldfish be disturbed if we had the fountain running more often, i.e., change the water more frequently, without actually cleaning it? Alternatively are you, as Sanitary Officer to the Hospital, prepared to assure yourself, from time to time, that no noxious or harmful smells are emanating from the pond which could possibly

cause offence to the Sisters in the East Wing?

From the foregoing you will observe that, whereas I am anxious to give the goldfish a chance to breed, I may have to seek the support of the Sanitary Officer of the Hospital in the process.

Yours sincerely,

C. C. CARUS WILSON,

Clerk to the Governors.

March 29, 1955.

The Clerk to the Governors,  
St. Bartholomew's Hospital,  
London, E.C.1.

Dear Mr. Carus Wilson,

I have pleasure in returning our agreement duly signed.

It distresses me exceedingly to hear that you may perhaps, for reasons which I had not foreseen, be unable to fulfil your part in this agreement. I must of course do my best to ensure that nothing may stand in your way. I will undertake as Sanitary Officer to keep constant watch on any effluvia perceptible in the square. So far as I am aware, to have the fountain playing should not interfere with the reproductive process of goldfish, and if any possible nuisance can be abated by turning on the water, say, once a week this should be a very happy and agreeable solution of the difficulty.

Yours sincerely,

L. P. GARROD.

March 30, 1955.

Dear Professor Garrod,

I am assured by the authorities that:—

1. The breeding season for goldfish is now so long past that if any activities of that kind had been undertaken by the fish in the fountain pond, their offspring would have by now appeared.

2. That no offspring have, in fact, appeared.

In the circumstances, I think you will probably agree that you would become liable, under the Agreement, to place in the fountain, at your own expense, and at a suitable time, four to six young goldfish in such a condition of health and well-being as will lead a reasonable person to suppose that in the months to come they will be able to perpetuate the species. I assume that, for this purpose, an appropriate distribution would be two males and two females, although I would, of course, pay the greatest regard to any other distribution you might care to suggest in view of your greater biological experience.

Yours sincerely,

C. C. CARUS WILSON,

Clerk to the Governors.

September 23, 1955.

Dear Mr. Carus Wilson,

Thank you for your letter of September 23. I have not answered this before since I have had to make some enquiries before I can fulfil my part of the contract.

I believe the date on which I become liable to add to the fountain stock of goldfish is November 1, and my recollection of the Agreement is that the number of fish I have undertaken to supply is not four but two.

Furthermore, I recollect no stipulation about their sex. I gather that the sex of a goldfish cannot be determined until it is of a considerable size and age and therefore incidentally very much more expensive. Since I shall be fulfilling my part of the contract by supplying comparatively small fish of unknown sex, this is what I propose to do. I sincerely trust that they will not immediately be decoured by the present inhabitants of the fountain.

I may add that the pond goldfish I have seen for sale are not all of a pure gold colour, and if it should prove that those with pale areas or black spots in their skin are less costly than the rest, provided they are properly to be described as goldfish, these are what I shall probably supply.

Perhaps you will kindly let me know at what time on November 1 it would be convenient to you to witness the addition of these fish to the present population of the fountain.

Yours sincerely,

L. P. GARROD.

October 25, 1955.

Dear Professor Garrod,

I have had your letter of October 25 about the goldfish, for which I thank you.

It would be quite convenient for me to witness the introduction of the new goldfish to the pond on November 1, at almost any time of day other than between the hours of 2.30 and 3.30 p.m.

I earnestly hope that you will observe the spirit as well as the letter of your contract, and see that the goldfish to be introduced to the pond are large enough to have a reasonable chance of escaping the fate which you mention in your letter as a possibility.

Yours sincerely,

C. C. CARUS WILSON,

Clerk to the Governors.

October 28, 1955.

Dear Mr. Carus Wilson,

I have delayed replying to your letter of yesterday until the goldfish were in the bag, or rather in a can. They are handsome creatures of the purest gold colour and I should judge well able to stand up for themselves and just approaching marriageable age. I regret infinitely however that I do not know their sex.

Would it be convenient to you to witness their addition to the population of the fountain at 2 p.m. to-day?

May I suggest that now that the period of our agreement is over the fountain should be cleaned

as soon as possible. Large quantities of leaves are accumulating in it and I am given to understand that when these decompose they give off noxious vapours which are liable to asphyxiate the fish.

Yours sincerely,

L. P. GARROD.

November 1, 1955.

P.S. I have just been told by Dr. Marshall that a good way to make goldfish breed is to put a placenta in their pond. I wish I had known this before.

Dear Professor Garrod,

The brief ceremony of depositing the goldfish into the pond which was due under your Agreement having now been completed, the matter is closed, and I am returning to you the Agreement which you signed in March last.

I also have to acknowledge your very handsome additional gift, quite unstipulated under our Agreement, of one packet (small size) of Brosian Pond Fish Food, which I accept and for which I have to tender on behalf of the Governors my most grateful thanks.

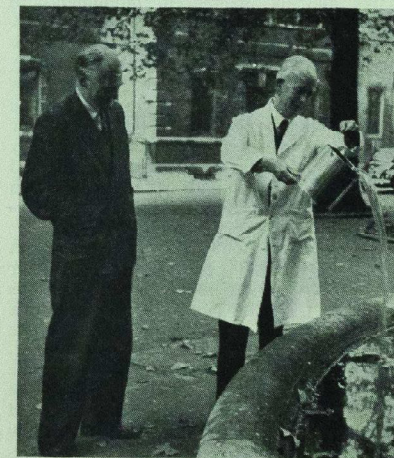
Yours sincerely,

C. C. CARUS WILSON

Clerk to the Governors.

November 1, 1955.

\* \* \*



*The dramatis personae*

## IMPRESSIONS OF MEXICO CITY

by J. T. SILVERSTONE

ARRIVING anywhere at 4 a.m., at the end of a twelve hour flight, is not calculated to make for sharpened senses; but as soon as I had left the ultra-modern airport, of which any interplanetary airline of the future would be proud, I entered cobbled stone streets lined by peeling plaster walls. Thus I immediately discovered the essential feature of Mexico City: contrast.

The city lies on an 8,000 feet high plateau almost completely surrounded by mountains, with the peak of Popocatepetl rising snow-capped in the distance. The design of the buildings varies from the Spanish-Baroque of the cathedral, the largest in the Western Hemisphere, to the square-cut modernity of a new twenty storey sky-scraper. This sky-scraper presented unique construction problems, for it is estimated that the surrounding buildings are sinking at the rate of a foot a year—Mexico City is built on a lake-bed that is slowly subsiding.

Many wide thoroughfares intersect the newer parts of the city, the Paseo de la Reforma being admired for its tree lined walks and its magnificent monuments to Charles V, to the Indian tribes, and to Independence. In the old quarters, narrow streets bustling with people are a picturesque, if somewhat nidorous, feature. Traffic, as in all cities, is becoming a problem, and is made worse here by the fiendish disregard for others with which the Mexicans drive. By comparison, the taxis of Paris are sedate and decorous. The climate is equitable, with cool nights throughout the year and a relatively mild rainy season in the summer.

The history of Mexico, crowded with change and incident, provides some basis for the variety of inhabitants and institutions within its Capital. The Aztecs were the first to build a town on the floor of dried Lake Texcoco. Two hundred years later, in 1521, Cortez and his conquistadores overthrew the Indians, razed the city and subjugated the natives under Spanish rule. The ruling and professional personnel were recruited solely from Spanish born for the next three hundred years, and the Church grew to control over half the property in the country. The

overbearing pride of the Spaniards led to resentment among the Creoles, or Mexican born whites. They bloodlessly achieved independence from Spain in 1821, but did nothing to redress the grievances of the Indians, nor to lessen the hold of the Church. Such local despotism lasted only until 1833, the year of *La Reforma*, when the privileges of the Church were severely curtailed. From 1821 until 1876, the year Diaz assumed the Presidency, was a turbulent period, during which there were no less than 74 governments and two invasions, one by the United States and the other by France. Diaz stabilized the country by ruling as a dictator and opening the mineral resources to foreign exploitation. The reaction of the intensely chauvinistic Mexicans against foreigners resulted in the famous revolution of 1911, which saw the banning of Church education and severe restrictions in foreign rights, as well as providing Pancho Villa and Zapata with an unparalleled opportunity for banditry. Since the revolution, there has been national expropriation, with compensation, of many mines and oil wells. Yet even in 1950 the English still controlled some of the railways and reaped the benefits of their oil investments.

From this background is emerging a country attempting to realize ambitious plans under severe economic handicaps. There are great differences in the standard of living between the *peón* and the rich industrialist, greater than in any European country I have visited. For instance, one night on leaving a nightclub, where it had been difficult to obtain a table owing to the smartly dressed crowd waiting to be amused, we almost stumbled over children lying curled up on the pavement. I indicated them to my Mexican companion, who displayed the lack of concern associated with the commonplace. He told me that there are homes for such children, but that they prefer freedom and discomfort to institutional discipline. In any restaurant or bar in the city, children sidle up to the table, raise their dark brown eyes and implore you to buy the chewing gum or newspapers they are selling. Apparently

they never go to bed, for they are to be found at all hours of the day and night.

South of the city, near the new university, there is a modern housing estate containing some of the most luxurious homes in America. Yet a ten minute walk from these wonderfully appointed Pedregal Gardens can lead to a small village, typical of many, with its unpaved street and houses consisting of nothing more than rough-hewn stone shelters, or wooden shacks, not dissimilar to the sheds dotted about the allotments in suburban London.

The contrasts are not only between rich and poor, ancient and modern, but also between Mexican and American. A 'super-market' (a self-service grocery shop) had been built in the suburb where I was staying. The women had just become used to wheeling their baskets from shelf to shelf, pulling down the goods they wanted and paying to the cashier without questioning the value of the merchandise. In the native, Indian or Mexican market, (no adjective really describes the quality by which non-American features differ from American), there is colour, smell and noise. Prune-faced Indian women sit against the wall of the market with neat little piles of dull-coloured dried herbs laid out before them. Each has her own particular variety, and remains mute and immobile, as if praying at a shrine. Bustling in and out of the market and along the pavement in front of the old women are the shoppers, trailed by small children hired to carry the baskets. Within the market proper, there is heard the sound of acrimonious bargaining and the chatter of gossiping women. But before one hears the sounds and notices the detail, one is almost blinded by the brilliant hues of the *zarapes* hanging above the stalls, woven as in a frenzied nightmare. They are reminiscent of a pageantry long-since dead in Europe. The pastel green and pink of entrails swirling from a hook in a butchers stall, and the toothsome leer of tropical fish give the market part of its distinctive character. Shopping is not as impersonal as in the 'gringo' market (gringo being a word applied derogatively to North Americans, as *Sassenach* is applied to the English by the Scots). Bargaining is enjoyed by everyone, and nothing is bought without many shrugs of disdain, remarks of disparagement, lies concerning cost and all the other tricks of this universal trade.

Can one blame such a colourful people for being resentful of the Americanization which is relentlessly changing the face and character of Mexico City? Occasionally, when the resinous wine of the country runs freely, this resentment is aggressively expressed. The visitor is reminded that he is in the country of Zapata; the country where human sacrifice ceased but four hundred years ago. Mexicans may have bravado, but they are helpless without the money available only north of the Rio Grande.

Despite this ill-feeling, the need for improvement in Public Services is great and not all the effects of American influence are unwelcome. Sanitation and medical services are grossly inadequate, every drop of water must be boiled, and it is estimated that half the population at least, harbours intestinal parasites. Education, although theoretically universal, is not available to many, and the illiteracy rate is high. Illiteracy will not easily be overcome in a country where sixty different Indian languages are still spoken.

Cheap labour has made many of the modern construction projects possible; it would have been difficult, for example, to ornament cinemas with their intricate mosaic façades, without the services of many craftsmen. The cinemas of Mexico City, where a fixed low price is placed on seats by order of the Government to make them readily accessible to the poor, are probably amongst the most lavish in the world. In addition to vivid exteriors, which offend some, depicting as they do Mexico rising from the chains and fetters of European exploitation, the interiors are extravagantly furnished. Fountains play in the foyers, which often have murals by eminent Mexican artists. One hesitates to leave such splendour for the doubtful pleasure of the film.

Mosaics and murals figure prominently in the new University City, which is built on a site studded with outcroppings of volcanic rock. This stone was used for most of the construction, thus ensuring harmony of the buildings with their background. The University City is divided into four blocks; two either side of the Pan-American Highway. The largest section contains the academic buildings, two fifteen storey towers at one end dominating the entrance from the highway. One of them, the library, is completely covered in mosaic Aztec symbols by the Mexican artist Juan O'Gorman. Running eastwards to the tall science building is a

1,000 feet long Humanities building with a colonnade facing the large lawn in the centre of the campus. At the eastern end is the glass-fronted medical school, connected to its strikingly painted main entrance by an interweaving series of ramps. Forming the southern side of the rectangle are the engineering buildings with beehive-like domes covering a flat roof. One oddity is a small concrete nissen hut on legs for trapping cosmic rays. Each faculty building has its own library, coffee bars, cafeteria and student common rooms, and although all the faculties are close together, each retains a social and architectural individuality.

During the construction a circular 'pyramid' was uncovered, said by archeologists to be the oldest building yet discovered in the Western Hemisphere. It was, like Pompei, overwhelmed by larva.

South of the academic buildings are the sports grounds and the splendid Olympic pool. Changing facilities are spacious, and the ground allotted to the various sports is more than adequate. Student housing is being erected in this area, so Mexican students can look forward to having the opportunity of an early morning swim without walking more than a hundred yards.

Across the highway, reached by a complex system of underpasses, is the Olympic Stadium, shaped like the crater of a volcano. On the wall facing the road is a bas relief by Diego Rivera representing the history of sport. This stadium was the site of the last Pan American Games, which saw unacclimatized athletes puffing away in the rarified atmosphere. It is also used for some of the many football matches so enjoyed by Mexicans. The standard of soccer throughout the country, as in most of Latin America, is very high, and the Mexicans follow the fates of the various European teams with interest.

The least developed quadrant is intended for faculty houses and apartments. The city when completed will be self-contained, with its own shops and transportation facilities, and will be able to accommodate 30,000 students in its class-rooms and laboratories.

Great national pride is taken in this magnificent project. However, there is a certain old world eccentricity in the economics of such an undertaking, when the bare necessities of life are virtually unobtainable for many. A professor told me that the country could ill afford such a university, but

the performance of such grandiose gestures was part of the national character.

Although the wisdom of constructing a new medical school can be questioned, the old building could hardly have survived many more years of student abuse. It is situated in the heart of the old city near the Zocalo, where the Cathedral and the National Palace are uneasy neighbours. It was once the home of the Inquisition, and today the iron-studded oak doors swing shut every evening as they did in the sixteenth century. Like most Spanish-style buildings there is a central courtyard surrounded by pillars supporting a balcony, and during the day students swarm all over the courtyard and lean or sit on the balcony; those above exchanging comments with their friends below, or whistling, hooting and shouting at any passing girl. Blond hair has a rarity value in Mexico, and any lady who possesses hair of a shade lighter than dark brown becomes the cynosure of her friends and the ideal of the men. In fact, one young lady medical student with fair hair hardly dared enter school in the morning during her first six months; for the pandemonium which broke loose on her appearance was enough to disconcert the most hardened film star.

The medical course lasts six years and includes the biological subjects required in England for the 1st. M.B. As the annual intake is a thousand students, all the classes have to be repeated several times. Starting at 8 a.m., classes continue throughout the day finishing at 9 p.m., but no student attends the whole day. Rather they decide which group they wish to join for the various subjects, and go to the college only when their group is scheduled for a class. This system leads to a very interrupted work-day, for a student may have one class at 9 o'clock in the morning, another at noon and nothing further until 8 in the evening.

The student activities do not differ greatly from those in England, excepting, perhaps, in the absence of organized sport. In Mexico, the medical student is expected to put such things behind him and to apply himself assiduously to his studies. Frequent examinations tend to discourage backsliding.

I mentioned the hooting and whistling by the medical students; loud demonstrations of approval or derision are common among Mexicans and are heard at their most unrestrained in the bull ring Mexico, in the habit of her northern neighbours, boasts the

largest bull ring in the world, and is conceded by many to have the best bulls. Bull-fighting is the most popular spectator sport in Mexico, and seats are difficult to obtain during the season, when Spanish and Mexican matadors come to Mexico City. The tradition remains Spanish; and as Spain sometimes attracts Englishmen to its rings, so Mexico trains American aspirants to the title of matador. Having never been to a bull-fight outside Mexico, I cannot compare the ceremonial within the ring. Although the ritual of the *corrida* may be the same in the two countries, I am sure the activities outside the ring in Mexico City are distinctively Mexican.

Encircling the Plaza de Toros is a chain of food stalls where delicacies of all kinds are available. The Mexican form of sandwich, called a 'tacos', is to be seen everywhere. The bread, or 'tortilla', (rather like the Indian chipatti), is rolled up with filling in the manner of a Swiss roll. Hot soups, and steaming crustaceans are ladled out to the hungry throng surrounding the stalls. In spite of the appetizing (to some) appearance, I should like to issue a warning to any who might be tempted. Two American friends of mine, who had visited Mexico on two different occasions, both returned with Amoebiasis contracted from eating *tacos* bought from street vendors.

Nearby are the bars. These combine the features of an open-air café and a continental cabaret. Tables are under cover, but the wall facing the street is open, allowing passers-by to enjoy the pulsating music. In the cafés and night-clubs typical Latin American music is played; harsh trumpets sound against a background of bongos, maracas, claves and marimbas (a xylophone long enough to be played by four people at once). From Cuba comes the dance rage of Mexico City, the Cha-cha-cha, a variation of the hippy mambo. There is a preponderance of men in such places, for Mexicans do not often take their wives out; despite the influence of American films which exalt emancipated womanhood, the wife's place in Mexico is still the home.

Mexican folk music is sung by troupes of players called mariaches. These were originally strolling minstrels who sang to guitar accompaniment of the loneliness of life in the ranches, of unrequited love, or of revenge. Flamboyant, throbbing and infinitely sad, the music is a true echo of Mexico.

---

## ANNOUNCEMENTS

---

### Births

CARSON.—On October 3, to Jean (*née* Marsh) and Dr. M. B. Carson, a son, a brother for Diane and Elizabeth.

GIBB.—On October 29, to Mary (*née* Feetham) and Dr. William Eric Gibb, a son.

HAIGH.—On October 1, to Sandra (*née* Hewett) and Dr. A. Haigh, a daughter, (Amanda Kathleen).

MOON.—On October 19, to Jean (*née* Lang) and Dr. A. J. Moon, a daughter (Jennifer Margaret).

PUGH.—On October 8, to Jessie (*née* Gosling) and Dr. J. I. Pugh, a son (John Harry).

READING.—On October 29, to Ena and Squadron Leader J. H. Reading, M.B., B.S., a daughter (Anne Elizabeth Rhianon).

SHAERF.—On October 20, to Valerie and Dr. David Shaerf, a son, (Robert Alan).

STANFORD.—On October 16, to Pauline (*née* Alexander) and Dr. R. Mark Stanford, a son (Brian Mark).

SYRED.—On October 15, to Margaret (*née* Francis) and Dr. Deryck Syred, a daughter (Lydia Jane).

### Engagement

STANLEY SMITH—PALMER. The engagement is announced between Dr. G. Stanley Smith and Miss M. K. Palmer.

### Marriage

ROXBURGH—JONES. On September 10 at St. Bartholomew-the-Great, Dr. Robert Alexander Roxburgh to Muriel M. Jones.

### Deaths

BOWES. On October 20 at Bedford, Gerald Kessick Bowes, D.M., D.P.H., aged 64. Qualified 1913.

HAMILTON.—On October 18 at St. Helier, Jersey, Major-General William Haywood Hamilton, C.B., C.I.E., C.B.E., D.S.O., F.R.C.S., aged 74. Qualified 1902.

TURNER.—On October 19, Percy Edward Turner, M.D., D.P.H., aged 85. Qualified 1893.

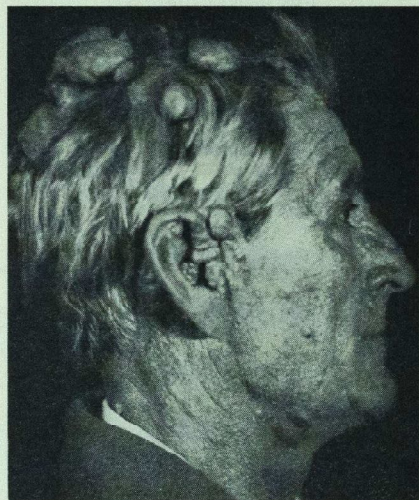


Fig. 1a. The patient before operation.

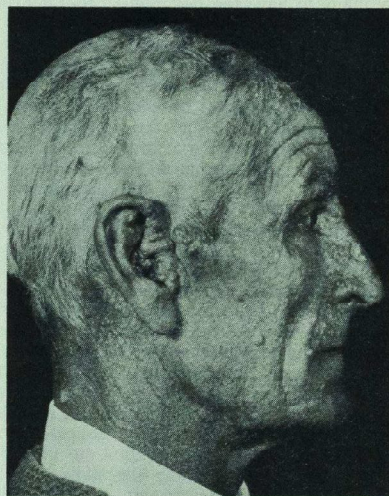


Fig. 2a. Seven months after operation.

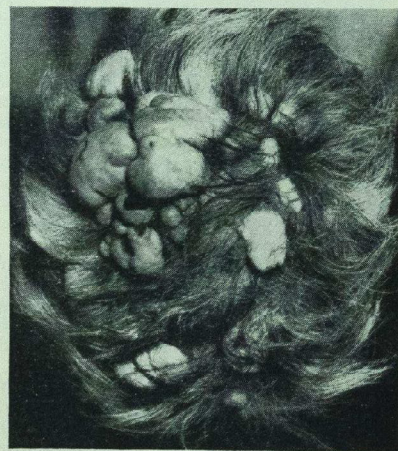


Fig. 1b. Scalp before operation.



Fig. 2b. Seven months after operation.

## TURBAN TUMOURS

by L. J. CHALSTREY

THE transmission of disease from one person to another has been of vital interest since the beginning of medical history. The occurrence of hereditary disease, in particular, has always proved a fascinating and—until relatively recently—mysterious phenomenon. When the hereditary condition is neoplastic it becomes even more interesting, not only as an example of the working of genetic factors in the production of disease, but also because it immediately draws us to the brink of that great and, as yet, largely unfathomed problem of the aetiology of new growths.

An account is presented here of a familial neoplastic disease sometimes known as 'Turban Tumours.' The case history of a patient and details of similarly affected relatives are given, followed by a discussion of various views as to the correct classification of the disease.

### CASE HISTORY

R.W. (232988), a 62-year-old farm worker, was seen on 16th March, 1955, while in hospital, for the treatment of multiple nodules on the head and body. The history dates back to 1912, when, at the age of 19, he first noticed a swelling on the head. This tumour was excised, but during the following years a few nodules appeared on his body, and in 1920 he had one removed from his back. In 1922 numerous nodules appeared on the scalp and he attended every week for some months for the removal of three or four at a time. For many years the nodules slowly increased in numbers and size. There were periodic visits to the Hospital for the removal of some of them. In 1950 the patient was admitted elsewhere for the mass excision of the tumours of the back, chest, and supra-pubic region. At that time the nodules were described as being of two varieties: (1) smooth, slightly lobulated, sessile and slightly bluish and (2) pedunculated, very lobulated, slack and somewhat pigmented. They were quite painless, but interfered with his work. Recovery was uneventful, though some small nodules remained. By 1954 the patient had multiple large tumours, particularly on the scalp, which had received no surgical attention for some years. They were unsightly and were often traumatised during his work. They ulcerated easily and healed with difficulty.

He was admitted to Bart's on 26th August, 1954, and about two dozen tumours were removed from

the scalp. During the following weeks a few lumps were removed from the legs and back under local anaesthesia. At the time of his readmission in March, 1955, there was massive involvement of the scalp, which made it difficult for him to wear a hat, and some of the tumours had broken down, discharging an unpleasant smelling material. There were tumours of all sizes from 0.3 to 4.0 cm. diameter. Some had coalesced into large masses. The shapes also varied; some were almost flat and appeared to be embedded in the surrounding skin, others were lobulated and freely movable on a short, wide base, and a few were pedunculated. Whereas many had a pinkish, fleshy appearance, others were bluish in colour. All were smooth and many (Figs. 1a and 1b) were hairless. The smaller nodules were of a firm consistency, while the larger ones, being softer and rubbery, gave the impression of being cystic. Numerous small nodules were present in the skin of the centre part of the face; some near the external auditory meatus on both sides blocked the passage of the outer ear and impaired hearing. Other lumps of varying sizes were observed on the neck, upper chest, upper back, sacral regions, calves and right scrotal region. The arms, lower abdomen, lower back, and thighs were free, but showed scars where growths had been removed. Lymphadenopathy was present in the posterior triangles of both sides of the neck, probably due to the low-grade infection which invariably developed when lumps on the scalp were traumatised and ulcerated.

On 18th March, 1955, the areas of the scalp most severely affected by growths were excised (Fig. 3) and split-thickness skin grafts applied to the defect. Figures 2a and b show the scalp seven months after operation. Histological sections showed typical basal cell carcinomata (turban tumours) consisting of nodular formations covered by a thin, flat, intact epidermis. Connective tissue capsules lined each tumour and projected inwards, dividing the tumour into clumps of basal cells lined by hyaline membranes. Small round deposits of hyaline material were also present between the cells, and in some places there were cystic spaces and pseudo-glandular formations. (Figs. 4a and b.)

Subsequent treatment has included a therapeutic test for radiosensitivity. A lesion in front of the right ear was irradiated on nine separate occasions in a period of two weeks, a total of 3150 r units being given. The lesion decreased in diameter from 2.5 cm. to 1.2 cm.

The patient was able to provide a considerable amount of information about members of his family. Three of his relatives have been seen at this Hospital, two at other Hospitals, and the remainder have given details of the condition of their skin in response to a questionnaire. In Table 1 solid symbols indicate members of the family having the disease.

(a) The patient's son, aged 28, was seen in April, 1955, complaining of lumps on the head and face. They first began to appear when he was 13. One in the region of the hair margin on the forehead gradually grew bigger until 1948, when it was excised. Since then another lump has grown in the same place and others have developed on the scalp. All have grown steadily, perhaps a little more rapidly during the past two years. The ones on the face have remained small. There has never been any pain or discomfort. In 1952 the small nodules on the nose were cauterised, but have now regained their former size. On examination,

patches near the alar base and on the upper and lower lips. The largest tumours were about 2.5 cm. in diameter and some were confluent. (Fig. 6) Many of the nodules have been excised at another hospital with no recurrence to date. They were reported as sebaceous adenomata. However, comparison of Figure 5 with the histological section of one of her father's lesions (Fig. 4h) makes it obvious that a similar pathological process is present.

(c) A brother of the patient, aged 60, was seen in October, 1955. He first noticed lumps on the head when he was 20 years old. They were the

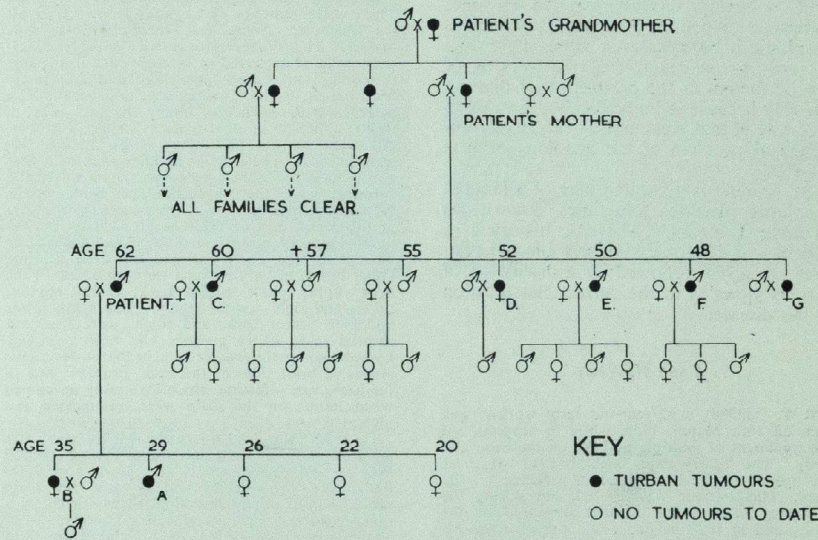


Table 1. Letters A-G refer to text.

twelve lumps were observed on the scalp. The largest of these was hemispherical and three quarters of an inch in diameter. In the centre of the face were numerous nodules, some of pinhead dimensions, others a little larger. Seven lumps on the anterior part of the scalp were excised; they all appeared to be well-encapsulated and microscopic examination revealed sub-epidermal, basal cell carcinomata. It was noted that, as in the case of his father, the scalp was extremely tough and it was thought probable that this is a characteristic feature of the condition.

(b) One of the patient's daughters, aged 35, noted the appearance of multiple nodules on her face and scalp at the age of 19. In recent years a few swellings have developed on the chest and all the tumours have grown more rapidly. Multiple tumours were present all over the scalp, forehead, and along the sides of the nose. There were further

size of small peas and remained so for about 20 years. Slowly enlarging tumours then appeared on his back, chest, and neck. During the past 7 years the growth rate has become more rapid and other nodules have appeared. In 1952 an ulcerated tumour was excised from above the left ear and a cluster of nodules removed from above the right ear, with the application of a skin graft. At present the scalp shows multiple growths varying in diameter from 0.2 cm. to 5.0 cm. (Fig. 7). All are smooth, purplish in colour and almost hairless, the larger ones being softer and lobulated. Some are sessile while others are pedunculated and all are quite painless. The centre of the face is clear but there are nodules on the neck, back and chest. A tumour in the left lumbar region 6.5 cm. in diameter, is raised 2.5 cm. above the skin on a short wide base, and is the largest one present.

(d) A sister of the patient, aged 52, first noticed lumps at the age of 38, when several appeared on both sides of her nose. They have remained very small, the largest one on the left temple being 0.5 cm. in diameter. The body is clear.

(e) Another brother, aged 50, first noticed several nodules on his head when 20 years old. They remained the same size for some years and then gradually grew larger. Other tumours appeared on the chest, back, and left hip, but the majority were situated on the vertex and left side of the scalp, the face being clear. Although painless, the swellings sometimes itched and tended



Fig. 6. A daughter of the patient (B).

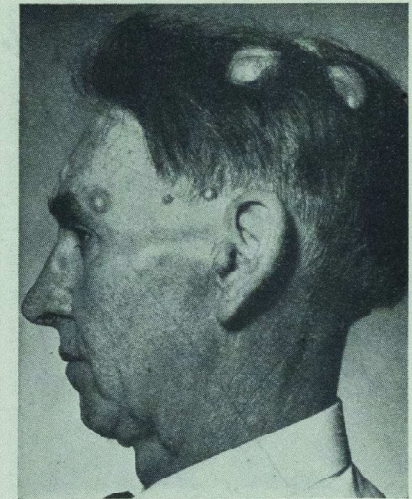


Fig. 7. A brother of the patient (C).



Fig. 8. A sister of the patient (G).

to bleed if scratched. As with the others, this patient's chief complaint was that the lumps were a nuisance and so unsightly as to be "... such a pest to me." Many of the tumours were excised and were reported to have the microscopic appearance of sweat gland adenomata, some having undergone cystic change.

(f) A third brother, aged 48, first noticed a nodule on top of his head when aged 38. This slowly grew bigger and others appeared. The largest are now 2 cm. in diameter. There are several lumps in the scalp and numerous small nodules on the forehead in the region of the hair margin. The body is clear.

(g) The patient's youngest sister first noticed a lump at the age of 29. Several appeared on the scalp and gradually grew. The largest are now 5 cm. in diameter. Numerous minute nodules are present on the left ala nasi and there are three lumps on her back and one on the abdomen.



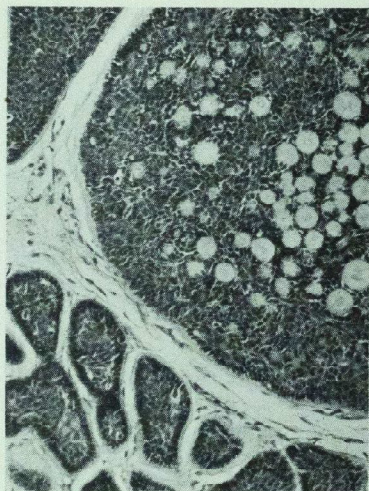


Fig. 4b

Clumps of basal cells are lined by hyaline membranes. Small, round deposits of hyaline material are present between the cells. (x150).

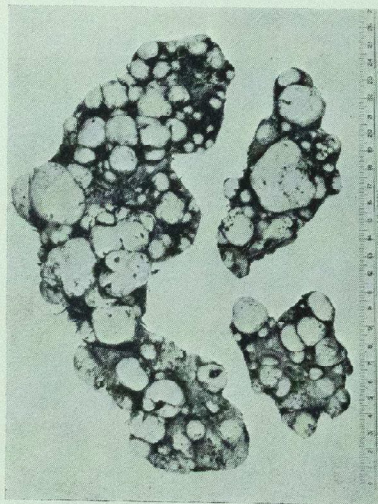


Fig. 3

Areas of scalp excised.



Fig. 5

Columns of basal cells surrounded by hyaline membranes are separated by connective tissue septa. The histology is similar to that in Fig. 4a and b. (x150).

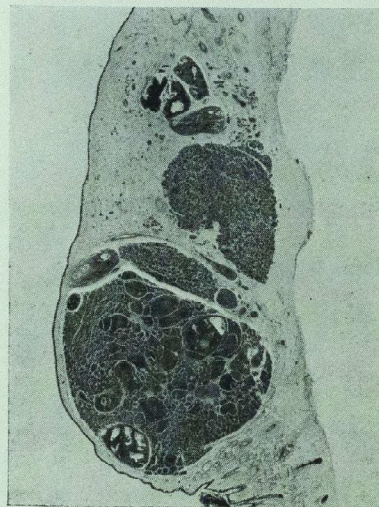


Fig. 4a

## Discussion

Basal cell carcinomata may be divided into two groups; some arise in the epidermis and produce a thickened plaque, which soon ulcerates to form a slow-growing 'rodent ulcer'; while others are formed deep in the dermis from the sweat and pilosebaceous systems, where they become well demarcated and often lobulated. The ones that have been described in the case histories are obviously of the second type.

Turban Tumours were first recorded in 1842 by Ancell, and following this several cases were reported in Europe and America. In a survey of the literature between 1842 and the end of 1954, Evans collected 47 cases, 30 of which were females and 17 males. In about one third of these cases other members of the family were also affected. He says that the disease is an example of a Mendelian dominant trait, stronger in the female sex. Since the beginning of 1955, a single case described in April (Lyon, 1955) and the one given here have brought the total to 49.

There has been much discussion and disagreement regarding the origin and classification of these tumours. The following names, which have been given to them are an indication of the confusion: epithelioma adenoides cysticum; benign epitheliomata with colloid degeneration; multiple benign cystic epithelioma; cystic basocellular epithelioma; Brooke's Tumour; Brooke-Fordyce Disease; adenoid cystic epithelioma; cylindroma; endothelioma capitis and Spiegler's Tumour. Some of the factors which have been employed in classification include: dominant sites on the body, gross clinical appearances, and characteristics—e.g., benignity, growth rate, radiosensitivity, and familial nature.

Some early writers on the subject considered these tumours to be of endothelial origin but the great majority of workers, including the most recent authorities, look upon them as epithelial. Ronchese (1933), in a summary of the literature, regards tumours of this nature as basal cell epitheliomata of naevic origin. He mentions that some workers have suggested that they are derived from sweat glands, but that a more satisfactory explanation is that they arise from the pilosebaceous system—particularly the epithelium of the sebaceous glands. In a number of cases reported, though not in the ones recorded in this article, histological sections

indicated a close proximity of tumour and sebaceous gland. In some sections, the tumour seemed to constitute part of a sebaceous gland undergoing transformation into an epithelial mass. (Stillians, 1933; Schlammadinger, 1935; Ormsby and Montgomery, 1948.).

In their discussion on the subject Warwi and Gates (1943) point out that it is too seldom recognised that tumours of entirely diverse histological structure may present identical clinical features. They go on to mention that at least two histologically distinct tumours fit the clinical picture of this condition, viz., sweat gland tumours and pilosebaceous gland tumours. The tumours arising from sweat glands are said to be located primarily on the chest. They have been termed syringomata and are often non-familial and radio-sensitive. Those coming from the pilosebaceous system are found primarily in the centre of the face, are usually familial and are radio-resistant. These they call epitheliomata adenoides cysticum.

Willis (1953) states that sub-epidermal, basal cell growths, arising from the pilosebaceous epithelium or the sweat glands, are of an extremely variable nature and cannot be divided into distinct groups, either clinically or histologically. He further maintains that they cannot be separated sharply from the superficial rodent ulcer on the one hand, and the truly glandular skin tumour on the other. Any sub-division, he says, is purely arbitrary, there being all intermediate types and mixtures of types. It is therefore needless to distinguish between true sebaceous adenomata and basal cell growths. Similarly, he suggests that there is no sharp distinction between a sweat gland adenoma—in which some glandular formation happens to have been maintained—and a basal cell carcinoma of sweat gland origin. It is worth noting that in the case of the family described here, one patient is reported as having sub-epidermal, basal cell carcinoma; while his brother, whose tumours were examined histologically by another pathologist, was said to have sweat gland adenoma.

Unfortunately, these tumours have never been given a definitive name. Both Brooke (1892) and Fordyce (1892) described cases in which the lesions were predominantly on the face and chest, and the condition is sometimes referred to as Brooke's Tumour or Brooke-Fordyce Disease. It was Brooke who gave the name epithelioma adenoides

cysticum to growths of this kind. When the lumps predominate on the scalp they are also known as Spiegler's Tumours (1899) and Turban Tumours. Warvi and Gates criticise the term epithelioma adenoides cysticum in that it is too vague. They mention that all non-keratinising epitheliomata tend to become cystic and that the term "does not connote a single, clearly defined pathological process and has been used for quite unrelated conditions." They further say that the term epithelioma adenoides cysticum should be reserved for a benign lesion of the hair follicle. While favouring separate classification, they do consider the possibility of a common cause. They suggest that in view of embryological relationship of the epidermis and cutaneous appendages, such as sweat glands and pilosebaceous systems, a congenital abnormality of the dermis might give rise to a variety of unusual epithelial structures.

Another possible factor which has been suggested as the cause of the skin tumours is the secretion of carcinogenic substances by the sweat and sebaceous glands. (Peacock, 1947). Experiments have been done in order to test for the presence of these substances, using extracts of tumours which were painted on to mice. No malignant growths resulted, but pre-cancerous changes were noted. (Evans, 1954).

#### SUMMARY AND CONCLUSIONS

The history of a patient and his relatives with multiple skin tumours has been discussed. Diversity of opinion as to aetiology, nomenclature and classification has been indicated.

The cases reported show clearly the characteristics of the disease. Onset is usually during adolescence or early adult life and is followed by several years in which there is little noticeable change. Then increase in the number and size of the tumours occurs, at first slowly, but later at a more rapid rate. By the sixth decade, multiple tumour masses are present on the head and often on the rest of the body. In seven out of the eight cases reported, nodules appeared first on the scalp, and this remained the main site of the disease. General health is unimpaired and the lesions are painless, the only complaint being their unsightliness. In advanced cases, the large tumours are easily traumatised and heal with difficulty.

The treatment of the condition is excision and skin grafting as necessary. In some

instances electrocautery has been employed for the removal of small nodules. Although the tumours are in some degree radiosensitive, X-ray therapy does not seem to be a practical method of treatment. Experiments (Evans, 1954) indicate that while irradiation causes regression it does not effect a cure, since the nodules usually recur after a few months. In the case reported, there was some regression of the remaining tumours, but it is too early to say whether or not they will recur.

In conclusion, an attractive and reasonable view is that these multiple benign, familial tumours of the skin and its epidermal appendages, are the varied manifestations of a common, inherited, underlying pathological process, the nature of which is at present unknown. With regard to nomenclature, the term multiple, benign, familial, nodular, sub-epidermal, basal cell epithelioma, with hyaline and cystic degeneration seems as complete a description as is possible—but it is far too long! When, as in these cases, the tumours are mainly situated on the head, the striking resemblance of the advanced condition to an Eastern head-dress makes the term 'Turban Tumour' still the shortest and best.

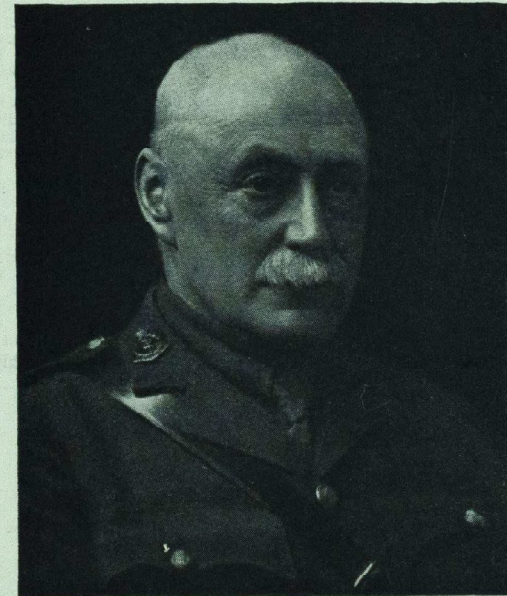
#### ACKNOWLEDGEMENT.

I wish to thank Mr. Alan Hunt for his encouragement and his permission to publish the case-history; Mr. W. Regan for his help in the preparation of the article; Mr. P. H. Jayes for giving details of a member of the family treated by him; Mr. Harrison of the Dept. of Medical Photography, and the many others who have given freely of their time.

#### REFERENCES

- Ancell, H. (1842) *Trans. med. Soc. Lond.*, 25, 227.  
 Brooke, H. G. (1892) *Brit. J. Derm.*, 4, 269.  
 Evans, C. D. (1954) *Brit. J. Derm.*, 66, 434.  
 Fordyce, J. A. (1892) *J. cutan. Dis.*, 10, 459.  
 Lyon, J. B. (1955) *Proc. R. Soc. Med. (Sect. Derm.)* 48, 772.  
 Ormsby, O. S. and Montgomery, H. (1948) *'Diseases of the skin'*, 7th ed. London: Henry Kimpton, p. 747.  
 Ronchese, F. (1933) *Amer. J. Cancer*, 18, 875.  
 Schlamadinger, J. (1935) *Arch. Derm. Syph.* Wien, 175, 682.  
 Spiegler, E. (1899) *Arch. Derm. Syph.* Wien, 50, 164.  
 Stillians, A. W. (1933) *Arch. Derm. Syph.*, Chicago, 27, 481.  
 Warvi, W. N. and Gates, O. (1943) *Amer. J. Path.* 19, 765.  
 Willis, R. A. (1953) *'Pathology of Tumours'*, 2nd ed., Butterworth and Co., pp. 262, 272, 276-7.

## SIR D'ARCY POWER (1855-1941)



'THE DEAR MAN'

When I grow old  
 As you refused to grow old,  
 Will charm turn cold  
 And memories stale ?

Across the span of the years,  
 Disenchanting and grey,  
 Your friendship steers  
 My faltering way.

I miss again  
 So wise a face,  
 So rich a grace  
 So rare a smile.

When I come to the turn of the lane,  
 To the end of the weary trail,  
 Will 'The Dear Man' once again  
 Help a lame dog over the stile ?

W. R. BETT.

## SPORTS NEWS

## RUGBY

## Annual General Meeting

The following officers were elected for the season 1955-56.

Captain : J. S. T. Tallack (re-elected).  
Vice-Captain : J. C. Mackenzie.  
Secretary : B. W. D. Badley.  
Treasurer : M. W. Sleight.  
Pre-clinical representative : L. Thomas.

The committee has appointed the following as captains of the junior teams :—

A XV—J. Worthy.  
Ex. A XV—M. L. B. Hayes.  
B XV—T. Shacklock.

## 1st XV v. R.M.A. Sandhurst. Lost 6-17

Despite the almost perfect conditions Bart's gave their most disappointing display of two seasons. Playing uphill in the first half, Bart's were soon 6 points down (a penalty and a try). They improved towards the interval and Badley reduced the lead with a penalty. In the opening minutes of the second half a scrambling try on the left evened the score. Bart's then lost Lofts with an injured ankle, who up to that time had outshone the other forwards. Some sparkling play by the Sandhurst outsiders enabled them to score a further 11 points before no-side.

TEAM : B. W. D. Badley, R. M. Phillips, J. Plant, J. Neely, D. A. Lammiman, R. R. Davies, C. A. C. Charlton, B. Lofts, C. Carr, D. B. Lloyd, B. Palmer, J. S. T. Tallack (Capt.), M. Whitehouse, M. W. Sleight, J. C. Mackenzie.

## 1st XV v. Cambridge University LX Club. Lost 3-6.

In dismal conditions, but on a perfect ground at Cambridge, Bart's took the field against a strong IX Club XV, who kicked off and began at a furious pace, pressing strongly with their fast backs, who handled the greasy ball perfectly. Bart's withstood this onslaught nobly and after ten minutes it was noticeable that the Cambridge pack were failing to maintain their initial effort. Bart's then took the initiative and cleared their line with good foot rushes and relieving kicks, so that the play became more even. It was unfortunate that during a sortie into the Bart's half Cambridge were awarded an easy penalty, which presented no difficulty to their kicker. Just before half-time, G. J. Halls, making a promising *début* in the Bart's side, narrowly missed kicking a penalty from a difficult position.

The second half opened with the expected attack of the LX Club; but the Hospital pack, well-supported by their backs, counter-attacked strongly. After the Cambridge line had suffered many narrow escapes, their right wing broke away and outpaced the defence to score wide out. The kick failed. This set-back was rather against the run of the play and the Hospital reduced the deficit with a beautiful goal by Halls, and might well have equalized had not the referee been unsighted when Carr carried the ball over the line. The remaining minutes were evenly contested and the XL Club must account themselves fortunate to have won such a keenly fought and enjoyable game.

Outstanding for Bart's were B. W. D. Badley, whose covering and kicking deserved the highest praise, and J. Neely, who, in both attack and defence, was a continual source of trouble to the Cambridge side. (The LX Club beat London Hospital 24-9, and St. Thomas's 28-12).

TEAM : B. W. D. Badley, J. Plant, G. J. Halls, J. Neely, D. A. Lammiman, R. R. Davies, C. A. C. Charlton, D. W. Downham, C. Carr, J. C. Dobson, K. E. A. Norbury, J. W. B. Palmer, M. Whitehouse, J. S. T. Tallack (Capt.), J. C. Mackenzie.

## 1st XV v. Old Whitgiftians. Won 12-3.

The Old Boys kicked off on a cold, blustery day to begin a scrappy first half. They took the lead after 15 minutes by scoring an unconverted try. Bart's retaliated with a series of attacks, which culminated in K. K. Davies kicking a cheeky dropped goal following a scrummage in the Whitgiftians' 25. There was no further score before half-time. In the second half Bart's gained the ascendancy. Following a scrummage Charlton broke away, kicked over the line and just won the race for the touch-down. An unfortunate misunderstanding led to the kick being charged down. A few minutes later Phillips, who had on earlier occasions spoiled some good individual runs by hanging on to the ball, ran through several defenders to score a good try. Soon after Lammiman dribbled half the length of the field to score his first try of the season.

TEAM : B. W. D. Badley, R. M. Phillips, G. J. Halls, J. Neely, D. A. Lammiman, R. R. Davies, C. A. C. Charlton, D. B. Lloyd, C. Carr, D. W. Downham, J. S. T. Tallack (Capt.), K. E. A. Norbury, M. Whitehouse, E. F. D. Gawne, J. C. Mackenzie.

## 1st XV v. U.S. Chatham. Lost 3-6.

Bart's were without their Captain, Tallack, and two regular members of the three-quarter line. Chatham had an impressive record this season and were captained by M. J. A. Davies, an old Bart's

man. The game began at a fast pace and play switched from end to end with sometimes alarming rapidity. The Hospital backs with a plentiful supply of the ball had a good day and clearly had the measure of their opponents. One beautiful movement in which the ball reached the wing and was passed back into the centre was spoiled by over anxiety from being a certain score. G. J. Halls settled down well into the unaccustomed position of stand-off half and his attacking and kicking were good. He kicked a good penalty from the touch-line; but the score was levelled when the Services were awarded an easy penalty following a scrum infringement.

Bart's started the second half well and Chatham were held for long periods within their own 25, where the kicking of Davies proved most valuable to them. A good cross-kick by Lammiman found the Bart's pack in position, but a dropped final pass prevented a score. Counter-attacks were well held by the Hospital three-quarters, who were well covered by the back row, especially by Mackenzie who was captaining the side. In the later stages of the game the superior weight of the Services pack carried play into the Bart's half and just before no-side Davies received the ball from a scrummage near the Bart's line and dropped a goal from a most unlikely position.

TEAM : B. W. D. Badley, J. Laurent, J. Plant, J. Neely, D. A. Lammiman, G. J. Halls, C. A. C. Charlton, J. C. Dobson, C. Carr, D. W. Downham, J. Creightmore, K. E. A. Norbury, H. Thomas, E. F. D. Gawne, J. C. Mackenzie (Capt.).

## THE CORNISH TOUR

## 1st XV v. Devonport Services. Won 5-3.

A very determined Bart's XV took the field against a strong Devonport side. The two packs immediately began to fight for supremacy in true West Country style. Although much lighter, the Hospital pack were more mobile and quicker in the loose.

In the first half there were some bitter exchanges on both sides, Services taking the lead with a penalty goal just before half-time. Gawne and Mackenzie were in great form and set an inspiring example to the other forwards.

In the second half the Bart's backs came into their own. Phillips, playing in the centre, was always dangerous, and it was he who scored the only try of the match. Lammiman caught his opposite wing in possession; Phillips, backing up, took the ball and ran hard down the touch-line to outwit the full-back and score under the posts. Halls had no difficulty with the conversion. From this time on Services pressed hard and once the ball was kicked over the Bart's dead-ball line; but there was no further score.

Gawne was ably supported in the pack by Roche and Norbury and the backs, especially Berry and Laurant, kept cool and tackled well under pressure.

TEAM : B. W. D. Badley, D. A. Lammiman, R. M. Phillips, G. Halls, J. Laurent, R. R. Davies, W. Berry, D. B. Lloyd, C. Carr, J. Dobson, K. E. A. Norbury, D. W. Roche, M. Whitehouse, E. F. D. Gawne, J. C. Mackenzie (Capt.).

## 1st XV v. Penzance and Newlyn. Lost 0-3.

Bart's made a poor start in their West Country tour, partly due to fatigue after the long journey and partly to the heavy ground, which had been softened by rain. At the beginning, both sides attempted to play open Rugby while the packs struggled for ascendancy. D. W. Roche made a welcome return to the side and excelled in the lineouts; but the set scrums were a different matter and Bart's were repeatedly pushed back in ragged fashion.

In the second half the play continued to be even, until the Penzance outside-half dropped a superb goal. This aroused the Hospital side and Penzance had to defend their line against several determined attacks. Towards the close Lammiman was unlucky not to score when he showed some of his old form in a grand run down the touch-line.

TEAM : B. W. D. Badley, D. A. Lammiman, J. Neely, G. J. Halls, R. M. Phillips, R. R. Davies, C. A. C. Charlton, J. Dobson, C. Carr, D. W. Downham, J. S. T. Tallack (Capt.), D. W. Roche, H. Thomas, E. F. D. Gawne, J. C. Mackenzie.

## 1st XV v. Paignton. Drawn 9-9.

Bart's attacked from the outset against a side considerably strengthened with guest players from Torquay, and soon showed their superiority with the dry ball. Within ten minutes Halls had put the Hospital six points ahead with two great penalty kicks. After this the appalling condition of the ground—it was nothing more than a sea of brown mud—began to tell. The game developed into a fierce battle between the forwards; both packs feeling it unwise to heel the slippery ball. A Bart's mistake was seized upon by Paignton and they scored an unconverted try. This roused the forwards and it is unfortunate to record that tempers became frayed on both sides. Numerous blows and kicks were exchanged and falling on the ball was too dangerous to be tried more than once.

Early in the second half Paignton scored an unconverted try. Bart's retaliated with some determined foot rushes. From a line-out near the Paignton line Roche gathered the ball and bulldozed his way over to score an unconverted try. The game swung from end to end and finally Paignton evened the score with another try. Shortly before no-side Mackenzie fractured a rib.

TEAM : W. Walton, D. A. Lammiman, J. Neely, G. Halls, R. M. Phillips, R. R. Davies, C. A. C. Charlton, D. B. Lloyd, C. Carr, D. W. Downham, D. W. Roche, J. S. T. Tallack (Capt.), H. Thomas, K. E. A. Norbury, J. C. Mackenzie.

## 1st XV v. Rugby. Lost 11-24.

Bart's kicked off into the sun against a strong side, which already had beaten Northampton and Coventry. Bart's frequently play better against a strong side and in the first 30 minutes their attractive football outshone this much vaunted Mid-land side.

After 15 minutes of vigorous forward play, it was obvious that the Hospital backs were a match for their opponents and the forwards endeavoured to give them the ball as often as possible. Gawne, Norbury and Roche monopolised the line-outs; but in the tight scrum we lost the ball, although Carr seemed to win the strike. Shortly after Rugby had taken the lead with a penalty goal, Bart's scored one of the best tries seen at Chislehurst for some time. R. Davies broke away in mid-field, threw off two tacklers, and passed to Howard Thomas, who was proving an able substitute for the injured Mackenzie. Thomas ran strongly through the defence and passed back to Davies, who went over between the posts. Halls kicked the goal. The Hospital morale was now high; Lammiman took the scrum-half's pass and in his characteristic high stepping style brushed off some ineffective tacklers to score far out. Halls kick just failed to cross the bar.

Shortly after half-time Rugby scored an unconverted try when Badley, who had been fielding and kicking well, had a high kick charged down. Bart's attached strongly; Tallack showing great form in the loose and encouraging the other forwards by his example. Davies added to the score with a neat dropped goal from a loose scrum.

The hard games played on the Cornish Tour began to tell and the Bart's side tired. The Rugby forwards pressed strongly and the Hospital were forced to defend their line. The scores were levelled by a fine goal and from then on the question was could the Hospital hold out until no-side. The Rugby forwards pressed relentlessly and their rushes were only stopped by the fearless falling of Charlton at scrum-half. Before time Rugby succeeded in adding two goals and a try, thus winning 24-11. Just before the whistle the Hospital rallied and Phillips went down the wing only to be pushed into touch just short of the line. A good end to a very fine game.

**1st XV v. Old Alleynians.** Won 13-6.

## ROWING

### Club Regatta

The Boat Club held their second scratch regatta with St. Thomas's Boat Club on November 2, at the London Rowing Club, Putney. Over 70 entries were received and an ambitious programme was arranged for Eights and Fours. Unfortunately things got rather out of hand, and few crews took the water as originally planned.

At the conclusion of the racing Mrs. Hadfield presented the prizes.

### WINNING CREWS

**CLINKER VIII's**  
*Felix Mas*: R. B. Harcourt (S.B.H.), R. Ridsdell-Smith (S.B.H.), J. R. Strong (S.B.H.), P. Johnson (S.T.H.), E. M. E. Ernst (S.B.H.), G. D. Stainsby (S.B.H.), M. Wilson (S.T.H.), A. J. Salter (S.T.H.), A. R. Geach (S.B.H.).

### LIGHT IV's

C. C. H. Dale (S.B.H.), D. A. Chamberlain (S.B.H.), J. Begley (S.T.H.), P. Pigott (S.T.H.).

### COXED IV's

*Lipoma*: J. Bartlett (S.B.H.), N. Reid (S.T.H.), G. Hall (S.B.H.), R. W. W. Kay (S.T.H.), J. Watson (S.T.H.).

### PRESIDENT'S SCULLS

*Final*: R. W. Beard beat R. Ridsdell-Smith by 3 lengths.

### United Hospitals Regatta

Bart's won the Double Sculls and reached the final in four other events. A full account will appear in the next issue.

## HOCKEY

### Annual General Meeting

The following officers were elected for the season:—

Captain: Miss J. Swallow.  
Vice-Captain: Miss A. Woolf.  
Hon. Secretary: Miss J. Chambers.  
Hon. Match Secretary: Miss J. Chambers.  
Treasurer: Miss G. Barraclough.  
Committee Members: Miss A. Tresidder.

Professor A. Wormald kindly consented to remain the Club's President for a further year, with Mr. B. Hume and Mrs. F. Woolf as Vice-Presidents. Colours were awarded to Miss B. Barnard, Miss J. Chambers and Miss A. Woolf.

**1st XI v. Middlesex Hospital.** Won 5-1.

**1st XI v. University College Oxford 2nd XI.** Lost 4-5.

The men once again proved their supremacy in speed and power, though in precision of stick work and accuracy of shooting the Bart's XI excelled. This was a most enjoyable game played at high speed and luckily one in which no bones were broken.

**1st XI v. Wimbledon.** Drawn 6-6.

Bart's went off to a flying start and were soon two goals up. Wimbledon's defence however was very strong and by half-time they had drawn level at three all. In the second half Bart's scored two quick goals, but Wimbledon retaliated and eventually went ahead at 6-5. Just before time Bart's began to play with added zest and scored a further goal.

### CAMBRIDGE TOUR

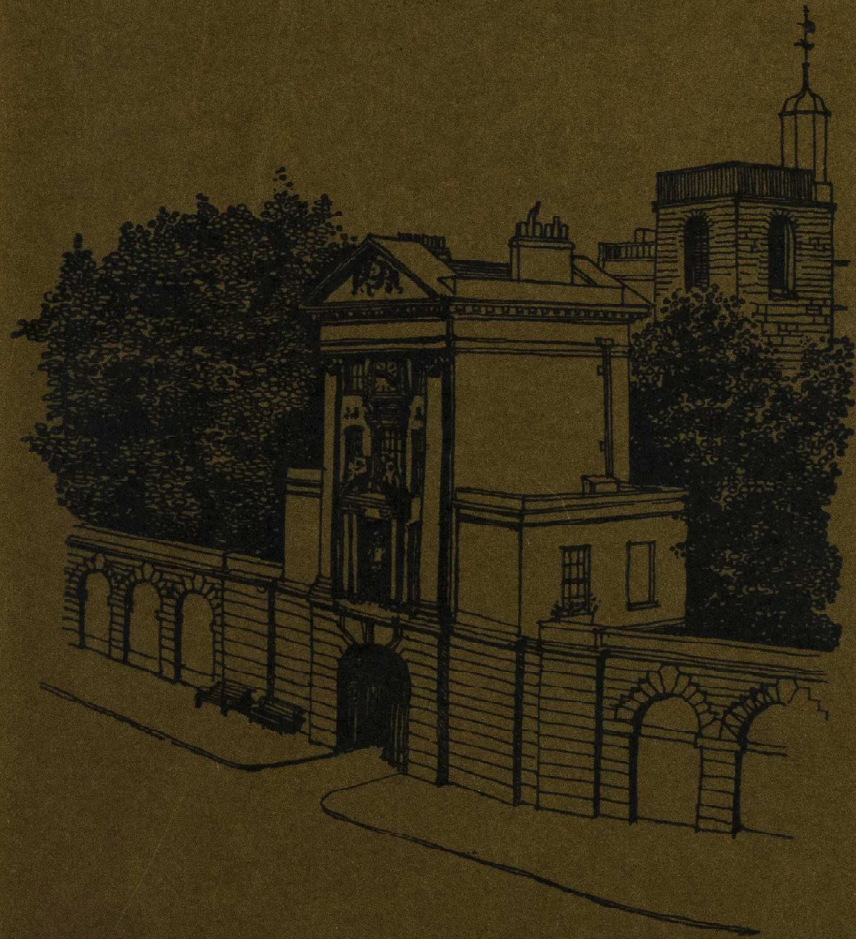
**1st XI v. Magdalene.** Drawn 3-3.

Considering that this game was played on a rugger pitch against eleven rugger players, it must be said that Bart's did well to draw. This match gave Miss I. Tonkins an opportunity to show her prowess as a goalkeeper by making some magnificent saves. Despite the size of the pitch, Bart's stood the pace until the final whistle.

**1st XI v. Girton.** Won 18-1.

As the result suggests, this match was a little one-sided and comment is therefore difficult. Miss J. Chambers set up a goal-scoring record, scoring 10 of the 18 goals.

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



# ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Editor: A. J. SALSBURY

Manager: DOUGLAS CHAMBERLAIN

January, 1955

## CONTENTS

A. C. Roxburgh, by Dr. R. M. B. MacKenna . . . . . 4	Nucleic Acids and Disease . . . . . 19
The Catering Company, 1910-1953, by C. E. Morris . . . . . 6	Sport . . . . . 27
M.F.C., by R.B.P. . . . . 9	Births and Deaths . . . . . 28
Time Lag, by Dr. R. M. B. MacKenna . . . . . 11	Examination Results . . . . . 29
Statistics, Medicine and Bart's by M. P. Curwen . . . . . 15	Book Reviews . . . . . 29

**CLINITEST** — available on the N.H.S.  
TRADE MARK  
 The dependable urine-sugar analysis set



Simple, reliable 'Clinitest' (Brand) Sets and Reagent tablets, essential in modern diabetic treatment, comply with the official specifications for appliances and reagents for urine-sugar analysis which may be prescribed on Form E.C.10. For accuracy and convenience this one-minute, no-heating, copper-reduction tablet test is unrivalled. The clear, unclouded colours of the test, easily matched against the sharply defined 'Clinitest' colour scale, give patients every confidence in their readings, eliminating many unnecessary visits to the practitioner.

**CLINITEST**  
TRADE MARK

Approved by the Diabetic Association Medical Advisory Committee

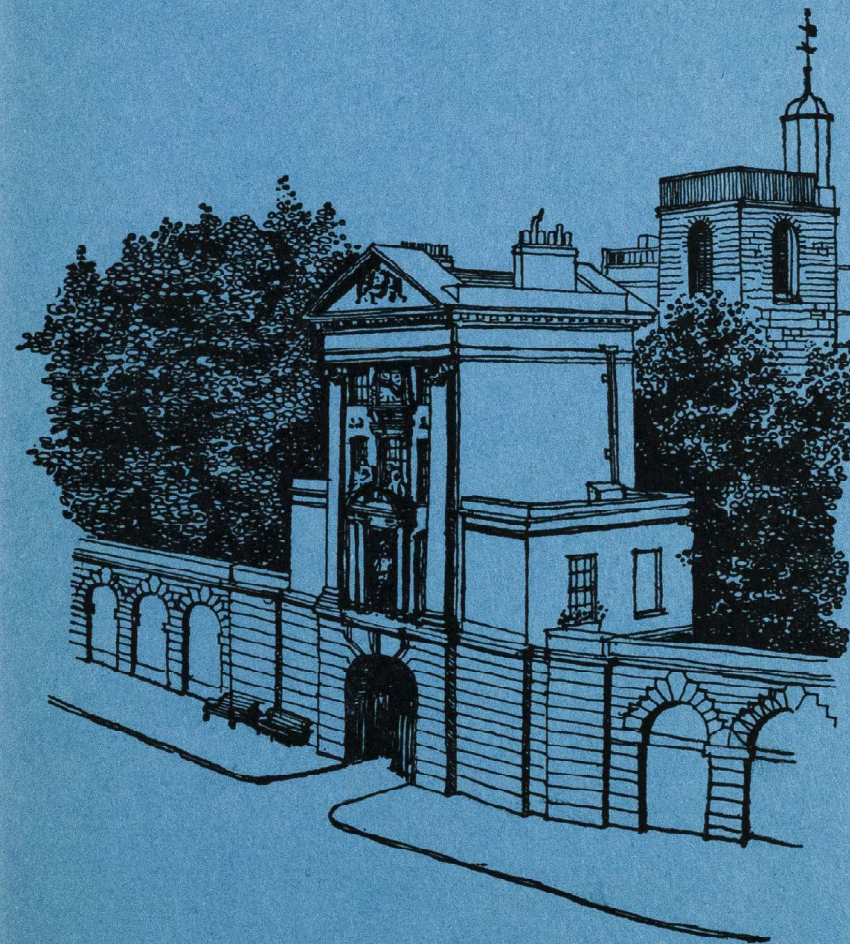
Complete Set, including 36 tablets . . . . . 10/-  
 Refill bottles (36 tablets) . . . . . 3/6

Supplies always available at all good-class chemists. Medical literature available on request to the sole distributors

**DON C. MORGAN LTD** · 58 ALBANY STREET, LONDON, N.W.1

Manufactured by Miles Laboratories Ltd., Bridgend, South Wales, under licence from Ames Company, Inc.

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL LIX

FEBRUARY 1955

No 2

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Editor: A. J. SALSURY

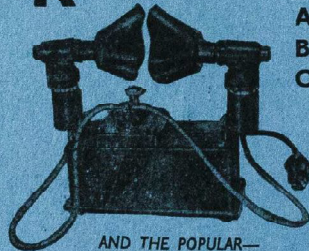
Manager: DOUGLAS CHAMBERLAIN

February, 1955

## CONTENTS

On Practising Generally, by R. G. D. Newill ... .. 34	New Year's Honours ... .. 53
So to Speak ... .. 35	Examination Results ... .. 53
Christmas in Bart's 1895. by Albert Pickard ... .. 36	The Pot-Pourri ... .. 54
Sunset, by J. D. P. ... .. 38	Sport ... .. 55
The Treatment of the Hemiplegic Patient by Physiotherapy, by Miss Wareham ... .. 39	Letters to the Editor ... .. 55
Bumbling, by J. B. Dawson ... .. 43	House Appointments ... .. 56
William Gilbert of Colchester, by A. G. Dawrant ... .. 47	Births and Deaths ... .. 57
	Book Reviews ... .. 58

## RIDDELL'S ALL BRITISH INHALERS



ARE UNSURPASSED FOR  
BRONCHITIS, HAYFEVER, **ASTHMA**  
OR FOR PENICILLIN ADMINISTRATION.

AND THE POPULAR—  
**RIDDOBRON**  
• **ASTHMA**  
• **INHALANT** •

The PNEUMOSTAT Electric Inhaler illustrated supplies sufficient atomised medicament for one or two patients at a time while a special model is available for up to six patients simultaneously.

Ten hand and electric INHALERS are available for Home, Office, Clinic or Hospital use.

An illustrated coloured brochure of inhalants and inhalers suitable for all respiratory complaints will be sent free on request.

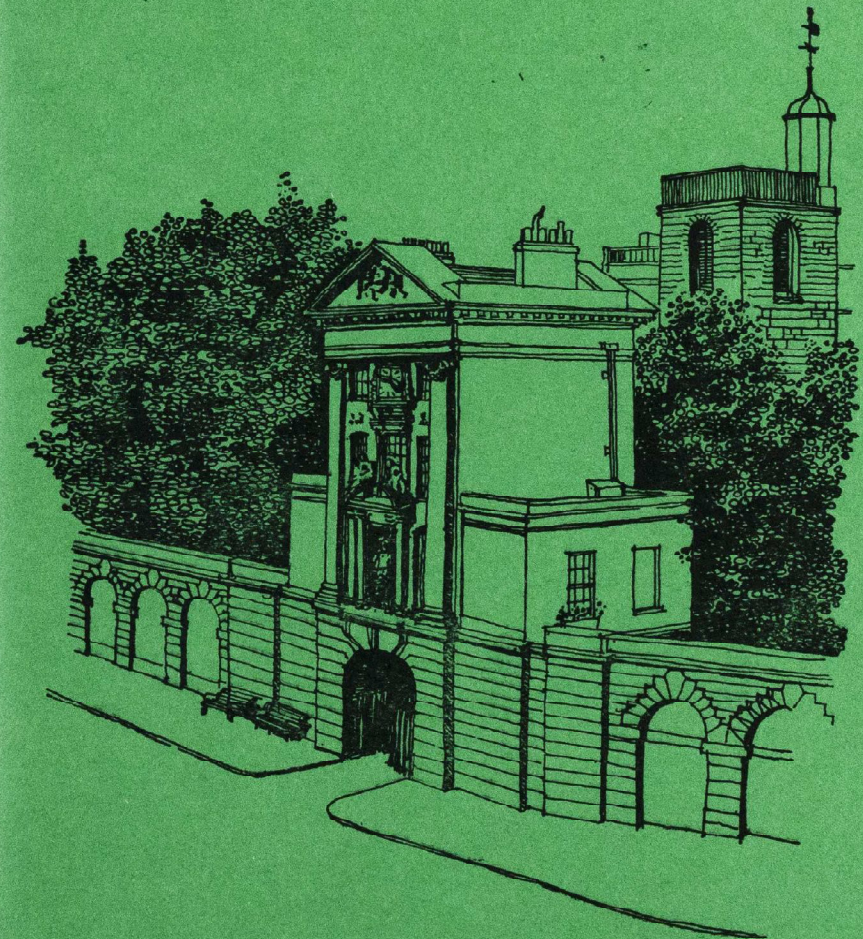
## • RIDDELL PRODUCTS LIMITED •

"THE LEADING HOUSE FOR INHALATION THERAPY"

RIDDELL HOUSE, DUNBRIDGE STREET, LONDON, E.2.

Telephone: BISHOPSGATE 0843 (3 lines) - - Telegrams: PNEUMOSTAT, BETH, LONDON

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL LIX

MARCH 1955

No 3

## ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Editor: A. J. SALSURY

Assistant Editor: G. R. KINROSS WRIGHT

Women's Representative: Miss N. COLTART

Manager: DOUGLAS CHAMBERLAIN

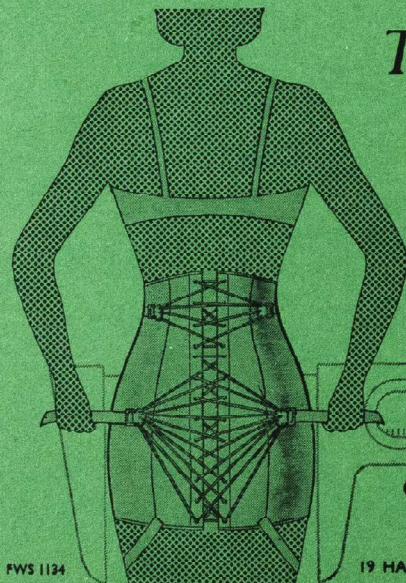
Assistant Manager: J. CHALSTREY

Charterhouse Representative: P. NORRIS

March, 1955

### CONTENTS

Letters to the Editor ... ..	61	Post Mortem, by J. D. P. ... ..	73
An Adventurous Book by J. B. Hume	64	Zermatt 1955 ... ..	74
Radiotherapy as a Career in Medicine, by I. G. Williams ... ..	65	Examination Results ... ..	75
A Week with a London G.P., by D. H. Bergel ... ..	68	Recent Papers by Bart's Men ... ..	77
So to Speak ... ..	69	Births and Deaths ... ..	79
Hypochondriasis, by R. de Alarcon ...	70	The Carol Concert ... ..	80
		Sport ... ..	81
		Book Reviews ... ..	82



## The Unique Lacing Adjustment

—originated by CAMP—ensures “vernier”  
precision in achieving the  
precise degree of support prescribed.  
*Illustrated Reference Book free on request.*



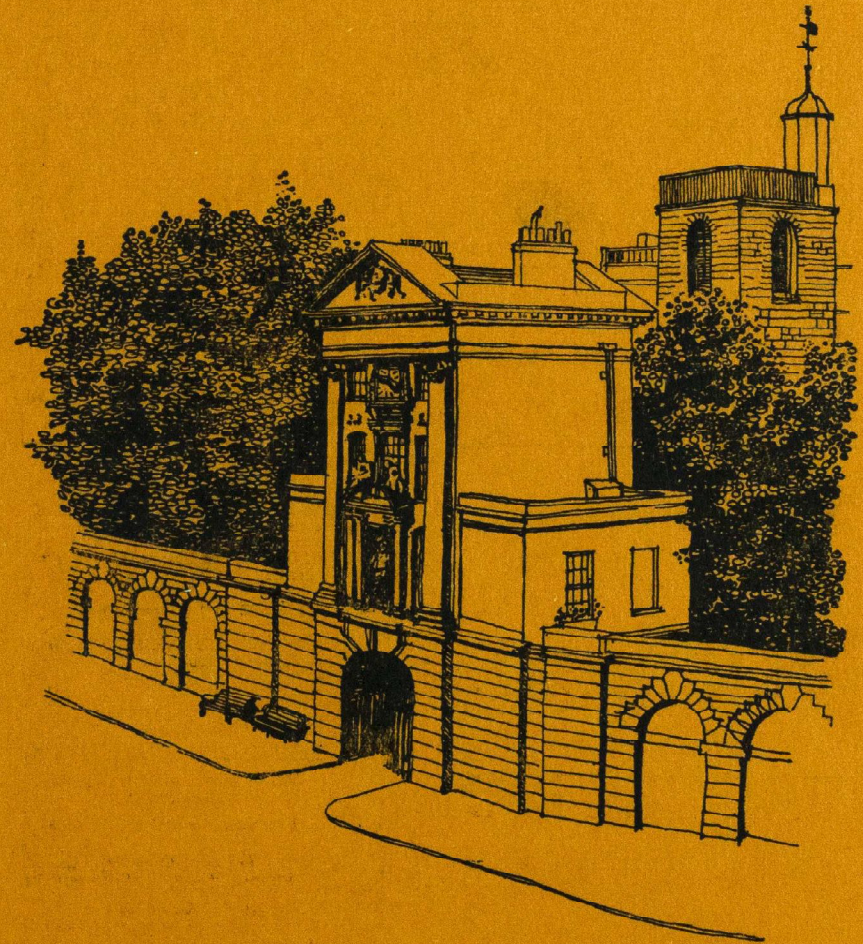
**CAMP ANATOMICAL SUPPORTS**

S. H. CAMP & COMPANY LTD.,

19 HANOVER SQUARE, LONDON, W.1. MAYfair 8575 (4 lines)

FWS 1124

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL LIX

APRIL 1955

No 4

## ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Editor: A. J. SALSURY  
 Assistant Editor: G. R. KINROSS WRIGHT  
 Women's Representative: Miss N. COLTART

Manager: DOUGLAS CHAMBERLAIN  
 Assistant Manager: J. CHALSTREY  
 Charterhouse Representative: P. NORRIS

April, 1955

### CONTENTS

Letters to the Editor ... ..	87	Dermatology at Bart's, by I. S. Hodgson-Jones ... ..	113
Miss Vaughan ... ..	88	Natural History Society ... ..	118
Lost Opportunities, by J. D. Parker ...	89	Births, Deaths and Marriages ... ..	119
Cutting for Stone, by A. W. Badenoch	90	Sport ... ..	120
The Treatment of Renal Calculus by Partial Nephrectomy by Richard Poyntz-Wright ... ..	96	Awards ... ..	126
The Andaman Islands, by Hermann Lehmann ... ..	99	Record Reviews ... ..	127
		Book Reviews ... ..	128

# MEDICAL PROTECTION

### TO ENSURE

UNLIMITED INDEMNITY against costs and damages.

PROTECTION against the risks of practice.

DEFENCE in legal proceedings.

ADVICE AND ASSISTANCE in professional problems.

### JOIN THE

#### MEDICAL PROTECTION SOCIETY

Victory House, Leicester Square, London, W.C.2

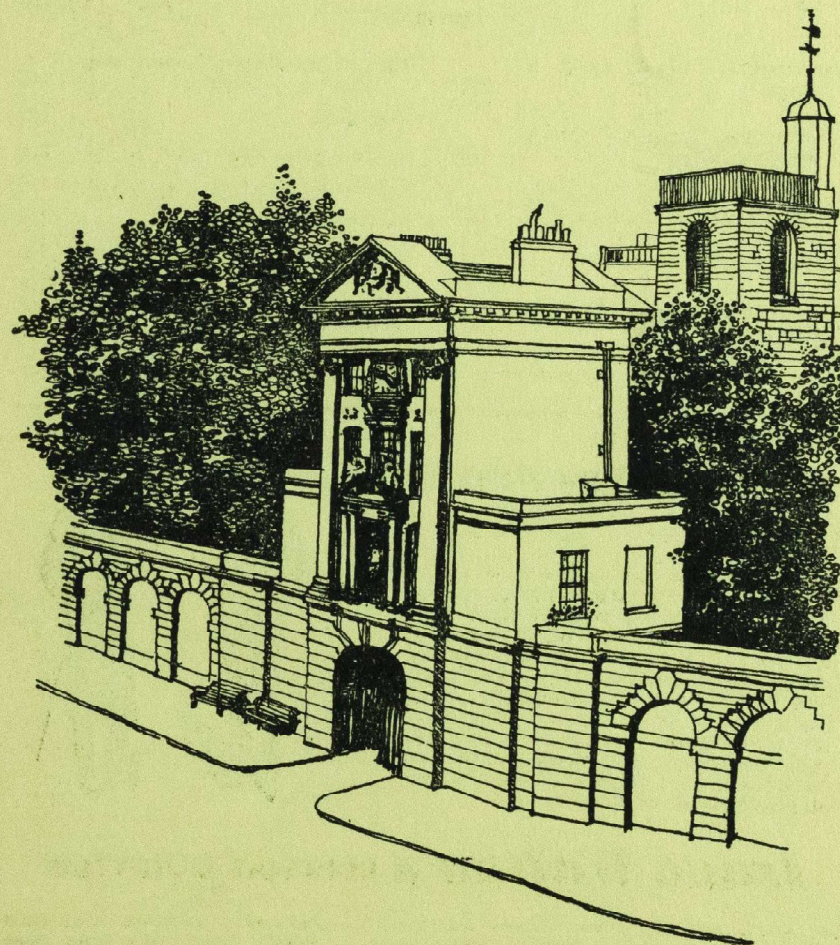
Telephone: Gerrard 4814 & 4553

Full particulars from:  
 DR. ALISTAIR FRENCH Secretary

ANNUAL SUBSCRIPTION: £1 for first three years for newly qualified practitioners and £2 thereafter.

For practice overseas an additional subscription secures the necessary extension of benefits.

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL LIX

MAY 1955

No 5



## ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Editor : A. J. SALSURY  
 Assistant Editor : G. R. KINROSS WRIGHT  
 Women's Representative : MISS N. COLTART

Manager : DOUGLAS CHAMBERLAIN  
 Assistant Manager : L. J. CHALSTREY  
 Charterhouse Representative : P. NORRIS

May, 1955

### CONTENTS

More Popular Fallacies by P. F. Lucas ... .. 134	The Life and Works of Louis Pasteur Part I by J. S. Malpas ... .. 150
An Abnormal First Rib by M. A. Newton ... .. 140	So to Speak ... .. 159
The Best Laid Schemes o' Mice an' Men by Ronald McGrigor ... 142	Recent Papers by Bart's Men ... .. 160
The Simple Life by J. D. Parker ... 146	Examination Results ... .. 163
The British Students Tuberculosis Foundation ... .. 147	Rahere Choir ... .. 164
	Births, Deaths and Marriages ... .. 165
	Sport ... .. 166
	Book Reviews ... .. 170

### Grave News from Mafeking

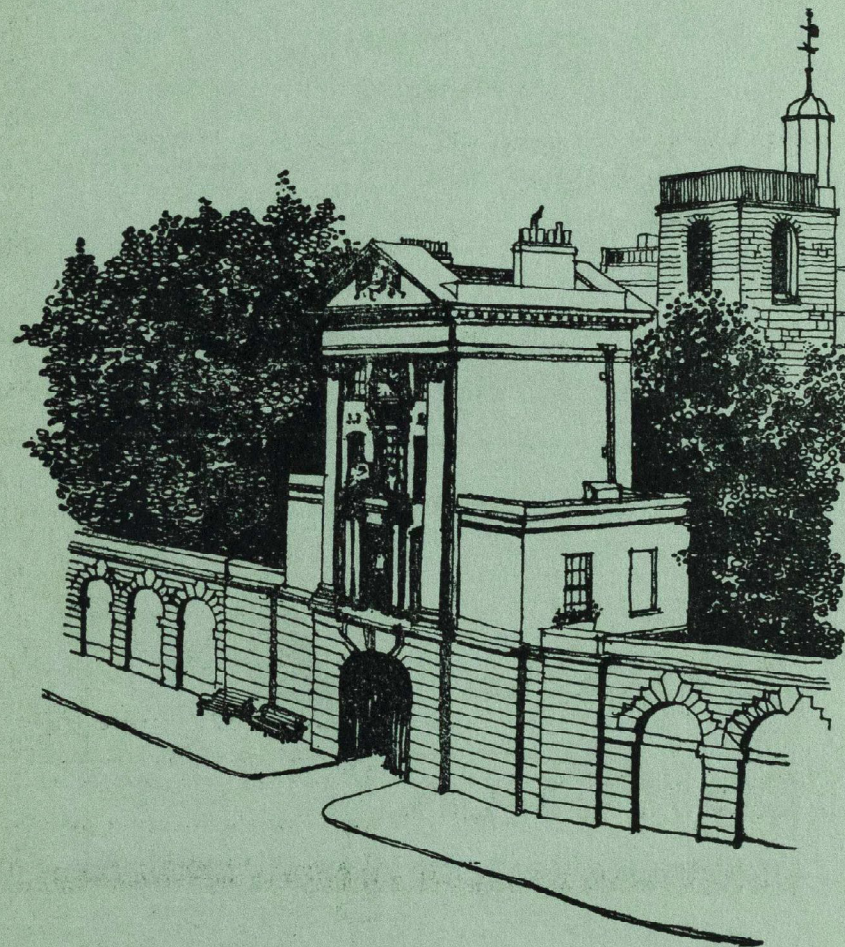
These fashion plates of ours are from an advertisement of nearly 60 years ago. In those days we were just beginning to build up our reputation for value for money which has been the basis of our business ever since. Maybe these fashions and the events which seemed so portentous half a century ago are laughable today. Yet the principle of good value abides, and we have built a moderately big private business on it. If old fashioned standards of craftsmanship and quality materials combined with present day styling in the best of taste appeal to you, you may well find we're the kind of people you like to deal with.



### Isaac Walton's COMPLEAT OUTFITTERS

City Branch and Head Office, London and Home Counties Area: LUDGATE HILL, E.C.4  
 WATFORD, 77 High Street. BROMLEY, Market Square. PALMERS GREEN, 363-5 Green Lanes  
 NEWCASTLE, Grainger Street, YORK, Lendal House, Lendal.

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL LIX

JUNE 1955

No 6

## ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Editor: A. J. SALSBUry  
 Assistant Editor: G. R. KINROSS WRIGHT  
 Women's Representative: Miss N. COLTART

Manager: DOUGLAS CHAMBERLAIN  
 Assistant Manager: L. J. CHALSTREY  
 Charterhouse Representative: P. NORRIS

June, 1955

### CONTENTS

Justice for the Doctor! ... .. 173	Orthopaedic Surgeons at St. Bartholomew's Hospital, London by J. L. Thornton ... .. 195
Social Psychiatry by J. P. Crawford ... 174	Sport ... .. 204
Pericardial Effusions by W. E. Gibb ... 181	Examination Results ... .. 206
Welfare State by J. D. Parker ... .. 184	Births, Deaths and Marriages ... .. 206
The Life and Works of Louis Pasteur by J. S. Malpas ... .. 185	

## MEDICAL PROTECTION

### TO ENSURE

UNLIMITED INDEMNITY against costs and damages.

PROTECTION against the risks of practice.

DEFENCE in legal proceedings.

ADVICE AND ASSISTANCE in professional problems.

### JOIN THE

#### MEDICAL PROTECTION SOCIETY

Victory House, Leicester Square,  
London, W.C.2

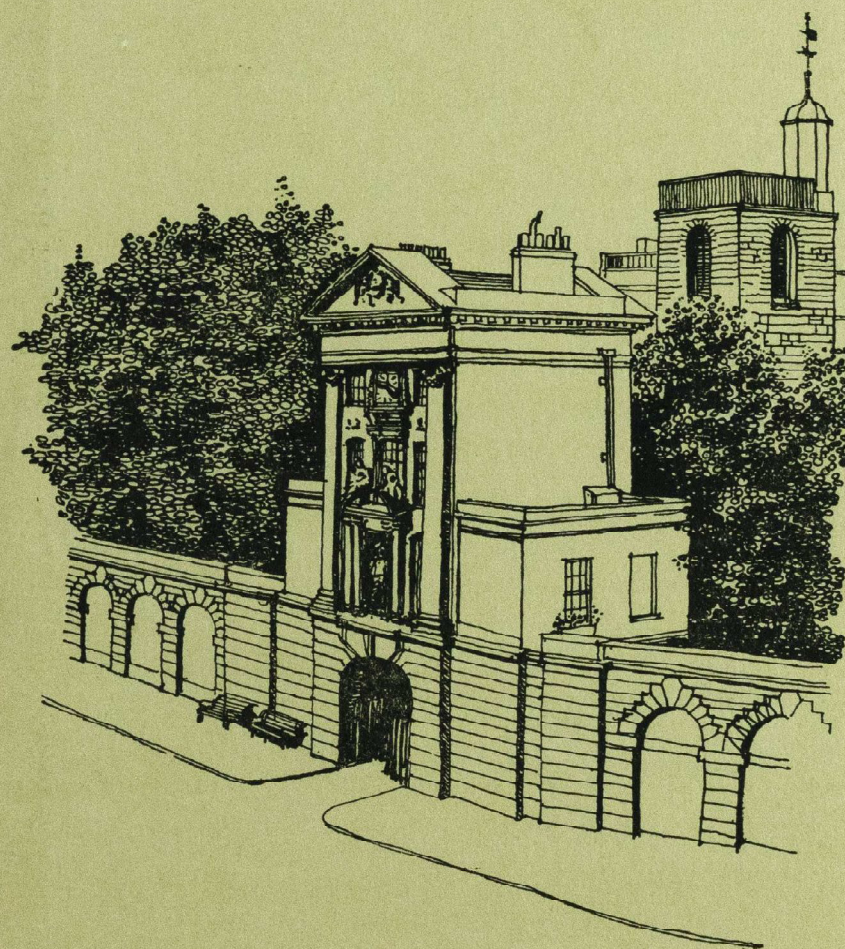
Telephone: Gerrard 4814 & 4553

Full particulars from:  
DR. ALISTAIR FRENCH Secretary

ANNUAL SUBSCRIPTION: £1 for first three years for newly qualified practitioners and £2 thereafter.

For practice overseas an additional subscription secures the necessary extension of benefits.

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL LIX

JULY 1955

No 7

## ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Editor: G. R. KINROSS WRIGHT  
 Women's Representative: MISS N. COLTART  
 Charterhouse Representative: MISS A. M. McDONALD

Manager: DOUGLAS CHAMBERLAIN  
 Assistant Manager: L. I. CHALSTREY

July 1955

### CONTENTS

Editorial ... ..	207	The Chamberlains' Secret, by P. J. Bekenn and J. F. Pigott ... ..	223
Harwell ... ..	211	Hadfield's Folly, by the Rowing Correspondent ... ..	228
Introducing the Family Doctor ...	212	Letters to the Editor ... ..	231
French Bayonets, by Penry Rowland	213	Examination Results ... ..	232
Antoine François, Comte de Fourcroy, by W. R. Bett ... ..	214	Record Reviews ... ..	233
Why I Baptised Michael Scott, by J. D. Parker ... ..	215	Sports ... ..	234
Births, Engagements and Deaths ...	217	Book Reviews ... ..	235
The Linear Accelerator at Bart's, by Professor J. Rotblat ... ..	218	Awards ... ..	238

### "Don't hurt that poor butterfly, Bertie!"

In 1898, when this illustration first appeared in Isaac Walton advertising, Arthur seemed to think he might have to "take the can back" for Bertie's high spirits. But, fortunately, even if our fashion plates did make these boys look a bit precious, the clothes were good and tough, with double seats in the trousers.

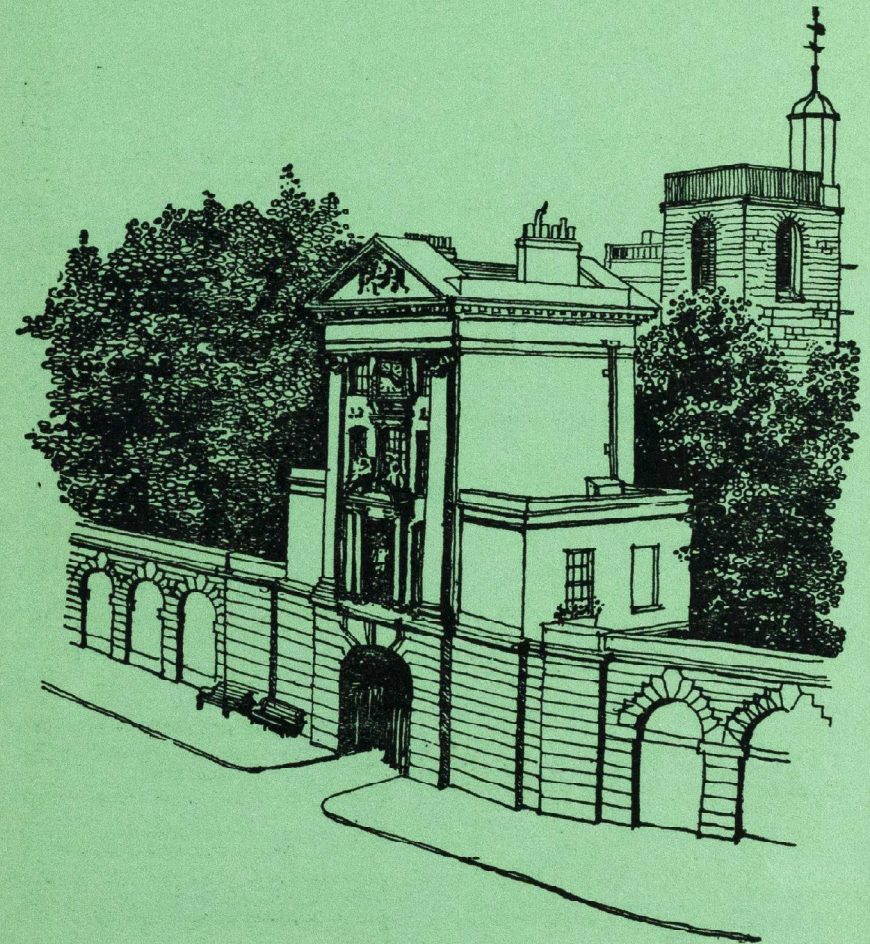
We cut our teeth in the business of school outfitting three-quarters of a century ago. By now we've cut our wisdom teeth at it. We are officially recognised outfitters to most schools in the neighbourhoods round about our shops, and we do a big trade with families whose children go to school outside our areas too. This is partly because we are still a family business and whole families—grandfather, father and son—find it pleasant to shop with us; and partly because we have high standards of value for money.



### Isaac Walton's COMPLEAT OUTFITTERS

City Branch and Head Office, London and Home Counties Area: Ludgate Hill, E.C.4.  
 WATFORD, 77 High Street. BROMLEY, Market Square. PALMERS GREEN, 363-5 Green Lane.  
 NEWCASTLE, Grainger Street. YORK, Lendal House, Lendal.

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL LIX

AUGUST 1955

No 8

## ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Editor: G. R. KINROSS WRIGHT  
Sports Editor: C. N. HUDSON  
Women's Representative: MISS N. COLTART

Manager: DOUGLAS CHAMBERLAIN  
Assistant Manager: L. J. CHALSTREY  
Charterhouse Representative: MISS A. M. McDONALD

### CONTENTS

August 1955

Editorial ... ..	239	Charterhouse, the Medieval Foundation — a book review ... ..	261
Notices ... ..	242	Sports Day ... ..	263
The Hormonal Basis of Personality by A. W. Spence ... ..	243	Births, Engagements, Marriages, Honours, etc. ... ..	265
An Exhibition of Hospital Archives by Miss M. V. Stokes ... ..	250	House Appointments ... ..	266
At Last he Sleeps Alone — A Poem by J. D. Parker ... ..	253	Examination Results ... ..	267
How Does a Falling Cat Turn Over? by D. A. McDonald ... ..	254	Sport ... ..	268
Recent Papers by Bart's men ... ..	259	Record Reviews ... ..	269
		Book Reviews ... ..	269

## MEDICAL PROTECTION

### TO ENSURE

UNLIMITED INDEMNITY against costs and damages.

PROTECTION against the risks of practice.

DEFENCE in legal proceedings.

ADVICE AND ASSISTANCE in professional problems.

### JOIN THE MEDICAL PROTECTION SOCIETY

Victory House, Leicester Square,  
London, W.C.2

Telephone: Gerrard 4814 & 4553

Full particulars from:  
DR. ALISTAIR FRENCH Secretary

ANNUAL SUBSCRIPTION: £1 for first three years for newly qualified practitioners and £2 thereafter.

For practice overseas an additional subscription secures the necessary extension of benefits.

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL LIX

SEPTEMBER 1955

No 9

## ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Editor: G. R. KINROSS WRIGHT  
 Assistant Editor: G. D. STAINSBY  
 Sports Editor: C. N. HUDSON

Manager: DOUGLAS CHAMBERLAIN  
 Assistant Manager: L. I. CHALSTREY  
 Women's Representative: Miss N. COLTART  
 Charterhouse Representative: Miss A. M. McDONALD

### CONTENTS

September, 1955

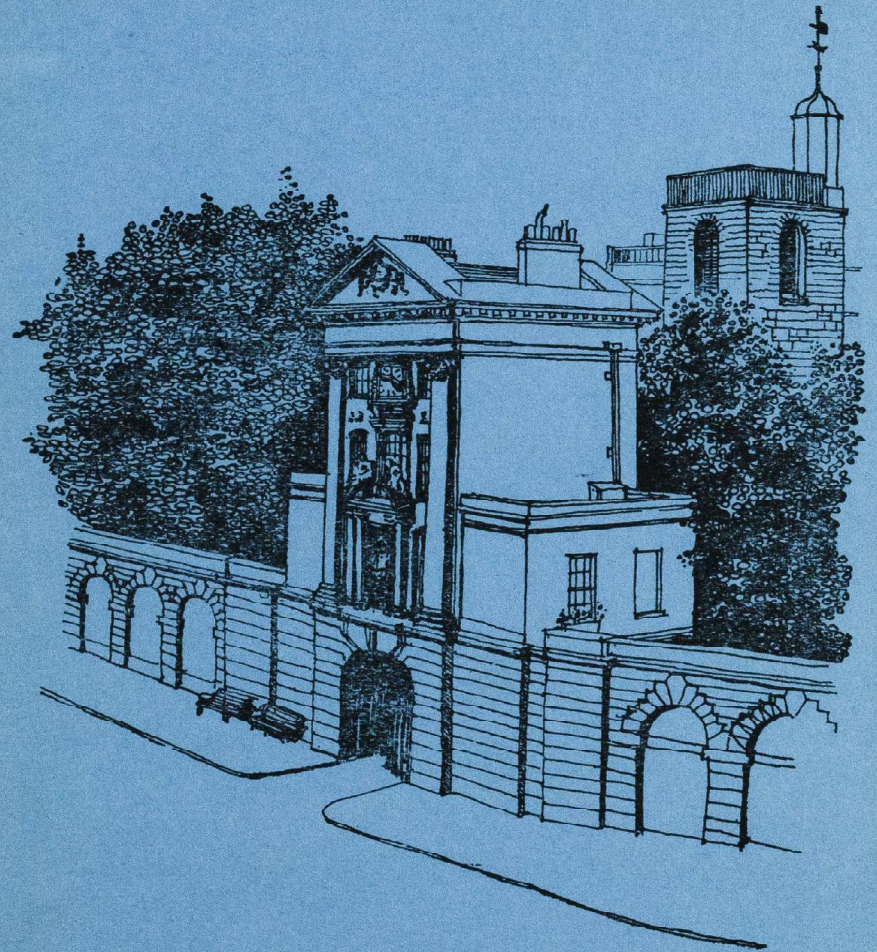
Editorial	271	An Historical Account of Medical Ethics, by Robert Forbes	282
A Tribute to Lord Horder, by Geoffrey Bourne	273	The Insulins and their use in the Treatment of Diabetes, by R. C. King	287
Dr. H. G. Adamson: an Obituary by R. M. B. McKenna	275	Candid Camera	290
Mr. John Martin-Jones: an Obituary by H. B. Stallard	277	Letters to the Editor	291
Births, Marriages, Deaths, Engagement, Changes of Address	278	Record Reviews: Things ain't what they used to be—an introduction to Jazz by Dulcie V. Coleman	294
Round the Fountain	279	Examination Results	297
Appointments, Honours, Notices	281	Sports News	298
		Book Reviews	300

- The same high standard of security and service which characterises "Car & General" Motor Policies applies to every other class of business transacted by the Company. A 'phone call (WHitehall 6161) or a postcard will bring you full information by return.

PERSONAL  
 ACCIDENT  
 BURGLARY  
 GOLFERS  
 Comprehensive  
 Home  
 FIRE

**CAR & GENERAL** INSURANCE CORPORATION LTD.  
 83 PALL MALL, LONDON, S.W.1

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL LIX

OCTOBER 1955

No 10

## ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Editor: G. R. KINROSS WRIGHT

Assistant Editor: G. D. STAINSBY

Sports Editor: C. N. HUDSON

Manager: DOUGLAS CHAMBERLAIN

Assistant Manager: L. J. CHALSTREY

Women's Representative: Miss N. COLTART

Charterhouse Representative: Miss A. M. McDONALD

### CONTENTS

October, 1955

Editorial ... ..	303	A Case of Hyperparathyroidism by P. J. Scott and C. B. S. Wood ...	320
Professor Christie ... ..	306	A Famous Patient: Nicolas Hart—The Great Sleeper ... ..	323
Notices ... ..	308	Births, Engagements and Deaths ...	322
"Bowly as I Knew Him," by Reginald M. Vick ... ..	309	Sports News ... ..	325
The Golden Boy ... ..	313	Hospital Appointments ... ..	327
Rahere and the Missing Book ... ..	315	Record Reviews ... ..	327
A Historical Account of Medical Ethics (Part II) by Robert Forbes ... ..	316	Examination Results ... ..	328
		Book Reviews ... ..	329

## MEDICAL PROTECTION

### TO ENSURE

UNLIMITED INDEMNITY against  
costs and damages.

PROTECTION against the risks of  
practice.

DEFENCE in legal proceedings.

ADVICE AND ASSISTANCE in  
professional problems.

### JOIN THE

#### MEDICAL PROTECTION SOCIETY

Victory House, Leicester Square,  
London, W.C.2

Telephone: Gerrard 4814 & 4553

Full particulars from:

DR. ALISTAIR FRENCH Secretary

ANNUAL SUBSCRIPTION: £1 for  
first three years for newly qualified  
practitioners and £2 thereafter.

For practice overseas an additional  
subscription secures the necessary  
extension of benefits.

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL LIX

NOVEMBER 1955

No 11

## ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Editor: G. R. KINROSS WRIGHT  
 Assistant Editor: G. D. STAINSBY  
 Sports Editor: C. N. HUDSON

Manager: DOUGLAS CHAMBERLAIN  
 Assistant Manager: L. J. CHALSTREY  
 Women's Representative: Miss N. COLTART

Charterhouse Representative: Miss A. M. McDONALD

### CONTENTS

November, 1955

Editorial	331	The Art Exhibition by J.G.	346
Notices	334	Births, Engagements, Deaths, etc.	349
Letters to the Editor	335	Students Union	350
The Development of Therapeutic Dietetics by Miss M. E. Furnivall	336	Rotunda '55 by 'Medical Davy'	351
Postman's Park by G.D.S.	340	Examination Results	352
Some Aspects of Medicine in Canada by Geoffrey Ffrench	342	Sports News	353
Pictures from an Exhibition	345	Recent Papers by Bart's Men	355
		Book Reviews	357

'I want you to wear a Lastonet stocking'



Lastonet surgical stockings are always made to measure for a perfect fit. The lightweight elastic net stretches in all directions for even support and allows air to come in contact with the skin. The stockings may be prescribed under the National Health Scheme.

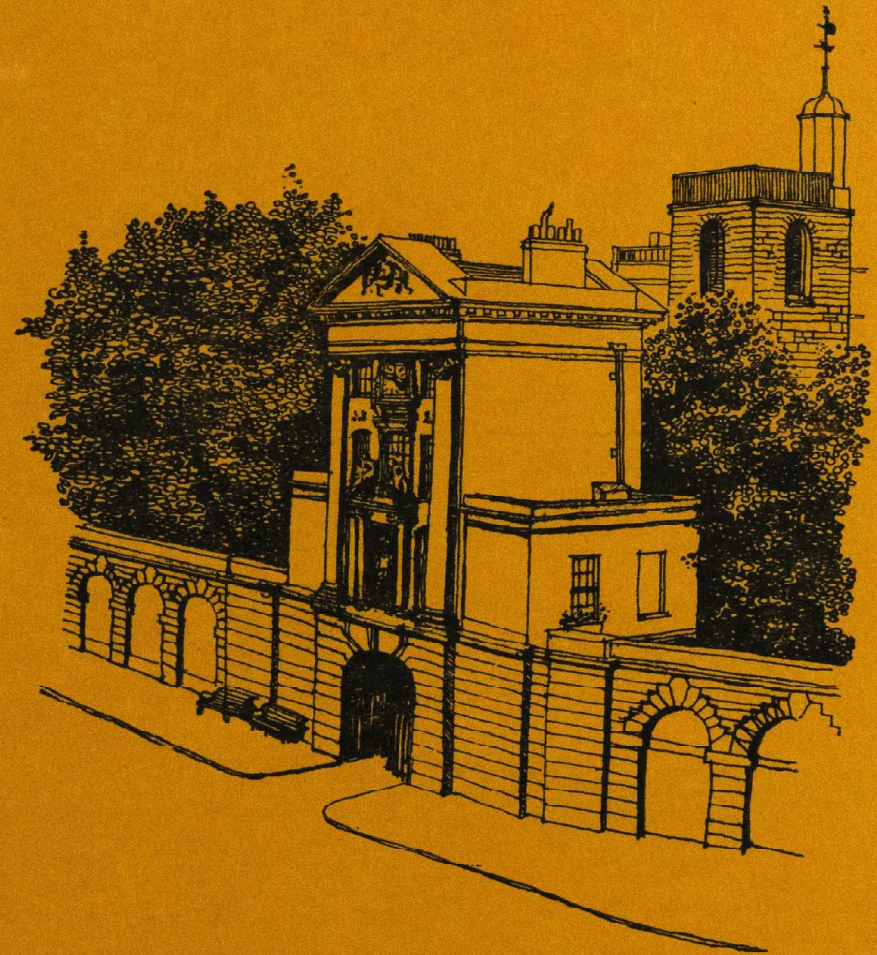
**Lastonet**  
 ELASTIC  
 NET STOCKING



LASTONET PRODUCTS LTD, CARN BREA, REDRUTH, CORNWALL

11

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL LIX

DECEMBER 1955

No 12

## ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Editor : G. R. KINROSS WRIGHT  
Assistant Editor : G. D. STAINSBY  
Sports Editor : C. N. HUDSON

Charterhouse Representative : Miss A. M. McDONALD

Manager : DOUGLAS CHAMBERLAIN  
Assistant Manager : L. J. CHALSTREY

Women's Representative : Miss N. COLTART

### CONTENTS

December, 1955

Editorial	358	Impressions of Mexico City by J. T. Silverstone	373
Notices	361		
Hospital Appointments	361	Births, Marriages, Deaths, etc.	376
Letters to the Editor	362	Turban Tumours by L. J. Chalstrey	378
Electromyography by K. M. Backhouse	364		
Reproduction in Goldfish—An exchange of letters between Professor L. P. Garrod and Mr. C. C. Carus Wilson	371	The Dear Man (Sir D'A. Power) —a poem by W. R. Bett	384
		Sports News	385

# MEDICAL PROTECTION

### TO ENSURE

UNLIMITED INDEMNITY against costs and damages.

PROTECTION against the risks of practice.

DEFENCE in legal proceedings.

ADVICE AND ASSISTANCE in professional problems.

### JOIN THE

### MEDICAL PROTECTION SOCIETY

Victory House, Leicester Square,  
London, W.C.2

Telephone: Gerrard 4814 & 4553

Full particulars from:  
DR. ALISTAIR FRENCH Secretary

ANNUAL SUBSCRIPTION: £1 for first three years for newly qualified practitioners and £2 thereafter.

For practice overseas an additional subscription secures the necessary extension of benefits.



