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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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EDITORIAL

I have made a short calculation, on good data, and estimate that twenty thousand guineas are annually paid by parents and guardians of medical students in order that a quarter of a million golden hours of youth may be wasted by compulsion in listening to feeble matter vilely delivered.

The Student's Guide to the Medical Profession *by* C. B. Keetley.

ONE often hears comparisons between the conditions of today and the conditions prevailing in an analogous society a generation or more ago. It is not unusual for parents to draw on their inevitably misty and biased memories and contrast their own generation with that of their children with most unfavourable results. The youth of today are considered to be irresponsible as to their behaviour and their attitude to money, to show a lack of politeness and an inability to entertain themselves. The children are thought by the parents to be more noisy and infinitely more expensive than they themselves were as children. However is it the children that have changed for the worse or is it the environment in which they have flourished that has changed and in particular has the environment in which the modern generation of Bart's medical students exist altered from that of twenty years ago?

Comparisons at any time are invidious but on occasions must be made and it is fair to ask at the beginning of 1958 whether Bart's like Punch is not so good as it was. One can easily take any arbitrary standpoint to justify whichever answer one elects to choose but nevertheless the proposition bears careful analysis before a fair assessment can be made.

On the credit side of the account the magnificent new buildings which have been erected at Charterhouse Square must head the list. The provision by the Medical College and London University of teaching and research laboratories, lecture theatres, and a College Hall which are unsurpassed by any similar projects in the other teaching hospitals of the country was indeed a piece of great and commendable foresight. To stay with the static improvements to the teaching facilities of the hospital one must include the new wing now nearing completion in Little Britain. This will vastly improve the opportunities for the student body to study the diagnosis, treatment and special nursing measures necessary in the highly specialized departments which are to be installed there. Also the provision of a new nurses' home to accommodate the nurses from Hill End will allay some students' fears of " while the cat's away " since no longer will there be twenty-odd miles of well-nigh impassable country between them.

It is indeed regrettable that whilst so much money has been spent in creating a Sub-

Utopia at Charterhouse Square for the pre-clinical students that no real efforts have been made to improve the teaching facilities at the hospital itself. The lecture theatre destroyed by enemy bombing in the war has not been replaced and the present clinical lecture theatre was first built as a dissecting room and now manifests the cold discomforts which are only too befitting for a dissecting room. The laboratories are obsolete, dark and uncomfortable.

Such are the changes which have, and have not, taken place on the face of Bart's but the real revolution has taken place beneath the surface of the hospital. The old relationship between students and the teaching staff seems to have been sacrificed vicariously on the altar of the Education and National Health Acts. Once so much an integral part of the soul of the hospital, based on respect and affection on the one part and humility and devotion on the other it has passed out of the life of the hospital and has been replaced by the unrelenting quest of the student body as a whole for appointments to the House from the very moment of their arrival at the Hospital. This is of course a local reflection of a national problem but is nonetheless regrettable for all that.

With the changing attitude of the student and the profession as a whole to the criteria necessary to a successful start to a medical career so the attitude of authority has changed. No longer is the undergraduate allowed any latitude in satisfying a large number of requirements before qualifying, not least amongst them being the compulsory attendance at certain lectures. This compulsion deprives the student of the exercise of what personal integrity he has, since no account is taken of the quality of the lecturer.

If medicine is to be considered as a subject which of its very nature is fascinating and absorbing in spite of the unfortunate presentation of the subject by a man who finds it difficult to carry his meaning across, then no lecture need be compulsory since they will be attended nonetheless. If conversely any lecture fails to be absorbing either in subject or in presentation then it has no right to be compulsory.

This gradual transition from a University College concerned with more than just producing doctors to a highly specialised technical school is perhaps the most regrettable change of all. Inevitably the breadth of vision enjoyed by the student becomes narrowed and his quest for knowledge stultified. There is something to be gained for Bart's if a compromise between the '*laissez faire*' attitude of older and well tried systems of undergraduate education and the needs of the ever-increasing scientific demands of medicine could be arranged. A completely '*laissez faire*' attitude would not be possible but a compromise should, or indeed, must be found.

Punch has managed to change its standards and modify its frames of reference with the times and has not lost its charm, its tradition nor its erudition. Bart's has changed and is still changing, posterity alone can judge to what. Perhaps in twenty or so years' time we too will look at our Hospital and nod sadly, saying "Bart's isn't what it used to be . . ." and then, remembering, say "Or is it?"

The View Day Ball

For the first time for many years the Senior Secretary of the Students' Union has been able to face an A.G.M. of the Union and publicly announce that apathy is no longer his bête noire. This was, however, not the only unusual feature of the meeting. The proposals of last year's Ball Committee to hold this year's View Day Ball in a marquee on the College Hall lawns came under fire, and the discussion lasted well over an hour, becoming somewhat acrimonious by the end.

The reasons for changing the venue for the ball are somewhat specious in quality. Firstly, there is no suggestion that there will be any financial advantage in holding it in a tent as compared to an hotel, but that the novelty of dancing on the lawns at Charterhouse Square will draw at least the same support as a ballroom at the Park Lane Hotel.

Whether in fact the idea that people who have long since forsaken the Hospital will find the new proposal attractive and come to the dance is one which can only be decided by experience. If, however, the dance is not a success, people who normally come will not be prepared to support it in later years.

In any case, the problem is to decide for whose enjoyment the Ball is primarily intended—the Past or the Present. If the latter, then the incentive to spend a quite considerable amount of money on a ticket is partly the opportunity to live for a few hours in surroundings to which they are unaccustomed.

It is, indeed, strange to hear that the traditional View Day Ball is to be held at the end of June, when View Day itself is on the second Wednesday in May. By the same token, the Ward Shows could well be held at the end of January, when the whole spirit of Christmas has disappeared. Perhaps an alternative name for the ball could be "The Students' Union Midsummer Madness".

The Dramatic Society

In the last week of November the Dramatic Society performed Ronald Jean's "Count Your Blessings" on the stage of the Cripplegate Theatre before an audience of encouraging magnitude. One must applaud their choice of play, for comedies, though more difficult to perform, are more palatable to an audience which is familiar with the players. Only one setting was required and this must have been a boon to the stage-manager and his assistants. The society is indeed fortunate to have, in John Sugden and his helpers, gentlemen who are prepared to give their time and energies to behind-the-scenes work.

This play has two long and exacting parts for the young husband and wife who are beset with financial difficulties. The most arduous task fell to Miss Jean Arnold and after a rather shaky start she rose nobly to the occasion. Her voice lacked flexibility for such a long part but it had a pleasant tone and carried well into the theatre. Victor Major mastered the part of the young husband extraordinarily well and gave an extremely polished display. If one can criticise his performance at all it is only to comment that his love scenes with his wife lacked ardour by medical student standards.

On the first night Miss Nancy Watts fidgeted in the wings as her entry cue in the first act was passed over and she failed to appear until the next scene. However, such an experienced campaigner as Miss Watts was not to be denied and on the second night she appeared to a warm ovation from the audience who were rewarded with an effusive and invigorating performance.

Peter Fenn achieved the correct note of superciliousness as the expectant brother-in-law, although his psuedo-Oxford accent tended to slip into the Bart's bedside baritone; but perhaps this was intentional. Miss Gillian Smith succeeded in arousing our sympathy for poor Charles Edward, whilst Miss Francis Aitkin made a succulent P.G. siren and some gentlemen in the audience were distinctly disappointed that the negligé of the script was replaced by a rather tomboyish pair of pyjamas. After his display as a mixed-up mid-European politician one expects any weekend to find Brian McGrath mounted on a soap-box in Hyde Park, though I fear he will quickly lose his sympathisers unless he becomes more audible. Miss Janice Swallow, well padded for the occasion, made a convincing char.

The audience as ever at the Cripplegate were willing to laugh in the wrong, but mainly in the right, places and one felt that all the cast might have profited by allowing the laughter to subside somewhat before proceeding. Such occasions have a notorious reputation for being a pleasure only to the cast and their relations and the society are to be congratulated for really entertaining their supporters. The evening was pleasantly rounded off by a brief curtain speech from the producer, Miss Dawn Watling, after which, Mr. Capps, the president of the society, presented flowers to the ladies and, thinking himself one bouquet short, gallantly kissed the lady concerned only to find more flowers produced from the wings. Altogether it was a most enjoyable evening and one can only wish that all amateur productions were of an equally high standard.

Overseas Scholarships

Over 100 scholarships are being offered to British students by 19 foreign countries for study abroad during the academic year 1958-59. They are mainly for university graduates and undergraduates, but some are open to candidates with non-academic qualifications.

The scholarships generally provide for free tuition and maintenance and most of them are tenable for a full academic year,

though there are a number of awards for shorter periods.

The countries offering the scholarships are: Austria, Belgium, Brazil, Denmark, Finland, France, Germany, Iceland, Iran, Italy, Japan, The Netherlands, Norway, Poland, Portugal, Spain, Sweden, Switzerland and Yugoslavia. Most of the scholarships correspond to awards made by the British Council to students from these countries for study in the United Kingdom.

The British Council assists in publicising the offers and in most cases in the recruitment of candidates. Closing dates for applications vary according to the country concerned, the earliest being 1st February, 1958.

Further information and application forms, for which a stamped, addressed foolscap envelope should be sent, can be obtained from any British Council office, or from the Director, Universities Department, The British Council, 65, Davies Street, London, W.1.

The Boat Club Dinner

Strains of "Poor Little Angeline" and similar bawdy songs echoing around Smithfield at midnight on the last Wednesday in November should have indicated to any informed observer that the serious business of the Boat Club's annual dinner had just been concluded and that the frivolities were about to begin.

"Helping hands"?

This year the dinner was held at the Rutland Hotel, West Smithfield, and this new venture proved an unqualified success. The club is indeed deeply indebted to Mr. Richford for the quality of the food and service and for the modest charge made to the fifty members present. The choice of wines, spirits or beer to be served with the meal was popular. During the dinner and at the post-prandial celebrations Mr. B. R. Collier was busy taking photographs, and the club will, we hope, repay his efforts by buying as many prints as possible.

The Guest of Honour this year was Mr. Charles Kindersley, who travelled up from Bath at the club's invitation. He was formerly secretary and captain of the Club, and also played Rugby Football for the 1st XV. In those far-off days the Boat Club consisted of only four members, one Blue and three trial caps; little wonder then that they should have carried off the United Hospitals' Trophy.

In proposing the toast to the guests, Mr. Bowles said that Mr. Kindersley claimed to be the only man ever to be suspended by his ankles from the gallery of the Empire, Leicester Square, and survive the experience. He then went on to welcome the other guests who were the Warden, Messrs. Peter Bell and Tim Edwards, from London Rowing Club, Mr. Morris and Mr. R. M. Phillips. Also present was Dr. Michael Taylor, of the Physiology Department, who is assisting the club in the design of a rowing tank. The first fruit of this project, a working model built to scale, was on display.

Mr. Kindersley then made a brief and witty reply and concluded by exhorting the members to enjoy themselves, as he felt that riotous youth led to responsible maturity. Professor Garrod, the President, then proposed the Boat Club, and Mr. Besser in his reply made the customary survey of results and prospects. In the Winter Regatta, four of the Hospital's boats raced in finals, but only the Rugger Club's IV could achieve victory. He concluded that the overall position was very encouraging.

New Addresses

Mr. Frankis Evans, 115, Chertsey Road, Twickenham, Middlesex.

Dr. Gunaratnam Cooke, Kerimalai, Kankasanthurai, Ceylon.

Dr. P. M. Goodrich, 3, The Ridings, East Preston, Sussex.

Journal Staff

Mr. J. K. Chong has resigned as editor of the *Journal*.

Mr. M. J. L. Patterson has been appointed editor of the *Journal*.

ANNOUNCEMENTS

Engagements

PLUMPTRE-PRISTON.—The engagement is announced between Martin Plumptre and Alison Priston.

TREHARNE-MERWOOD.—The engagement is announced between Philip Gordon Treharne and Hermione Ann Merwood.

Births

IVENS.—On November 10, 1957, to Daphne, wife of Dr. Hugh Ivens, a son (Paul Michael), a brother for Hilary and Christopher.

JENKINS.—On November 15, to Elizabeth and Dr. George Jenkins, a son (Mark Andrew).

ROGERS.—On November 26, to Mary, wife of Dr. David Rogers, a daughter.

TODD.—On November 10, to Jean, wife of Ian P. Todd, a son (Steuart).

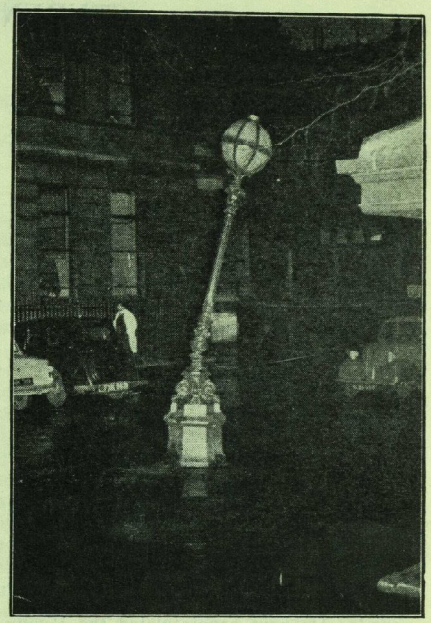
Deaths

COLT.—On October 26, George Herbert Colt, aged 79, Qualified 1904.

HANCOCK.—On October 25, Frank Thompson, aged 76. Qualified 1908.

MOORE.—On November 13, Charles Gordon Moore, C.V.O., aged 72. Qualified 1910.

WILSON.—On October 7, Ambrose Cyril Wilson. Qualified 1908.



"Odd leanings"

CALENDAR

Sat. 11th.—Dr. G. Bourne and Mr. J. B. Hume on duty.
Anaesthetist: Mr. F. T. Evans.
Soccer: v. Old Chigwellians **H.**
Hockey: v. National Provincial Bank **H.**

Wed. 15th.—Soccer: v. Charing Cross and Royal Dental Hospital 'A' XI **A.**

Sat. 18th.—Dr. A. W. Spence and Mr. C. Naunton Morgan on duty.
Anaesthetist: Mr. R. A. Bowen.
Soccer: v. St. Thomas' Hospital **A.**
Hockey v. Bluehairts **H.**

Fri. 24th.—Soccer v. Trinity College, Oxford **A.**

Sat. 25th.—Dr. R. Bodley Scott and Mr. R. Corbett on duty.
Anaesthetist: Mr. R. W. Ballantine.
Hockey: v. Goldsmith's College **H.**

Wed. 29th.—Soccer v. Guy's Hospital (L) **A.**

Sat. 1st.—Dr. E. R. Cullinan and Mr. J. P. Hosford on duty.
Anaesthetist: Mr. C. E. Langton Hewer.
Soccer v. Queen's College, Cambs. **H.**
Hockey: v. National Physical Laboratories, Teddington **A.**

STUDENTS UNION

The Annual General Meeting of the Students Union was held on Thursday, November 28th, at 5.30 p.m. in the Clinical Lecture Theatre.

Mr. Hume was in the chair.

The minutes of the 1956 A.G.M. were read and approved.

It was announced that the following officers had been elected by the Council:

President: Mr. J. B. Hume.

Vice-Presidents: R. G. White, T. Silverstone, J. Owens.

Treasurers: Dr. G. W. Hayward, Dr. H. W. Balme, Dr. A. Macdonald.

Senior Secretary: G. R. Hobday.

Financial Secretary: F. Abercrombie.

The Senior Secretary, Mr. J. Owens, gave his report in a concise and amusing manner. He thanked the College on behalf of the male students for renovating the men's cloakroom which had cost several thousand pounds. He next congratulated the Rugby Club on reaching the finals of the Hospitals Cup and only being beaten in a replay. The Cricket Club, Women's Hockey Club and Rifle Club had also had very successful seasons. He deplored the lack of support given to the Rahere Music Society and Dramatic Society which had resulted in some financial losses. He congratulated Mr. Brian Richards on his starting of a Gilbert and Sullivan Society which had been very successful and congratulated the View Day Ball Committee on the excellent Ball held in the Park Lane Hotel. They had recommended that the 1958 Ball be held in a marquee on Charterhouse lawn. He then mentioned the rise in prices of food in the Refectory and said that Mr. Morris had agreed to put on a set meal for 2s. 3d., sacrificing quality for bulk. He then expressed the Freshmen's appreciation for the Students Union Guidebook, edited by Messrs. Bootes and Howes.

He then expressed his thanks to Dr. Cullinan, Mr. Hume, Dr. Balme and Dr. Macdonald for the help and encouragement they had given him and for the interest they had taken in Students Union affairs.

The Secretaries' report was adopted.

Mr. Sugden proposed that the View Day Ball be held again in the Park Lane Hotel in 1958. This motion was defeated heavily.

The Financial Secretary, Mr. T. Silverstone, then gave his report and said that the College had agreed to take over the running of Foxbury and to rent it to the Students Union for £450 p.a., but in spite of this saving the S.U. subscriptions would have to be raised from 6 guineas to 7 guineas per annum.

The Financial Secretary's report was adopted.

The B.M.S.A. representative then gave his report and said he unfortunately had apathy to report in regard to hospital interest in the B.M.S.A. He then pointed out that the B.M.S.A. arranged clinical courses all over Europe for those interested and had Student travel grants for those in need.

A vote of thanks was expressed to Mr. B. Hill for his work as editor of the B.M.S.A. Journal. The meeting closed at 7.30 p.m.

Council Meeting

A meeting of the Students Union Council was held in the Abernethian Committee Room at 12 noon on Wednesday, December 4th. Mr. J. B. Hume was in the chair.

Mr. C. G. Beardwell was elected Junior Secretary by the outgoing Council.

Mr. B. McGrath proposed that a Gramophone Society be formed with a view to having a gramophone and records in a suitable room in the Hospital for clinical students. A sub-committee was formed to look into this.

It was decided to post a list in the Abernethian Room to determine which were the most popular newspapers and in the interim to purchase another copy of the *Daily Mail* and *Daily Express*.

It was decided that the Union should take more part in the University of London Union's affairs and Mr. Hadley was elected as the Council's representative.

The meeting closed at 1.30 p.m.

NO FLIGHT OF FANCY

by H. A. NORTON

IT WAS a glorious Winter afternoon in 1929; and in that part of North Queensland we could depend on fine weather from May to October. That afternoon I had left Glen Isla, and was on my way to Manfred when another car drew level and the driver told me that I was wanted on the phone at Glen Isla—only ten miles back! It was my churchwarden—agent for QANTAS Airways then—phoning to tell me that the flying Doctor would be calling there to pick me up. We were to go to a Gulf property. I was instructed to find a paddock over which I could drive safely at 30 m.p.h. for at least a quarter of a mile each way, and to light a smoke fire in a corner of it—for recognition and for wind direction indication. Strangely enough, only two days before that, I had told my Warden that if I *had* to go in that ancient-vintage Moth plane for duty I would hardly relish it. When the plane came down—it had come from Cloncurry—the Doctor told me that I would certainly be needed, he might not be. Dr. Alan Vickers had not very long been at Cloncurry, where he was to stay for many years. That afternoon we little realised that he would for a long while live at my house, or that I would, one day, marry him to a Cloncurry girl on my return from England in 1932. Often we were to fly together, and always he was a splendid G.P., and a grand friend.

The Rev. John Flynn had had the ability to bring to reality the dream of many folk; a dream of more safety in the outback of North Queensland, and for similar parts of Australia. Flynn was a Presbyterian, a friendly man, to whom all churches subscribed in his Flying Doctor Scheme. QANTAS (still the same name is used, though it stands for Queensland and Northern Territory Aerial Service) kept a spare plane and spare pilot ready to go almost anywhere at short notice. Alf. Trager, from Adelaide, had designed a cheap wireless transmitter-receiver for sending morse messages from isolated cattle or sheep properties. Such sets were given first to the most isolated places, then gradually more and more were issued till most places which had no phone, and were a good distance away from Cloncurry, had their 'pedal' wireless sets. Power for transmitting was generated by pedalling—as with a cycle—and so turning a small generator. Each day, at stated hours, Alf or Harry Kinzbrunner would be listening for calls for the doctor, for messages, and for telegrams to be sent from Cloncurry Post Office. The Doctor was there too, listening for details, and giving advice concerning patients. The Doctor had beds at Cloncurry General Hospital. There were times, in the first few years, when the Flying Doctor Scheme was in desperate need of money. But far and wide in Australia, people rallied round, and kept it going. Then the Federal Government—I think that it was the Federal and not the State Government—stepped in to help financially. It has done so ever since.

Now there is a mantle of safety spread all over Australia. The Flying Doctor mentioned—Alan Vickers—is still connected with the scheme. He was over here a few years ago hoping and working for similar schemes in other parts of the Commonwealth such as Central Africa and Pakistan. The little beginning at Cloncurry has taken place in many other similar parts of Australia. When there is the chance of quick transport to hospital, over big distances such as we had, there is more likelihood that men will settle, will marry and have families in the outback places.

To the memory of the Rev. John Flynn a fine church has been built at Alice Spring. To that, as to his Flying Doctor Scheme, all denominations contributed most gladly. His work will go on.

Yet what a difference there was in means of communication between 1929 and the last time I was in the "wild and woolly West" in 1948. At first we used a plane with an engine of World War I vintage—a Siddeley-Jaguar. It stood up to the work wonderfully.

Then, Qantas planes were known fairly well in Australia, but now their routes extend nearly all over the world. The pilots who used to stand by for emergency calls have become well known — possibly the widest known being Charles Scott. He, with Campbell Black as co-pilot, won the Centenary Air Race from London to Melbourne in the first named "Comet". With well-tried aircraft, and splendid pilots; with conscientious doctors, and ability to send and to receive messages, the scheme has gone on. Small nursing homes, staffed by two fully trained nursing Sisters, who are assisted by local trainees, have been established in some places far from hospitals. Dunbar Station, for example, a cattle property of J. S. Love, in the Gulf country (Gulf of Carpentaria) is well known, and so is the little hospital there. Both miles from anywhere.

The wireless sets, nowadays not confined to sending morse, are used not only for S.O.S. messages, but as a means of having a chat with folks scores of miles away, and also for giving day-school and Sunday-school lessons. We, in England, who have schools and churches so close, will realise what a boon this is to less fortunately placed people.

Having seen these advances made in so few years, Dr. Vickers wants other similarly situated parts of the Commonwealth to be helped in the same way.

When she was last in Australia, Her Majesty the Queen spoke over the Flying Doctor radio network, and learned at first hand something of this splendid example of team work.

PSYCHOLOGY – AN ALIBI FOR SIN?

by E. B. Strauss

I WONDER whether the subject which is under discussion could best be tackled by the psychiatrist, the lawyer, the philosopher, or the moral theologian, for it seems to me that it is only the old question of determinism versus free will over again, even if it is presented in somewhat modern dress. Therefore, to prevent the discussion developing on too abstract lines, may I assume that free will can never be proved philosophically, any more than can the existence of God, for instance; but that, unless it be admitted as a valid operative factor in the human situation, the whole debate would become woolly.

Our Common Law depends entirely on the axiomatic acceptance of the principle which accords a large measure of freedom of choice in matters of conduct to adult members of society not deemed to be insane or grossly mentally defective.

Is the whole applecart to be upset because certain psychologists of the unconscious come along and say that our behaviour is ineluctably determined by the emotionally significant experiences occurring in the first four years of life? In other words, is the modern psychiatrist, especially the psychiatrist with a psycho-analytical bias, undermining society by destroying man's belief in his capacity for making moral choices? Or is he perhaps to be regarded as an angel of enlightenment bearing a new concept of justice by relieving man of an intolerable and crippling load of guilt which he has carried unnecessarily over the millenia of his organised existence. I think that both points of view have something to be said for them; nor are they necessarily mutually contradictory.

In order to clarify our ideas, it is important from the start to understand what is meant by the term "psychological determinism". Is there in point of fact so much difference between psychological determinism and other factors which, as would be universally accorded, limit the operation of free choice? Let us, therefore, now consider some of these forms of so-called determinism, if you agree to the term, starting with bodily or somatic determinants or possible determinants of behaviour-patterns. If my brain-cells become

"Opening remarks as Guest Speaker at a meeting of the '51' club in Manchester on February 26, 1957, and subsequently broadcast in the North of England Home Service of the B.B.C."

infected with the micro-organism responsible for syphilis, I may become grossly deluded, forgetful and irresponsible and commit anti-social acts arising from the resultant pathological world-picture. Clearly moral responsibility is from the forensic point of view greatly reduced.

If I harbour a certain type of gene, inevitably by the time I reach my forties or even earlier I begin to exhibit involuntary movements resembling those occurring in St. Vitus' Dance, and my mental faculties deteriorate eventually to the level of imbecility or idiocy. This is an example of genetic determinism.

If I belong to a society which believes it to be right and proper to bury aged parents alive and execute a ritual dance over the grave, my behaviour will be the result of cultural determinism.

If from an early age, I am apprenticed, as it were, to a modern Mr. Fagin, I will pick pockets with a good conscience and be mainly concerned with my professional efficiency. This would be an example of psychological determinism, my reactions having been over-influenced by the psychological environment of my formative years.

No one would dispute these various types of determinism; and there are many others. The only novel element introduced into the situation by Freud, Jung and other psychopathologists of genius is the assertion that many of these psychological determinants are unconscious. Nevertheless, it cannot be asserted categorically that moral choice is inevitably destroyed thereby.

I may, for example, have a psychologically determined fear of heights, combined with a desire to precipitate myself from on high; but whether I in fact destroy myself in that way, so long that is, as I remain merely neurotic rather than positively insane, depends on my choice. Moreover, many of the psychological explanations of conduct put forward by enthusiasts are highly speculative and debatable; nor are they necessarily explanatory in a causal sense. At their best, they establish part-causes only, in so far as they can disclose previously unconscious psychological antecedents. Good hypotheses are always spoilt by enthusiasts. Thus, if a psychiatrist were to get up in a court of law and state under oath that John Smith is not responsible for having set fire to Farmer Giles' haystack because he (John Smith) was rejected as a child by his overstrict father who was identified unconsciously with Farmer Giles, he (the psychiatrist) would be doing his kind of psychiatry a disservice and at the same time would bring the whole of psychiatry into disrepute. What psychiatry can do — and, with increasing knowledge, will be able to do more and more efficiently — is to help to establish to what extent free choice, and hence moral responsibility, are limited by such antecedent factors. Nor must it be forgotten, as I have already indicated, that it is not only psychological antecedents which must be taken into account when assessing moral responsibility in the case of anti-social acts. Thus a man, in one of his recurrent fits of violent rage inadvertently kills his wife. These fits of rage, combined with severe headaches and epileptiform attacks, followed a severe head-injury sustained some years previously — somatic or bodily determinism. Again, a woman gases her two children and attempts suicide by the same method, influenced by the melancholic delusion that life is so awful that it would be wrong for her to allow her children to continue to face its horrors. This was not her first attack of melancholia which had come on out of the blue, let us say. This would be a case of the operation of constitutional determinism.

It is clear, then, that if a psychiatrist can soberly and scientifically indicate the various ways in which the operation of free choice may be restricted, thereby limiting the moral responsibility, he is performing a useful service. He can help a judge or a magistrate — or, in the case of a capital offence a jury — to decide as to the best and most equitable means of disposal: should a man be sent to a mental hospital, sentenced to imprisonment, placed on probation, or disposed of in another way, both with regard to the best interests of society and of the offender himself? On the other hand, if half-baked psychological theories are so influencing the climate of modern thought as to lead men and women to think that they are the sports of fate in one form or another, psychological medicine, with which these wild theories may come to be identified in the public mind, may be deemed to be mischievous. In any case, however, any scientific discipline which helps to reveal the hidden sources of human behaviour in relation to society, leads in the long run to enlightened understanding and sympathy and discourages smugness, self-righteousness and brutal intolerance.

THE END OF THE ALEXANDRA HOSPITAL

by H. B. Lee

Most of the London teaching hospitals have several " designated " hospitals, which function as part of their organisation. Bart's has only one, which is now threatened with closure by the decision of the Ministry of Health. Many Bart's students visit the hospital at Luton with the Surgical Professorial Unit and know something of its work, but perhaps a premature obituary notice in the *Journal* may help to obviate the need for a posthumous one.

The Alexandra was founded in Queen Square, a few doors from the Examination Hall, in 1867 for the treatment of " Hip Disease" in children. This was, of course, tuberculous arthritis, which was a common condition in those days and unless properly treated caused severe pain and illness with almost inevitable death from amyloid disease. Howard Marsh, the Alexandra's first surgeon, showed that it could in the majority of cases be cured by prolonged rest. No hospital at that time, however, could keep patients long enough, and the Alexandra was started to keep them till they were cured, no matter how long it might take. No patient was to be discharged simply to make room for another, and this principle holds good even under the changed conditions of the present time. So great was the demand for beds that soon many additional cases were treated in their homes by a sister who visited them regularly, naturally with less success than with in-patients.

Orthopaedic tuberculosis has gradually become a rarity in this country, and the work of the hospital has gradually changed. In 1920 it moved to Swanley, Kent, where it took over the old Bart's convalescent home, in the grounds of which the Bart's laundry still remains. General orthopaedics made up an increasing proportion of the work, but most of the patients were and are still " long-term ". In 1940, Swanley was a risky place for children, and a very quick move was made to the present hospital, Stockwood Park, an 18th century mansion near Luton.

Poliomyelitis first became widespread in England in 1947, and another epidemic in 1948 was followed by a series of years in which there was a fairly high incidence of the disease. Two patients who were babies when they became paralysed have been in the hospital nine years, and some severely handicapped children remain from each of the later epidemics. They need a lot of care and treatment, besides education. At the same time they need home life, and the Alexandra tries to give them the best of both worlds. A large proportion go home at weekends, and for part or all of the school holidays. This has meant that the parents have to be taught how to look after them, and in many cases they have to arrange to be away from work to do so. They find it very well worth while, and their children don't become " institutionalised " in outlook. Those who cannot have their children home regularly usually go to considerable trouble to visit them.

In recent years there has been a great interest in " spastics " stimulated largely by parents' associations in this country and the U.S.A. The picture often conjured up in the mind is of semi-idiotic children of revolting aspect, for whom nothing can be done. Like other children, however, many of them are charming and responsive. Because of its emotional associations the word " spastic " is better avoided as far as possible, and replaced by " infantile cerebral palsy " which is much more accurate and descriptive. It is usually to be traced to birth trauma with neonatal asphyxia. Brain dramage is usually widespread and not confined to the motor areas where it would cause spasticity alone. It can be of any degree, and there can be gross motor damage without mental impairment. An intellect thus denied all normal associations and outlets is bound to suffer severe frustration and emotional strain.

The Alexandra has been able to help a lot of these children, as much by giving them a social life and schooling as by the various " therapies ", physio-, speech and occupational. All these influences must work together if any real good is to be done. Experienced ward sisters who have the capacity for loving other people's children are essential to provide emotional stability and to train the parents and junior ward staff. Similar considerations apply to the children of lower mental abilities. A mixture of various grades of intellect, provided that the number of the lower ones is not more than one or two to a ward, seems to work out very well, and the brighter ones stimulate the duller without themselves being kept back.

The patients are selected from a large number who apply for admission usually through County Medical Officers of Health. We try to take those whom we feel can most be benefited. This, to a large extent, rules out the really low grades of intelligence. Quite often, however, there is real doubt as to what a child's mind is like, and we admit a few for assessment. If a child cannot indicate its thoughts except by a nod or a grunt, it is tempting to imagine that it has no thoughts worth the name and relegate it to a mental hospital.

We try to observe these doubtful cases for a month or two until we feel pretty sure of our ground and have worked out the best ways of looking after them. Then we can give a reasonably firm prognosis which may be a great help to the other members of the family by enabling them to make the proper emotional and social adjustments. Parents are only human, and won't always accept a diagnosis of mental deficiency based on a two-minute interview. Often they are right and the doctors wrong. Usually they know the truth, and will admit it to themselves if enough time can be spent in explanation and discussion. Having achieved mental peace they are much less likely to spend themselves, their money and the State's, in fruitless wandering from one clinic to another in search of consolation.

None of this work can be spectacularly successful. Some physical improvement can usually be achieved, but it is bound to be gradual, needing great patience from everybody. It would be a miserably inhumane National Health Service that would deny these children the best that can be done for them. Their total numbers are not large, but their problems are very distressing both to themselves and their families, and they are troubling the public conscience to an increasing extent. Non-medical people have to bear too much of the burden at present, and it is right that the teaching hospitals should do their share of the work so that progress can be on a sound medical basis.

Salvage work is often the best we can do at present. We make no pretence to be a machine that turns damaged children into able-bodied workers. In terms of cash results our work may seem economically unsound ; this seems to be the official view and is a short-sighted one. The humanitarian traditions of eight centuries at Bart's have always rejected such thinking, and the same has been true for 90 years at the Alexandra. We cannot accept the logic of the totalitarians, which leads to the gas-chamber, even when the authoritarians are disguised as harmless bureaucrats.

The Alexandra is to be closed as a measure of economy by the 1st April, 1958, though the Governors of Bart's have done their best to prevent such a disaster and have offered to pay for necessary structural work out of " free " moneys, so that no expense would fall on the State. Somebody will have to look after each patient. If it is to be the parents, they may not be able to go to work. If it is to be another hospital there will be no saving. If their treatment is interrupted more patients will need permanent institutional care in later life, and fewer will become independent and useful citizens. If their disabilities can be minimized now they will need less trained people later on to look after and give them the basic attention compatible with contemporary ideas of humanity.

The economy may be much less than is thought, and may turn into the extravagance of years to come. This is of little importance. What really matters is the degradation of an attempt to keep up our standards of civilisation.

OBITER DICTA

Dr. N.....E O.....D. " Getting on in medicine is like walking a tightrope ; where you fall off you stick,"

ST. JOHN'S GATE

by B. M. J. McGRATH

HAVING entitled this paper " St. John's Gate " I feel some diffidence at taking you on a winding thread through a thousand years, often dealing with Mediterranean events rather than English. However this wide net is essential for a chonological correlation of the available data. St. John's Gate is found at the end of St. John's Lane, off the Clerkenwell Road ; it looks out on a small cobbled square. Huddled amongst meat warehouses and the like, it is easily missed. When come upon by the uninitiated, it is accepted as one of the gates of the City of London. On the contrary, far from being connected with the Wall of London, this structure originally made up the Gatehouse of a Priory. The buildings and lands lay to the west of what is now Smithfield Market.

This Priory was founded some years before the erection in 1123 of the Priory and Hospital of St. Bartholomew, and was called the Priory of St. John, of Jerusalem. It was run by the Order of Knights Hospitallers : it was singled out by Wat Tyler during the Peasants' Revolt of 1381, for destruction. The closely neighbouring Priory of St. Bartholomew and the Carthusian Monastery were left unharmed at this time. It has associations with the Knights of Rhodes, the Knights of Malta, the Knights of the White Cross, and the Knights of the Holy Sepulchre.

It is towards an understanding of these associations that much of this paper is directed.

In the year 600, Pope Gregory the Great instigated the establishment in Jerusalem of a Hospice for Pilgrims ; this existed for the following two hundred years. In the year 800, the ruler of the territory, Harun-el-Rashid, allowed Charlemagne to finance the re-building of this centre for pilgrims ; sixty-seven years later ,a monk from Brittany, Bernard the Wise, visiting Jerusalem, described the Hospice : " . . . in which are received all the pilgrims who speak the Roman tongue . . . has a church in honour of St. Mary ; 12 houses ; fields ; vineyards ; a garden ; a market in front of the house, yielding market dues . . ." In the year 1010 this Hospice was destroyed by the reigning Caliph but 13 years later, the pilgrim traffic having regained momentum, the merchants of Amalfi (a seaport in Southern Italy, at this time very prosperous) financed the building of a new House, served initially by Benedictine monks.

In 1069 there came into existence in Jerusalem a group of monks designated " the Poor Brethren of the Hospital of St. John, of Jerusalem", dedicated to sheltering pilgrims and ministering to the sick amongst them. Over the next 30 years these brethren worked on, kindling the admiration of many of the cosmopolitan pilgrims. In 1099 the First Crusade, under Godfrey de Bouillon, captured Jerusalem. Initially, the Poor Brethren were imprisoned ; later, however, they were released to look after the wounded Crusaders. At this time a Brother Gerard was the leader of the Poor Brethren. With the enthronement of Godfrey de Bouillon as King of Jerusalem, this Crusader endowed the Brethren with considerable lands, thereby establishing them as a rich House. The Brethren, utilising the favourable atmosphere in many European States, rapidly established daughter houses dedicated to ministering to the sick, describing themselves as the Order of St. John, of Jerusalem.

Before following the advent of the Order to England, the genesis of its Rule will be traced as it evolved during the first 20 years of the Crusader Kingdom of Jerusalem. About 1112, Pope Paschall II took the Order under his protection ; at about this time the Order was given exemption from tithes and all episcopal jurisdiction. It thus became a complete autonomy. Six years later a Crusader, Raymond du Puy, became its leader. During his term of office, he extended the aims of the Order to cover the defence of the sick as well as their hospitalization ; this concept allowed the step to be taken of committing the Order to the protection in general of the Crusader Kingdoms. A year later the purely military order of the Templars came into existence, dedicated (albeit under solemn vows of chastity, poverty and obedience) to defend pilgrims to the Holy Places from the ever-threatening attacks of the Saracens. With this model before him, and the responsibility of holding the numerous properties bestowed on the Order by crusading princes and nobles, Raymond du Puy moulded the Order anew. He divided its members into three grades :

(1) The Knights, who formed a fighting force for the defence of the Latin Kingdom of Jerusalem and the Holy Sepulchre against the Saracens ;

(2) The Chaplains, who were to carry on the spiritual traditions of the Order ; and

(3) The Serving Brethren, whose work lay in the manual tasks of the community.

All members of the Order wore a black robe and cowl, having a white cross of eight points upon the left breast. The ruling power was vested in the Grand Master, President of the Council. Certain knights of the fraternity were appointed by the Council to administer the affairs of the Order in those European countries in which it had possessions.

One can now follow the coming of the Order to England. Some months after the capture of Jerusalem, there returned to England a Crusader with a philanthropic bent, called Jordan Briset. Together with his wife Muriel, he gave a tract of his land near London to the Poor Brethren of the Hospital of St. John (or rather to the Order of St. John, of Jerusalem, the name the Brethren had recently taken), so that they might set about building an English house ; this land was situated about half a mile nor' nor' west of the "New Gate" of the City of London Wall. This point and the following topographical data can be gleaned from some maps in Chauvois' " William Harvey ", a copy of which is in the College Library. From the North side of the New Gate the Wall passed to a tower situated in what is now the G.P.O. van-yard, under the south windows of Outpatients'. From this tower the Wall ran East. Up to the Norman conquest the country to the north-west of the City had remained waste, being largely marsh ; this was true even up to the Wall itself at this region. It was not safe for small houses to be alone in such wilds. But with the settling in of the new authoritarian regime, projects could materialise. It would seem reasonable to suppose that the dawn of the second millenium of Christ stimulated concepts of re-awakening the fervour of the early Christians. It came about that there began construction at sites scattered over this barren waste-land, of houses for a number of communal religious bodies, dedicated to good works. Our own St. Bartholomew's was founded in 1123, on the initiative of Rahere. The Priory of St. John's was finally completed in 1144. It was dedicated in 1185, when Heraclitus, Patriarch of Jerusalem, visited England. There seems to be no specific information on the working of the Hospital attached to the London Priory of St. John; being the mother house in these islands it failed to analyse itself. Probably a routine was followed that was at least a skeleton of that current in 1575 at the Order's Hospital in Malta. The total period of the active existence of the Priory was from 1144 to 1540. So for 400 years there were Knights Hospitallers in London, waxing and waning in the impact they made politically, but constant to a substantial outline of the original Rule of their Order.

In the course of the 14th century the Black Plague was decimating the European nations. In 1349, during an exacerbation of fatalities, the routine parochial churchyards became excessively crowded. Desiring to dedicate an adequate extra site for these plague burials, Bishop Ralph of Stratford, acquired from St. John's Priory a plot of three acres, situated at the north boundary of their lands, just south of those belonging to the Abbot of Westminister. This plot was given to Carthusian monks, who built a chapel and monastery, and dedicated themselves to pray for the plague dead buried in the pits nearby. For the next 200 years this Carthusian Monastery quietly existed near its bustling neighbour, the Priory of St. John. A manuscript dated 1430 details the help given the Carthusians by the Hospitallers in the construction of a piped water-supply from the heights of Islington village. With the expulsion of the monks by orders of Henry VIII in 1540, the buildings stood effectively idle until in 1611 an imaginative City banker, Thomas Sutton, bought them up and founded a " twin-extremes " establishment, a boys' school and an old men's alms house. This became the Charterhouse.

For a while I want to halt this chronological sequence, and survey what would have been seen by a citizen standing on the City Wall, close to the New Gate. In the early 13th century, William Fitzstephen, in his life of Thomas à Becket, writes : " . . . there are on the . . . side of London

fields for pasture and a delightful plain of meadow-land, interspersed with flowing streams, on which stand mills, whose clack is very pleasing to the ear. There are also about London on the North-West side, excellent springs, with sweet clear and refreshing water, flowing rippling over bright stones; among these springs are Holy Well, Clerk Well and St. Clement's Well; these wells are frequented by great numbers of scholars and youths of the city in summer evenings, when they walk forth to take the air."

Surveying the region about the year 1360, one would have looked out across the ditch which bounded the thirty-foot high wall along its entire length, to an expanse of fields bare of housing, with the exception of the three monasteries which had by then been founded. In fact, apart from a cluster of cottages lying between the estates of St. John's Priory and of the Charterhouse, the land outside the Walls of the City to the North-West remained largely bare of houses until Elizabethan times.

With the increasing wealth of the Order of the Knight's Hospitallers, their leaders entered the field of those traditionally called upon by the monarchal group for the governance of England, as individuals who by virtue of their calling would have little spur towards involving themselves in dynastic squabbling. By 1381, the Prior Robert Hales held the office of Treasurer of England. Since the exacerbations of the Black Death of, especially, 1349, the extreme poverty of the mass of the peasants had lightened sufficiently, due to the extreme labour shortage, for the most enterprising amongst them to afford previously inaccessible consumer goods. This was suddenly stopped by the Poll Taxes, imposed to cover the cost of the wars that the Government were waging against France and Scotland. The efforts of Government agents to bring in the Poll Tax sparked off local risings all over England, approximately simultaneously, in 1381. A band of men in Kent elected Wat Tyler as their leader; this group, rapidly snowballing in numbers, captured Rochester Castle, and then turned towards London. Friends on London Bridge lowered the drawbridge, and Wat Tyler led a partly regimented peasant horde into London. The men of Essex, led by Jack Straw, passed through Aldgate, over which Chaucer was living at this time. The association of Robert Hales, the Prior of St. John's of Clerkenwell, with the notoriously corrupt financier, John of Gaunt, caused the peasants to connect the Knights Hospitallers with the lawyers, whom they regarded as the artificers of the Poll Tax which had precipitated their revolt. After negotiating with the adolescent Richard II and his advisors, at Mile End, and again at Rotherhithe, the peasants divided their strength. One party repaired to the Tower of London, entered it without resistance, and seized Robert Hales, Simon Sudbury (Archbishop of Canterbury and Chancellor of England), William Appleton (the King's Confessor), and John Legg (a Sergeant). These four were taken to Tower Hill, condemned as traitors to the people, and beheaded. The second party of peasants attacked the Priory of St. John, setting it on fire. The flames were still active five or six days later, when they formed a backcurtain to the final scene of the Revolt. The peasant forces had assembled in the open space of Smithfield for a culminating negotiation with Richard II. Among the King's horsemen was the Mayor of London, William Walworth, embittered at having lost at the hands of the peasants a number of his tenements (houses of ill-repute though they were). In the course of Tyler's preamble he was struck down by Walworth. In the confused dispersal that followed, the wounded Wat Tyler was given into the hands of the monks of Bart's. But later Walworth led a group into the Priory precincts, and was able to take Tyler back into Smithfield, there to have him beheaded.

Although the English Knights Hospitallers quickly reorganised themselves, it was not until 123 years later that the Priory was finally rebuilt; the finishing point being a large Gatehouse, added by the Prior, Thomas Docwra. Also a high Bell Tower was added, to be described by Stow, in his "Survey of London, 1598", as "... a most curious piece of workmanship, graven, gilt and enamelled, to the great beautifying of the City ..." However, even by 1430 the Priory of St. John was as active as of old, for there exists the following description of a hallowed custom: "... the Knights of St. John claimed sanctuary for any who had given alms to their Order, in so far as the Priory had the privilege of burying their bodies, however they might have died ... by this device they became possessed of the bodies of felons ... which they caused to be conveyed to the Charterhouse's Pardon Grave-

yard ... such corpses were usually fetched thither in a close cart, baled over and covered with billark, having a plain white cross thwarting and at the fore end a St. John's Cross without, and within a bell ringing by the shaking of the cart, whereby the same might be heard when it passed, and this was called the friery-cart, which belonged to St. John's, and had the privilege of sanctuary ...".

Rather than leave a loose end, I would like to cover the Mediterranean history of the Mother Order of St. John, especially as this history explains the association of the Priory in Clerkenwell with the various synonyms for the Order, mentioned at the beginning of this paper.

After internecine quarrelling up to 1137, the Hospitallers co-operated with the Templars, as the mainstay for fifty years of the Crusader Kingdom of Jerusalem, up to its capture by Saladin. The Crusader power then returned to Acre, which it held for the next hundred years, finally abandoning the town, to embark on the sizeable fleet possessed even at that time. In 1310 a fleet of the Order of St. John captured Rhodes. This island had a fertile soil and an adequate harbour; and it was but 25 miles from the mainland of Asia Minor, so that Christian refugees who reached the tented camp of Smyrna, or when Smyrna was lost to the Saracens, the fortified castle of Budrum, could easily be transferred to Rhodes. In 1312, Pope Clement V abolished the validity of the Templars, as no longer fulfilling any purpose. To take the fate of their former lands out of the cauldron of European monarchal intrigue, the Pope persuaded all the Powers to support the transfer of these former Templar possessions to the Knights Hospitallers, who thereby became by 1324 immensely wealthy, having large holdings in Europe and wielding a great fleet of galleys manned by hordes of Moslem slaves. Over the next 150 years the Order, by virtue of its commanding hold over the East-West Mediterranean trade route, was instrumental in staying the military and commercial penetration westwards of the Turks. In 1453, the Turks captured Constantinople. From then on, the Order slowly girded itself for the inevitable conflict. In 1470, a general summons to Rhodes was sent to all the Langues (Provence, Auvergne, France, Italy, Arragon, Germany and England). An experienced soldier, Pete d'Aubasson, having become Grand Master, effective fortifications were constructed, so that when a Turkish army landed in 1430 on Rhodes, it was repulsed. However, 40 years later a second Turkish siege forced the Order to abandon Rhodes. Over the next seven years the fleet sailed the Mediterranean, while the Grand Master travelled Europe searching for a permanent home. He even visited England, where, ironically, the same King whose sanctuary he now sought, would in 20 years destroy the Order in England. In 1549, the Knights Hospitallers accepted the Island of Malta, as a gift from the Holy Roman Emperor of the time. In 1565, this island was successfully defended against the Turks, with the aid of many of the English Langue, who that year had been finally dispersed from England by Elizabeth 1st, after a brief revival under Queen Mary. By 1575, the Order had relaxed sufficiently to begin a general purposes hospital on the island of Malta.

Prior to the Malta episode, the details are very sparse concerning the construction or management of the hospitals of the Order. But of this hospital at Valetta, there were printed regulations, a translated copy of which exists in the Bart's library. Some extracts are of interest:—

The Personnel of the Hospital were the Grand Master; the Grand Hospitaller; the Infirmarian, with care of the sick, checking on the work of the physicians, on the fulfilment of their prescriptions, and on the availability of the allotted food allowances for the patients (all kinds of different soups, soaked bread, vermicelli, herbs, boiled decoctions, milk, bread, and meat, mainly game), and special charge of the house of the foundlings, all within his charge; two Knights, amongst whose duties there lay the giving of bandages and crutches to the cripples, and the superintending of the management of the hot baths and the mercurial anointings; Armorie, charged with the care of the silver-plate used by well-to-do patients and by patients who were staff (the slaves who were patients used pewterware); Clerk of the Habit, to draw up the wills of the sick; a secular Lincier, in charge of the linen, with slaves to beat the wool of the mattresses; and the Bottigliere, in charge of all Urine, Bread, and Oil.

The training of the Brothers of the Order: Each provincial langue on one day had to wait on the patients with their food. A

watch was kept for absentees. On Holy Thursday, the Grand Master with all the Knights of the French Langue assembled, and with exemplary charity washed the feet of twelve poor men, to whom were given plentiful alms afterwards.

The medical personnel. Three chief physicians and two assistants; three chief surgeons and two assistants; six young men as assistants; a barber-surgeon (phlebotomist), in charge of leeches, cataplasms, and vessicants; an experienced elderly woman, retained to attend to cases of scurvy.

The Wards: (1) Knights and persons of the Habit, with two side rooms for wounded. (2) Middle-class laity, religious Orders, and pilgrims. (3) Large, for feverish and slight ailments. (4) Small, for severe cases and the dying. (5) Haemorrhages and Lithotomies. (6) Wounded. (7) Very large, for Galley-slaves. (8) Room, for mad people. (9) Mercurial anointings. (10) Those who take hot baths.

Consumption beds to be burnt without exception. Every ward has its chapel fitted up for saying of Mass. Also there is the chapel of the most Holy Sacrament, the door of which opens towards the ward of the dying, for the convenience of the dying.

In 1798, Napoleon Bonaparte captured Malta without any resistance from the Knights. In 1800 the British captured the island. In the Treaty of Amiens they promised to restore Malta to the Order, under pressure from their allies, who feared British naval supremacy, and were led at Amiens by the Czar, who was under the impression that the bestowal by refugees of the Order of the Grand Mastership on him, had been valid. As might have been predicted, the British kept Malta.

The end of the Order in England came in 1540, when Henry VIII rewarded the combatants of a large tournament by giving to each of the challengers and their heirs forever, in recognition of their valiant jousting in this tournament, one hundred marks yearly and a house to live in, to be maintained out of the yearly revenue pertaining to the Priory of St. John. Under his Order for Montastic Suppression, the Priory itself was closed.

In 1731, Edward Cave bought the Gatehouse, publishing there the "Gentlemen's Magazine", and employing Dr. Johnson as a hack. In 1736, Cave started printing accounts of the proceedings of Parliament in this magazine under the cover of being "Debates in the Senate of Lilliput," contained in a bogus "Appendix to Captain Lemuel Gulliver's Account of the famous Empire of Lilliput". Around Cave there collected many brilliant and talented people, including Richard Savage and David Garrick, the latter reading over his plays to the appreciative audience in the room over the Gateway. After Cave's death, the Gatehouse passed obscure years, until in the first half of the 19th century it became a tavern called the "Jerusalem", the centre for a time of a bogus revival of the Order as a sort of stag-club. The Jerusalem was run by a man called B. Foster, who published in 1851 a highly imaginative version of the Gatehouse's history. In 1874 the Victorian "Order of St. John" bought the Gate, making it the headquarters of their First Aid and Ambulance Movement.

The quibbles about the connection, dubious and devious at best, between this last movement and the historical Order, can best be ignored, as irrelevant to the very real work that the movement has done during the 80 odd years of its existence. After the British capture of Malta, a remnant of the Knights went eventually to Rome, where the theoretical headquarters still are.

In conclusion I would stress that St. John's Gate well merits a visit. Near to the present Gate there existed the Priory Church. This was, I believe almost unique in having a rectangular chancel and a circular nave, in imitation of the Church of the Holy Sepulchre at Jerusalem. The position of the round nave of this church is marked in the cobbles of St. John's Square; its crypt, re-discovered in 1896, under the now bombed church, contains a 16th century alabaster effigy, brought from the old cathedral of Valladolid, of a Knight of the Order of St. John, recumbent, with the eight-pointed cross on his breastplate, and a boy asleep against his legs. Within the Gate there is housed an intriguing library, containing for example an illuminated Missal made for the altar at Rhodes, in 1504, and also a museum, with a comprehensive collection of the coins of the Crusader kingdoms. Should anyone want to visit the Gate, an appointment should first be made with the custodian.

A Paper read to the Junior Osler Society on Tuesday, 2nd March, 1957.

NIGGERS IN THE WOODPILE

by Dr. Geoffrey Bourne

This colourful transatlantic phrase strikes the imagination by the apparent inconsequence of its content. What the nigger was doing in the woodpile no one has ever found out, but his sudden discovery there is taken to illustrate the introduction into some situation of a completely unforeseen complication. In these days of racial readjustment a companion picture may perhaps be offered of a white man in a snowdrift. Either position is equally unexpected and uncomfortable.

In clinical medicine there are some situations which are dangerous, not only from their being rare and therefore unsuspected, but from the fact that lack of suspicion and the associated lack of a proper diagnosis may produce unpleasant consequences. The results may be serious for the patient, for the reputation of the practitioner, and even sometimes disastrous for the community. The first examples discussed below come from the writer's earlier days when general medicine had an equal interest with cardiology, the latter "niggers" are cardiological.

Typhoid Fever. Typhoid fever has now become rare, thanks to the activities of public health authorities and to the improvement in sewage disposal. Nevertheless occasional sporadic cases occur. They are found in patients who have arrived from overseas, but may also occur as a result of carrier infection. Such cases can easily be the start of epidemics, especially if they remain undiagnosed. Epidemics have in the past sometimes been due to deviation from social routine, for example to the distorted pride of some carrier who feels it beneath his dignity to use the bucket provided for urination or defecation at the bottom of an artesian well or by the side of a reservoir in which he is working.

At the onset a case of typhoid fever is apt to be rather insidious, but the following points should always lead to the suspicion of enteric. Headache is nearly always unusually severe, and is often associated with abdominal discomfort, also with some change in bowel habit either in the direction of constipation or of diarrhœa. Examination of the patient shows an unusually slow pulse rate in spite of the presence of considerable fever. Furthermore, the spleen although soft can frequently be felt. At this stage a white blood count invariably shows a leucopenia. In the first week the Widal reaction is negative, but the blood culture, particularly in a bile medium, is on the contrary usually positive.

Smallpox. A second rare but dangerous disease which may insinuate itself unsuspected into practice is smallpox. One afternoon some years ago I came to the Hospital to do my afternoon round and was met by the house psysician in the Square. I asked him whether there was any good teaching case in the wards and he replied "No, there is only a patient with rather severe influenza." In view of the paucity of material I spent some considerable time over this case. He was a man of 24 who had been perfectly well until a few days previously when he became febrile and began to suffer from fairly severe pain in the lumbar region. I discussed the possible causes of lower lumbar pain, both acute and chronic, and proceeded to examine the patient. A definite but not very profuse eruption was present over the forehead. It looked rather like a scattered type of acne. I remarked to the patient that he had probably had these spots for quite a long time. "No", he replied, "they came out two days ago". Rapid calculation elicited the fact that there was an interval of exactly three days between the first symptoms and the appearance of these spots. He was then stripped naked and examined carefully. A few more spots were found, all of them on the fingers or on the feet. The Medical Officer of Health of London was summoned by telephone and on his arrival he confirmed that the patient had attenuated smallpox; thanks to vaccination in infancy he made a good recovery. A case of smallpox in Bart's made some little stir; failure to diagnose it would have had unforeseen consequences.

The diagnosis was suggested by the pain in the back, the exact relationship between the onset of symptoms and the onset of the rash, and by the fact that the eruption was clearly centripetal rather than centrifugal.

Amoebiasis. A third example of an insidious condition rare in this country, but important because of its good response to treatment, is amoebiasis. This usually shows itself in England in the form of hepatitis, and there has quite often been a long interval between the original attack of amoebic dysentery and the inflammation of the liver. Such an interval may extend over a period of years. The disease starts with comparative suddenness, the outstanding symptoms and signs being fever, sometimes with profuse sweating, liver discomfort and pain, and sometimes a right-sided pleurisy. The type of pain over the liver is characteristic.

I was asked to see a young man who was thought to be suffering from influenza with secondary pleurisy, but his symptoms had failed to respond to antibiotics. It was during the course of an epidemic of influenza, and the fever, sweating and general discomfort were indistinguishable from those of the influenza patients. He had a right-sided pleurisy with a friction rub, but in addition he complained of pain in the upper abdomen radiating to the right flank, which was obviously elicited by liver movement. When he turned to the right or to the left this pain, arising from local peritoneal inflammation, was induced by the consequent displacement of the heavy organ to either side. At this stage he was asked whether he had ever been in the East and he answered in the affirmative. He also admitted to having had dysentery there some seven or eight years previously. Amoebic cysts were found in the motions and his symptoms quickly subsided with emetine treatment.

Gout. Chronic and latent gout provides another of these " negroid " diseases. Perusal of 18th and 19th century memoirs show a high incidence of acute and chronic gout among prominent individuals. Accurate description proves beyond a doubt that the diagnosis was correct. Moreover gout is an inborn error of metabolism which is not infrequently familial, and which could hardly die out of the population. This conjunction of facts makes one wonder why obvious clinical gout has become so rare. There is some evidence to suggest that in fact gout is still present in many people, but for some reason — nutritional or environmental — it has ceased to light up into an acute clinical picture. Chronic gout may be suspected in the following type of case: an individual whose youth makes unlikely a diagnosis of what, in an older person, would be that of fibrositis; or an older patient complaining of arthritis which affects at different times different joints, and whose signs and symptoms are clearly not those of rheumatoid arthritis, osteo-arthritis, or infective arthritis. In each case the symptoms clear up completely and only return at intervals. A raised blood uric acid is found and treatment as for gout clears up the situation completely.

Thyrotoxicosis. The first of the cardiological " niggers " is toxic goitre. This may show itself as simple congestive heart failure, often with auricular fibrillation. The age of the patient is usually between 50 and 60. As a result of a full history-taking and a complete physical examination no aetiology which could be responsible for the heart failure is discovered. The patient has never had rheumatic fever, there has at no time been hypertension, and all positive evidence of coronary disease in the shape of anginal pain or electrocardiographic changes is absent. The characteristic here is the inability to account for the heart failure.

A second way in which toxic goitre may reveal itself is by the presence of auricular fibrillation, here again without any evidence of a causative aetiology, but in this case without heart failure. Furthermore the auricular fibrillation fails to respond to adequate digitalis therapy even although the patient is carefully nursed in bed. Digitalis in such cases can be pressed to full doses but the ventricular rate remains at about 100 to 120.

A third indication of the presence of toxic goitre is paroxysmal attacks of tachycardia. These may be in the shape of classical auricular paroxysmal tachycardia, or of paroxysms of auricular fibrillation, or finally of atacks of auricular flutter. Once more no adequate aetiological cause can be found in the patient.

In these three clinical situations the points to look for in the patient are as follows. The history may elicit loss of weight which has usually occurred recently, say within the last six months. Furthermore the patient may have been conscious of feeling unduly warm. Sweating may have become prominent, or nervousness and nervous tension may have been noticed. On examination the patient may have a slightly staring look but great care must be taken to find out whether this is a personal peculiarity, having always been present, or whether friends and relations have recently remarked upon it. Inspection in such cases may reveal no exophthalmos as such, but one eye is clearly a little more prominent than the other, a fraction more of the sclerotic showing above the iris on that side. On palpation the skin of the patient is uniformly warm to the touch and rather suggests that he or she may have recently come out of a warm bath. The surface may also be slightly moist, but there is no markedly local sweating. Tremulousness may be present, tachycardia is usually found and the pulse pressure is quite often increased. Careful examination of the thyroid may or may not reveal a definite swelling. This, though slight, may be diffuse, or it may be restricted to a single adenomatous lump buried deep in the neck. As the patient swallows it may become visible, or it may be detectable by careful palpation. The diagnosis is confirmed by basal metabolic estimation, or by measurement of the radioactive iodine uptake.

Subacute Bacterial Endocarditis. Subacute bacterial endocarditis is by no means always diagnosed during its earlier stages. The following points are suggestive of it. A patient with a heart murmur may have started to sweat at night, and if the temperature has been taken fever has been found. Pains ascribed vaguely to rheumatism are often present at this stage of the disease, the important point being that they have only been of comparatively recent onset, never having been noticed before; and that the patient is young to be a martyr of what is usually regarded as a prerogative of the elderly.

It is curious that the murmurs which are heard are usually murmurs of regurgitation, either mitral or aortic, rather than those of stenosis of these valves. This is an inexplicable but definite clinical truth.

Syphilitic Aortitis. Syphilitic aortitis is another condition in which the aetiology is not always suspected. There is usually the murmur of aortic regurgitation. A careful history often reveals that the patient has been examined in earlier years for the Services, for life insurance, or for some civilian activity, and that the heart was then found to be normal. In other words, the aortic diastolic murmur appears for the first time after the age of 35, usually later. The diastolic aortic murmur is nearly always louder on the right side of the sternum than on the left. In early stages the heart is little enlarged and the diastolic pressure has not appreciably fallen. The patient remains singularly free from symptoms, even after the aortic leak has become considerable.

Coarctation of the Aorta. Coarctation of the aorta is a further cardiological abnormality which is less rare than is often supposed. All young individuals whether children, adolescents, or young adults, in whom the blood pressure is thought to be higher than normal, should be carefully examined for this condition. The aorta must be palpated in the abdomen, and the femoral vessels in the groins. If pulsation is absent or obviously diminished the blood pressure should then be taken in the legs as well as in the arms. Contrary to the usual procedure a more accurate correlation is obtained between these two sets of figures by taking the blood pressure in the radial artery by palpation, rather than by auscultation, and comparing it with the blood pressure in the dorsalis pedis or the posterior tibial vessel, estimated also by palpation. The interscapular area should then be inspected for the presence of visible arteries, the patient standing in an oblique light with the head drooped and the arms also hanging loosely forwards. Radiological investigation will usually show the diagnostic subcostal symmetrical grooves, especially beneath the lower ribs. Surgery is generally curative.

Dissecting Aneurysm. Dissecting aneurysm is a further example of a condition considerably more common than is generally supposed. It often masquerades as myocardial infarction. The onset of symptoms is nearly always rapid. Pain is the outstanding one. It is felt in most cases rather lower in the chest than is that of myocardial infarction. Furthermore the pain may be more to one side than the other. Shock is frequently severe. If the carotid vessels are involved mental confusion or hemiplegia may supervene. Arterial pulsation may be unequal as between the arms or the legs, as revealed by the sphygmomanometer. Aortic incompetence, recent in origin, or blood-stained pleural effusion may complicate the picture. The electrocardiogram in most cases remains normal.

MEDICINE AND THE ARMY

by LIEUT. GENERAL SIR ALEXANDER DRUMMOND, K.B.E., C.B., Q.H.S., F.R.C.S., D.L.O.,

Director-General Army Medical Services

The Abernethian Society was founded in 1795 at a time very similar to the present. Britain was in a state of what we describe today as cold warfare. Frigate battles were taking place around the coast of France, Lieut.-Col. John Moore, the future hero of Corunna was in Corsica and the Dutch were being relieved of the Island of Ceylon. Since that time many of our distinguished medical officers have been recruited from your ranks. In times of emergency you have never failed to hasten to our aid.

Within living memory the most distinguished of your company who came to our assistance was Major-General Sir Antony Bowlby. He and Lady Bowlby were both with us in the Boer War. I would remind you that in the 1914-18 or Great War, it was due to Sir Antony's researches, industry and self-sacrifice that so much was done to reduce the morbidity and the mortality of the wounded. I would repeat self-sacrifice — Sir Anthony unlike so many of his eminent contemporaries gave up much of the practical and the more rewarding side of surgery in order to obtain the "know how" in what we term today the forward defended localities. Here, he analysed the results of individuals and ably grouped suitable and kindred surgeons into operating teams. What is more he inspired them to consider themselves as integral members of a master plan which provided the surgical cover for our armies in France. It was largely due to his intuition that surgeons and medical units were pressed forward to deal with the wounded at the earliest possible moment. Further, he taught the front-line surgeon to realise that his task was to undertake the primary stage of the definitive work which would be completed at the base. It will interest you to know that Sir Antony's method of surgical cover has today become the routine practice of all enlightened armies. It was from notes such as these written in small pocket books that he was able to devise and plan the means of efficient treatment of mass casualties. These are the actual diaries which were given to the safe custody of the officers of the Royal Army Medical Corps by that very charming person — Lady Bowlby — shortly before she died.

On Sir Antony's experience, investigations and his accumulated statistics it became possible to forecast with sufficient accuracy the expected number of seriously and dangerously wounded that would occur in any big attack and his simple rule of 2 per cent enabled the staff to make all arrangements to meet the needs of the wounded. He found that in every 100 cases certain wounds might be expected to occur at a rate of two per cent. These were wounds of — the skull, the thorax, the abdomen, the femur, the knee joint, the leg, the humerus, the fore-arm and the elbow totalling 18 per cent in all. If today we add six per cent for burn cases we obtain the approximate figure of dangerously ill patients in modern warfare. As the result of his organisation in the surgical field Antony Bowlby became an important instrument in reducing man-power wastage. Through his charm and friendliness he became the confidant of the great captains and his opinions on diverse subjects were sought. In consequence he did much to raise the standards and status of the Medical Services of the Army

In the Army today the relationship between the Medical Services and the Command is very close. This has not always been the case. As would be expected, the degree of relationship has always been in direct proportion to the usefulness and efficiency of the medical officer. In the Middle Ages Commanders were normally accompanied to war by their private physicians and barbers. With the formation of the standing Army in 1660, surgeons and physicians purchased or were given their commissions and were appointed to regiments. Here, they concerned themselves not only with doctoring the troops but also with the care of the regimental families. Even in these early days the value of contented and stable married families was well recognised. At the time of the Crimea Campaign the overall control of the Army Medical Establishment was centred in a medical board comprising an Inspector General of Hospitals, a Surgeon General and a Physician General. The drugs, medical equipment, supplies and stores, were not under the charge of this Board but of an Officer designated the Apothecary General. The supply and issue of what today we call accommodation stores, as the bed in which the patient lay, the blankets which covered him and also the supply of rations, were the concern of yet another individual called the Purveyor whose department was directly responsible to the Secretary of State for War. It was, therefore, small wonder that medical officers were considered of secondary importance. To senior military officials it seemed that medical officers although skilled in curative medicine, therapeutics and morbid anatomy were fit for nothing but to take care of those suffering from the effects of war or foreign climates, in fact, before this campaign, doctors — civilian or military — had contributed little or nothing to the prevention of manpower wastage.

At the time of the Crimean War Louis Pasteur was postulating the spread of diseases by germs, but, as yet the medical officers lacked the applied knowledge that bacteriology and immunology were later to afford them. The necessity for well qualified medical officers was realised and in 1898, a new corps, The Royal Army Medical Corps, was formed, the members of which were, incidentally, given the same ranks and insignia, the same status, and the same executive and disciplinary powers as their combatant colleagues. This was a most important advance as these privileges, I believe, have not yet been fully accorded to the medical officers in the sister services of the Defence Forces of Great Britain.

Anti-typhoid and other inoculations were now protecting the armies in India ; at the same time, advances were being made in tropical medicine and epidemiology. For example, Bruce who originally discovered the organism of brucellosis, had traced its reservoir to goats. Leishman had revealed the causal protozon of leishmaniasis. LeLean was working on the downward displacement of steam as an effective sterilising agent. It may be safely said that at the outbreak of the Great War in 1914 the Army Medical officer had the training and knowledge, and I would add, the efficiency to warrant his place in the councils of war. Enteric was no longer a fatal disease. Hygiene and sanitation were curtailing typhus, while malaria and dysentery were being checked. Tetanus and gas gangrene presented as lethal diseases to be eventually controlled.

Nervous disorders and psychoneuroses took pride of place as manpower wasters of the Great War. The immediate remedy was therapeutic which gained the Medical Services of the Army a few marks and cost the nation a considerable amount of money in pensions. It was not however until the advent of the World War of 1939 that personnel selection was introduced as a means of preventing this form of manpower wastage.

Protection against Gas was one of the problems of the Great War that the medical services were asked to solve. The expedient instructions issued that those liable to be affected should climb up the nearest tree although theoretically sound was not practicable. The Royal Army Medical College with the help of the Royal Engineers provided the solution.

The devastating epidemics of measles and cerebro-spinal fever were other problems which were dealt with largely by the Medical Officers' ability to administer and organise.

The successful treatment of the masses of casualties in France and other theatres brought credit to the Medical Services. The Royal Army Medical Corps had achieved a position of responsibility as savers of manpower.

In the inter-war period stress was again laid on improving the professional standards of the Medical Services. In addition, the importance of training for war was taken up with greater emphasis then ever before. It was realised that it would be upon the scaffolding formed by the regular Medical Corps that the Army Medical Service would have to expand. What of the 1939-45 War. How did the medical officer stand with his commander? What has Field Marshal Viscount Montgomery of Alamein to say when making a presentation to the Medical Services ?

> "To the Royal Army Medical Corps with admiration and high regard, and with gratitude to a Corps whose contribution to history has been beyond all calculation".

In a despatch he wrote of the

> "... truly remarkable success of medical organisation. ... Doctors are prepared to lay fifteen to one that once a man gets into their hands whatever his injury, they

would save his life and restore him to fitness ".

As you would expect the duties of a medical officer in the British Army are varied. Automatically at all levels, no matter what his specialty he is an adviser to his commander. The more senior the commanders in the British Army the more medically minded they become. To give confidence, therefore, the medical officer must be up to date in his professional knowledge and be rational in all his arguments. Except in operational necessity his advice is readily accepted. Should operational necessity arise a working compromise is always effected.

In planning a campaign, medical at all stages is called in. Advice is given in the form of a written appreciation which assists the staff and its commander in making their plans and decisions. The medical adviser is today a valued member of the staff. His advice, as was the case in the South West of the campaign. This position of confidence Pacific in the last war, influences the whole has been gained as a result of concerted medical efforts chiefly in maintaining the health and saving manpower wastage of the Army over many years.

Medical officers by the efficient handling of their medical resources can demonstrate to the soldier that he will be quickly and adequately treated if wounded. This knowledge plays an important part in maintaining what Field Marshal Montgomery has referred to as the most important single factor in winning the battle, namely, morale.

It is for the future that the medical officers of today must train. A sound professional knowledge is the essential background. In his academic qualification, training and experience he must at least equal his civilian colleague. What is important is that in the Army of today he is given ample opportunity to achieve this.

You no doubt will have realised that after each major war, it has become almost traditional for the Government to reshape its Army Medical Services. The recommendations invariably include schemes for improving conditions of service and enhancing the professional or clinical standing of the members. The last Committee — The Waverley Committee — in 1956, among other things, recommended that our sister services should bring the professional standards required by their specialists into conformity with those laid down by the Army. This recognition of our professional standards was very gratifying, not only to members of the Medical Services of the Army, but also to our civilian colleagues who ever since the formation of the regular Army have gone out of their way to encourage and help us in raising these standards.

What are our present standards? It is necessary that senior specialists in the Medical Services hold the higher academic qualification of their specialties and have the requisite training and the experience recommended by the Royal Colleges and the Joint Consultants' Committee of the British Medical Association. In order to attain these standards a career guidance scheme was laid down as far back as 1947.

Today 40 per cent of our regular officers are specialising. Before grading as a specialist the candidate is interviewed by a board consisting mainly of leading civilian consultants, who assess his qualifications and experience and if they equate with those of a civilian consultant, recommend that the candidate should be graded and appointed as a specialist in the Army. The board then recommends that he be posted to a particular unit for a tour of duty. This system is identical with civilian procedure.

At present approximately 40 per cent of our regular officers hold postgraduate or higher medical qualifications — a greater proportion than, I believe, is found in civilian life.

Although the career guidance scheme is normally confined to regular and short service officers I am happy to say that a large number of our National Service officers also benefit.

Before being permitted to train as specialists, officers are required to pass satisfactorily the Junior Course of the Royal Army Medical College.

If selected the candidate at an appropriate time is sent on a three months' surgical basic science course, or a membership course for the examination of the Royal College of Physicians. If successful the surgical aspirant studies for the final Fellowship examination while the new Member of the Royal College of Physicians works for his doctorate.

What happens if a candidate is not successful on the junior course?

On one occasion I was rung up and informed that such an officer had been successful in his Membership examination. Originally it was has intention and still is, to specialise in psychiatry. He was told to show his capabilities by passing his membership examination, after which we would train him and make him into a psychiatrist. About this same time another officer wished to become a pathologist but did not gain sufficient marks. Similarly he was told to obtain his Membership. Unfortunately the Suez operations interrupted his academic progress. As M.O. to the Scots Guards there was little time to get down to the books. It will not surprise me if after the next examination he reports that he has obtained his membership. If so he will start his training as a pathologist the next day.

All postgraduate training is now co-ordinated by the Director of Studies, who is Commandant of the Royal Army Medical College. Today it is thought necessary that all officers, specialist and non-specialist, returning from an overseas tour should undergo a refresher course in their particular subject.

Our career guidance scheme is theoretically simple and few difficulties are encountered with the unmarried officer. When a difficulty arises it usually concerns the married officer's family which very rightly must be considered. The career guidance staff appreciate that one of the first principles in running a contented service is to maintain a happy community which involves focussing particular attention on the family. To this end in selecting officers for regular commissions special attention is now paid to their family background.

The Suez operation was an important Medical Exercise. Surgically a lot had to be re-learnt. It has certainly given us timely guidance for the future. During the planning stage it was decided that casualties occurring in the first phase of the landing would be ferried direct to the ships until such time as the medical units had been disembarked. On the outward voyage, aircraft carriers of the Royal Navy and military transports, carried the striking force. Consequently the public rooms of these vessels which were to be converted into wards, operating theatres and sterilising rooms could not be prepared and organised for their medical role until the disembarkation of the troops was well under way.

Instructions were given to the Cambridge Military Hospital, Aldershot to pack and sterilise all dressings, gloves, gowns, theatre linen and syringes to cover the requirements of the military units both afloat and on the beach for the first phase. In other words the Cambridge Military Hospital, which normally provides some 50 medical units of the Aldershot area with sterile syringes and supplies, on this occasion extended its sterile supply service to cover the Mediterranean operational area. It is of interest to find that among other things the forward surgeons of the Great War recommended that it was advisable to issue field units, etc., sterile dressings packed in parcels of three different sizes.

In this operation some medical officers neglected the cardinal principle of military surgery, namely, never to undertake the primary suture of a wound received in battle. Delayed primary suture for many years has been the established rule whether or not antibiotics are used. Frankly, the temptation to close a wound and allow it to heal by first intention was great. Time was on the Surgeon's side and antibiotics at his call: Had not some of the troops been flown from their transport, landed on the beach, joined in the fight, been wounded, flown back as casualties and were now lying comfortably as patients in the ship's hospital all within twenty minutes?

Helicopters were the answer, they are wonderful time savers but it had to be re-learnt that speed and antibiotics are not the alternative to efficient debridement. Unfortunately it was also forgotten that the missile passing through tissues still retains its disruptive and damaging effect and its tract must be followed up. Forward surgery was the lesson of the 1914-18 or Great War, that of the second or World War, delayed primary suture. If wounds were treated as directed 90% of them could be sutured in five days. In the best interests of his patient the experienced forward surgeon appreciates that his job is to prepare the patient's wound for a delayed suture in 5 or 6 days time. If he does this adequately, massive scar tissue is eliminated, compound fractures are converted into simple ones and sinus formation prevented. In fact the forward surgeon if he carries out his allotted task, reduces manpower wastage and is the chief

means of restoring his patient to fighting fitness in the minimum of time.

You will remember that with the publication of a recent white paper the division gave way to the brigade group, a stream lined force designed to meet our modern commitments be they cold, limited or global. The object of the cold war is well known. It aims at destroying man's peace of mind and undermining his morale. This was obvious at the Congress of Military Medicine held in Belgrade last month.

In considering defence in nuclear warfare with particular reference to the effects of radiation. Delegates were being persuaded into making a collective recommendation which the Congress desired to send through ministerial channels to the governments of those participating. The purport of the recommendation was that the military surgeons present had no effective remedy at their disposal, and the position in their opinion was hopeless. The situation described by the Preacher in Ecclesiastes came to mind—

> 'in the day when the keepers of the house shall tremble, and the strong men shall bow themselves, and the grinders cease because they are few, and those that look out of the windows be darkened.'

This today is the mental state of those who live under the shadow of the iron curtain. Their doctors and surgeons have been so conditioned that they now fear radiation of any kind be it from their wristlet watches or the asphalt on the roads. These brain washed people are worried. They fear the unknown.

Catastrophe or major disaster is not unknown to you people of St. Bartholomew's. In 1603 no fewer than 30,000 died around this hospital. A similar number perished in 1636. The Great Plague of 1665 did not destroy such a large number. It however struck the imagination for it came at an age of greater civilisation, comfort and security when such calamities are less expected. The plague was not confined to London, the towns of East Anglia also suffered very severely. Harrison Ainsworth's words in Old St. Paul's are descriptive of what might occur today should there be a nuclear attack.

> "London had become one vast lazar house, and seemed in a fair way of becoming a mighty sepulchre."

The chief feature of nuclear warfare is the complete and sudden nature of the casualties occurring in all depths of the theatre of operations. While factors of size, speed and multiplicity increase the complexity of the problem, progress in medicine and science equip us better to deal with it and give a solution far removed from the pest house and plague pit of old London.

Individual training, versatility and mobility of medical units tied to a flexible organisation are, we feel, the means of meeting the difficult but possible nuclear commitments.

It is now of paramount importance that every medical or patient holding unit, be it a field ambulance or a military general hospital, be trained and organised in the sorting, filtering, early management and sustaining of casualties. In the modern Army the field ambulance is trained and organised to filter some 6,000 casualties in 24 hours.

At the site of an incident the field ambulance will sort out its casualties into three groups. First the lightly wounded—patients with fractured limbs and lacerations. Fractures will be put up in gutter plasters by R.A.M.C. or Q.A.R.A.N.C. nursing orderlies. A team of twelve who have been specially trained are capable of putting up 100 cases inside one hour. These orderlies do not set the fracture but merely straighten the limb and immobilise it by means of a quick setting plaster slab.

The second group are the transportation risk cases which some people might call moribund. These patients are set aside and treated expectantly — but they must be treated or morale will suffer. The third group are the seriously injured who may require life saving procedures which can be readily undertaken if surgical teams are available. It is unlikely however that there will be sufficient surgical teams and the unit will have to sustain these casualties for anything up to eight days.

Let me now tell you what we expect our medical units to be. There will be a unit of—

3 medical officers.
3 nursing officers or SRNs
33 nursing orderlies
3 cooks
3 clerks

It is so organised as to divide into three sections or wards. The commitment is 100 dangerously ill patients. The brick complete with its tentage, equipment and personnel can be carried on six 3 tonners and three trailers.

On arrival on site it can unload, erect its tentage, lay out the beds and admit its 100 dangerously ill patients within 1½ to 2 hours by which time the majority of the patients have been documented and put on support treatment, i.e., temperature, pulse, respiration and blood pressure have been recorded, they have been sedated and given their antibiotics or chemotherapy. Those that require gastric suction or a gastric drip have had a Ryle's tube passed. It is anticipated that by this time an intravenous drip has been started in 60 per cent. of patients.

A lecture given to the Abernethian Society on 19th November, 1957

Meanwhile the cooks have prepared the patients' and staffs' diets and food while other orderlies have provided the required sanitary arrangements.

This standard of proficiency has been achieved by streamlining the training and making it more interesting. It will surprise you that the personnel of these medical companies are not hand picked but contain a goodly proportion of people with SG 4 or 5 gradings, people who are not usually given responsibility and are apt to be described as dullards. In this organisation we have been able to bring the medical officer and the other rank into a much closer relationship than ever before. As you can well imagine everything depends as never before upon the leadership of the medical officers.

SPORTS NEWS

Viewpoint

Readers of the National Daily Papers may have noticed that the Bart's Rugger boat was the only Crew to win for the Hospital in the Hospitals' Regatta Although this may seem to be yet another "feather" (if the expression be excused) in the cap of the Rugby Club, it should be pointed out that the four victorious oarsmen had I am informed served the Boat Club faithfully and skilfully for some years previously, and that their allegiance to the Rugby Club, was, with deference, of short standing. Alas for the old amateur spirit (if there ever was such a thing) which is slowly being ousted by mechanically streamlined professionalism.

The Sporting Calendar has been enlarged to include fixtures for the month following that in which the *Journal* is published. This is a logical and self-explanatory step.

1st XV v. Old Paulines at Thames Ditton. November 16th. Won 12 – 0.

The 1st XV scored a convincing win over Old Paulines at Thames Ditton by 12 - 0 and had they accepted their chances and not missed several easy shots at penalties, could easily have doubled their score.

The Hospital kicked off on a dull but dry afternoon and soon established a foothold in the Old Paulines half, staying there for most of the first half. Stevens opened the scoring with a thirty-yard penalty after twenty minutes and ten minutes later, McMaster finished off a good move by beating two men to score an unconverted try in the corner. During this phase of the game, the Hospital forwards were getting an equal share of the ball from the set-scrums and line-outs and often made 20 - 30 yards by well-controlled dribbles in the loose. After the interval, Bart's again re-established themselves in the Paulines' twenty-five and further scores came in a try scored by Halls after a well-placed kick-ahead by Bamford and a 35-yard penalty by Pennington.

It was, however, a pity to see so many scoring chances wasted as the Old Boys were noticeably weak in the centre. More determination and ruthlessness must be shown by the Hospital against weak opposition as it is in these matches that the skill and fire required next January must be developed.

It was pleasing to see all the junior sides win again as it is a comforting thought to know that the general standard of rugby throughout the Hospital is definitely improving.

Team :

M. Britz ; J. Stevens, G. J. Halls, J. Bamford, A. B. M. McMaster ; R. R. Davies, B. Richards ; J. L. C. Dobson, J. Hamilton, B. Lofts ; L. R. Thomas (Capt.), J. Pennington ; P. D. Moynagh, W. P. Boladz, R. P. Davies.

1st XV v. Old Alleynians at Dulwich. Lost 5 – 11. November 23rd.

With the excellent record of having won six of the first ten matches, the 1st XV were reasonably confident of beating one of the stronger Old Boys sides in London. However, as in past years, the ground at Dulwich proved to be very greasy and towards the end of the game, became extremely muddy.

Bart's kicked off and were soon attacking up the slope and early on, Halls and Bamford engineered a clever opening for Halls to break right through. However, the vital final pass went astray and the Hospital lost an early opportunity of taking the lead. The remainder of the half was very even with Bart's getting their fair share of the ball, forward D. A. Richards making a very welcome come-back for the first time this season since his injury of last season, was often prominent in the loose mauls and line-outs. During the last quarter of an hour of this half, the Old Boys missed three easy shots at penalty goals.

After the interval, The Old Alleynian kicker, Wait, kicked a good 35-yard penalty which was followed almost immediately by a try by their right wing who won the race for the touch-down after a very well-placed diagonal kick by their fly-half. This was converted by Wait who then kicked a second penalty goal five minutes later.

At long last, the Hospital were galvanised into activity and scored a try by McMaster after he had won the race for a touch-down from a diagonal kick by R. R. Davies, J. Stevens converting with an excellent kick from the touchline. The match ended with Bart's unable to penetrate one of the tightest defences it had met this season. In the second half, the old fault of running across the field showed up again in our back division. This must quickly be eradicated and replaced by smart, quick passing to the wings as it is only by these methods that we will tire the opposing forwards and go a long way towards compiling a few big wins before the Cup matches in January.

Team :

J. Stevens ; J. C. D. Plant, J. Bamford, G. J. Halls, A. B. M. McMaster ; R. R. Davies, B. Richards ; D. A. Richards, J. W. Hamilton, B. Lofts, L. R. Thomas (Capt.), J. Pennington ; J. C. Mackenzie, R. Jones, R. P. Davies.

1st XV v. Saracens. At Chislehurst on December 14th. Won 3–0.

The 1st XV gained a well deserved victory at Chislehurst by beating a strong Saracens side by a try to nil. It was all the more commendable since Phillips, L. R. Thomas, Halls, Britz, Bamford and Dobson were absent through injuries and notable deputies were Neely, Ross and J. Martin.

With Mackenzie leading the side for the first time since his victorious season of last year, the tactics were well planned beforehand in that the ball was kept forward as much as possible and resolute tackling by Stevens and Neely in particular completely upset the opposing three-quarter line.

Winning the toss, Bart's elected to play against a strong wind and battle was soon joined between two vigorous and occasionally over-enthusiastic packs. It was noticeable at this stage, as throughout the game, how Mackenzie held the Saracens fly-half in submission and Charlton's sudden sharp breaks round the scrum were often productive in gaining twenty or thirty yards. After Saracens had missed two fairly easy shots at penalties, Bart's took the lead with an excellent try in the right-hand corner. Heeling the ball from a loose maul fifteen yards from the opposition line, R. R. Davies created an opening and with a one man overlap on his right, passed out immediately. Quick passing by the centres enabled J. Martin, playing his first game for the 1st XV, to dive over in the corner, Stevens narrowly missing the conversion.

After the interval, although the forwards were often beaten in the set scrummage, they were much quicker on to the loose ball than their opposing numbers and possession was often more of a hindrance to Saracens due to the excellent tackling of Martin, Stevens and Neely. Ross, also playing his first game for the 1st XV in the full-back position, time and again fielded the ball and found a good touch with great confidence. During the last ten minutes, twice he saved almost certain tries with fearless tackles. Beyond this, Saracens rarely looked like penetrating Cup-match standard defence although they did miss two penalties before the close.

This, indeed, was a most heartening performance as a month previous, Saracens had beaten St. Mary's 19-0 and drawn with the London Hospital 6-6. With such a boost to morale, it is to be hoped that everyone will train all the harder for the Cup match against St. Thomas's in a month's time.

Team :

A. P. Ross ; J. Martin, J. C. Neely, J. Stevens, A. B. M. McMaster ; R. R. Davies, C. A. C. Charlton ; D. A. Richards, J. W. Hamilton, B. Lofts, J. Pennington, C. C. H. Dale, R. P. Davies, W. P. Boladz, J. C. Mackenzie (Capt.).

BOOKS RECEIVED

Inclusion in this column does not preclude review at a later date.

I Walk on Wheels *by* Elizabeth Shepard-Jones. Geoffrey Bles. Pp. 187. Price 15/-.

Chronic Bronchitis, Emphysema and Cor Pulmonale *by* C. H. Stuart-Harris and T. Hanley. John Wright & Sons. pp. 252. Price 42/-.

How to Study *by* Morgan & Deese. McGraw Hill. Price 11/6.

Handbook of Neurological Examination *by* Denny-Brown. Oxford University Press. Price 22/-.

BOOK REVIEWS

HANDBOOK OF HISTOPATHOLOGICAL TECHNIQUE (including Museum Technique) *by* C. F. A. Culling, F.I.M.L.T. Butterworth. Pp. 446 and 79 figures 45s

This book has been written primarily for laboratory technologists and the author in his preface makes it clear that he has had the examination syllabus of the Institute of Medical Laboratory Technology in mind while writing. Nevertheless, he hopes that the "book will also be of use to those wishing to learn or practice histopathology or histology—such as students of biology, physiology or medicine". Whilst this is the ideal bench book for serious students of histopathological technique, the contents are for the most part too specialised to appeal to the average medical student.

As chief technician at the Westminster Hospital Medical School, with many years' experience of both teaching and practising histopathological techniques, the author is well qualified to write a book of this kind. It is essentially a practical handbook and, as such, it gains enormously in value from Mr. Culling's personal experience of his subject. As Prof. R. J. V. Pulvertaft remarks in the foreword, "In this book he has set out the methods which he himself employs, with all the detail which makes the difference between success and failure".

The book is divided into six parts. Part I is a short introductory section on the cell, with an outline of the methods of examination of tissues and cells. Part 2 deals with fixation, processing and section cutting, and Part 3 (comprising nearly half the book) is concerned with staining methods and mountants. Part 4, on "Special Procedures", contains short chapters on Autoradiography, Vital Staining, Micro-incineration and Injection Techniques. Part 5 deals adequately with Museum Technique, and Part 6 on "The Microscope" gives a very valuable account of the principles of microscopy and the types of instrument now in general use.

The arrangement of the book is good, and it is clearly written, although in one or two parts of the text which deal with theory rather than practice, clarity has been sacrificed in the cause of brevity. The illustrations are well chosen and produced, and the book contains some useful tables. A few printing errors have been found — the legends for figure 32 (g) and 32 (h) have been transposed; an asterisk has been omitted before the footnote on p. 215; the name Perenyi has been mis-spelt in the index and the wrong page number has been given for the index reference to his decalcifying agent. As one who constantly suffers from having his name mis-spelt, your reviewer must also draw attention to the incorrect spelling of the following names: Tompsett (p. 350), McManus (p. 455) and Heiffor (Index p. 12). The name Kultschitsky has a different spelling in the text from that in the index. Some factual errors have also been noted—on p. 31 it is stated that fixation in formol saline is usually complete in 24 hours at room temperature; on page 236 it is implied that plasma cells are of normal occurrence in serous membranes instead of mucous membranes, and it is no longer true to say that the function of mast cells is not known (p. 294). These are, however, minor faults in an excellent book which is certain to become a standard work for technologists in histopathology. The book is beautifully produced, the paper is good, the print clear, and the publishers claim that the binding is both waterproof and acid resistant. It cannot be denied, however, that the cost is high, having consideration for the type of person for whom this work is primarily intended.

G. STANSFELD.

THE SHOULDER *by* James Cyriax. Cassell. Pp. 40. Price 5/-.

The various conditions occurring in and around about the shoulder joint are notorious both for their confused nomenclature and for their largely conjectional pathology. As a result, the effects of treatment at times not only variable but often disappointing.

In his new book "The Shoulder", Dr. Cyriax has assembled and described these conditions with a simplicity and clarity which will please and assist the General Practitioners and Physiotherapists, for whom it has been written. Due emphasis is laid upon accurate diagnosis, and the appropriate treatment is concisely defined.

Nonetheless, there remain those time-honoured terms such as adhesions, chronic bursitis, contracture of the costo-coracoid fascia and so on, terms which appeal to the imagination but which are difficult to demonstrate to the academic eye. Thus, wihout the advantage of a convincing pathology with which to incriminate these structures, it still remains difficult to be impressed by the therapeutic measures which are applied to them.

R. C. FARROW.

ANAESTHESIA FOR NURSES. Eric Goodwin. Published John Wright & Sons, Ltd. Price

The scope of this little book is wider than its title implies, and covers in outline the management of many types of patient before operation, as well as the methods of administering anaesthetics, the care of the unconscious patient, the complications to avoid, and a glossary of drugs and instruments in use. There is a brief chapter on the anatomy and physiology of respiration as it affects anaesthetic techniques, and a practical section on the causes and avoidance of anaesthetic explosions. The successful management of the

infusion is rightly deemed to be a part of post-anaesthetic care, and methods of ensuring that compatible blood is used are described.

It would be better to give the approved than the proprietory names of drugs, and the description of bronchopneumonia on page 12 appears to apply to lobar collapse. All views expressed are modern and sensible, except for the suggestion on page 31 that the pharynx of an unconscious patient may be mopped out using swabs held in the fingers.

W.E.H.

AIDS TO MATERIA MEDICA FOR NURSES *by* A. E. Squibbs. Baillière, Tindall & Cox. Price 8s. 6d.

A preliminary sample of the index to find how up to date the revision of this edition has been is reassuring. On reading the book this impression is confirmed; a very thorough review has been made.

Approved names for drugs have been used throughout, and dosage is given primarily in metric measure. Latin has disappeared from the titles, and it is to be hoped that this will be better received by nurses than was the effort in this direction by the editors of the National Formulary. It would be sad to see this elegant language falling into disuse, if it were always used elegantly, but it is ruthlessly abused and abbreviated and nurses are probably well advised to use English.

Miss Squibbs is among the best known and best liked of nursing teachers today and I wish her every success with this new edition.

W. E. HECTOR.

PSYCHOLOGY AND PSYCHOLOGICAL MEDICINE FOR NURSES *by* Portia Holman. Heinemann. Price 10s. 6d.

Once upon a time nurses and doctors were alleged to think about "cases", and were exhorted to consider not diseases but patients. Now we have moved on to a different stage, and are asked to think about our clients not as patients but as people. The people whom we look after have been moulded by the pressure of events and the weight of their inheritance into their present pattern, which will profoundly affect their reactions to illness, and often even decide what that illness is to be. It is this attitude which Dr. Holman's book describes.

The biggest part of the book is taken up by a description of normal psychological development from birth to old age, and Dr. Holman manages to avoid suggesting as so many psychologists do, that nothing very interesting or important happens after the age of 5. The section on mental illness is very brief, and even for the nurse in general training does scant justice to the branch of medicine which occupies most beds in this country. Accuracy is sometimes sacrificed to brevity, as here: "Paranoid patients suffer from what are known as delusions of grandeur".

The final section describes the reactions of some patients to illness. The whole book is written simply and avoids technical obscurity. If the facts of Freudian psychology are stated in their extreme form, student nurses who have little time to study them tend to reject them totally and to abandon interest in the subject. Here they can see mental life as a developing process, in which illness may be an incident determined by the patient's past, and one which will influence his future.

W. E. HECTOR.

HOUSE APPOINTMENTS

Dr. Bourne	B. W. D. Badley
Dr. Cullinan	J. Q. Creightmore
Dr. Spence	J. B. Nichols
Dr. Bodley Scott	C. F. Allenby
Dr. Scowen	M. A. Newton
Mr. Hume	L. J. Chalstrey
Mr. Corbett	V. T. D. H. Major
Mr. Hosford	T. D. Cochrane
Prof. Sir J. P. Ross	M. E. J. Hackett
Mr. Naunton Morgan	D. R. Dunkerley
CASUALTY H.P.	J. Hinton
CASUALTY H.S.	R. H. Visick
Children's Dept.	P. J. Bekenn S. E. Newton
E.N.T. Dept.	D. Stainton Ellis A. M. M. Plumptre
Skin and V.D.	I. H. Cochrane
Eye Dept.	M. A. Bedford
Gynae and Obstetrics	H. J. O. White L. Pringle
Junior H.S.	F. G. Hall
Anaesthetics	E. Clissold E. F. Brooks
Dental Dept.	M. Harris
Orthopaedic Dept.	N. J. C. Grant
at Hill End	C. S. Goodwin
" " "	M. M. McKerrow
Thoracic Dept.	D. H. Black N. E. C. Coltart
Neurosurgical Dept.	H. V. Blake J. A. McKinna

EXAMINATION RESULTS

ROYAL COLLEGE OF SURGEONS

Primary Fellowship Examination — November 1957

Harris, W. G.

Final Fellowship Examination — November 1957

Winstone, N. E.	Gracey, L. R. H.
Griffith, A. N.*	Ross, H. B.
Mehta, J. S.	Blacklock, N. J.

* in Otolaryngology.

SOCIETY OF APOTHECARIES

Final Examination — November 1957

Midwifery — Casson, A. J.

UNIVERSITY OF LONDON

Final M.B., B.S. — October 1957

Hinton, J., honours in medicine.

Alade, R. B.	Sutton, W. K.
Coakey, M. C.	Vyle, E. A.
Hackett, M. E. J.	Williams, J. C. L.
Laidlaw, C. D'A.	Badley, B. W. D.
Major, V. T. D. H.	Ellison, J. A.
Richings, J. C. H.	
Hall, F. G.	Grasset-Molloy,
Long, J. D. N.	G. J. M.
Rowswell, E. F. D.	Hawkes, P. H. R.
Pidcock, B. M. H.	McKerrow, M. M.
Taggart, P. I.	Plumptre, A. M. M.
Ware, J. M.	Stuart, I. M.
Woolf, A. J. N.	Visick, R. H.
Billardis, D. G.	Watts, N. M.

Part I

Al-Adwani, A. R. M.	Farrow, L. H.
	Martin, J.
Cocker, W. J. P.	Tabor, A. S.
Farren, P.	White, S. J.
Marks, A. P.	Charlton, C. A. C.
Simpson, R. I. D.	Ellison, A. J. H.
White, R. G.	Fenn, P. J.
Bench, J. T.	Norris, P. L.
Dale, C. C. H.	Thwaites, J. M.

Part II

Chinery, A. R. O.	Lewis, J. H.
Tallack, J. S. T.	Marston, M. S.

Part III

Lewis, J. H.	Tallack, J. S. T.

Part IV

Laurent, J. M.	Lewis, J. H.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXII **FEBRUARY 1958** **No. 2**

EDITORIAL

It is with some hesitancy and great regret that the *Journal* must at last give way to the general trend and raise its subscription rates. The rise is in keeping with the increased cost of producing the *Journal*, which includes printing and postage as well as many other very costly items. It had been hoped in the past that the determined drive by the Manager and his assistant to increase both our advertising and our subscription list would offset the rising costs and enable us to carry on at the old rates. This unfortunately has not proved financially practical.

It should be well understood that the *Journal* is entirely self-supporting, receiving no financial aid whatsoever from any source and has for the last few years eked out a precarious existence only just above the bread-line. The *Journal* and only one other society the Catholic Society survive without a grant from the Students' Union, and yet the Journal presents to the Students Union about 500 copies a month free, gratis and for nothing.

It may well be that in future the *Journal* may have to ask the Students' Union for a definite contribution towards the finances instead of the present somewhat tenuous arrangement for them to cover our losses if and when they occur.

Next year promises to bring an extra load on to our financial backs since the cost of printing is to go up by an estimated 7½ per cent., which is, in hard materialistic terms, about £150, the cost of postage has already doubled and now costs an extra £90. This means that a further £250 has to be found to break even, all other factors remaining equal. The probability is that all the other factors will not remain equal and so more will have to be found.

In an effort to meet the increased costs the *Journal* Committee considered three definite possibilities, and it was decided to investigate them all thoroughly. The first possibility was to increase our advertising no matter how, and this the Manager has in hand. The position of the advertising in the *Journal* has become more and more grave, and this constitutes an important part of our income. It is possible in the very near future that a Government which is disinclined to any form of private enterprise and which openly declares itself to be antagonistic to advertising on the part of private firms, will be returned to power and our advertising will disappear. Hence we must insure against being left completely without means of survival.

The second possibility was as indicated above—an approach to the Students' Union for an annual grant.

The question of students paying individually was discussed, and dismissed, since every student still at Bart's has a moral obligation to read the *Journal* and they should not be given the opportunity to contract out of this obligation.

The third possibility was to raise the subscription rate for all new subscribers and also to charge more for individual copies sold. This was reluctantly decided to be an unavoidable step, and the new annual Subscription is to be £1 5s. to old Bart's men.

Unless the *Journal* can pay its way it may become inevitable that we shall have to change our whole attitude to its production and introduce austerity and stark realism to the only thing which can link the past, the present and the future with bonds more reliable than memories and more flexible than tradition.

The late Mr. E. A. Garwood

The student body as a whole has suffered a great loss with the death of Mr. Garwood. Mr. Garwood had been the mainstay of the Men's cloakroom for many years past and had been a most reliable helper in any social function, both by printing the posters and by distributing the tickets.

An appreciation of Mr. Garwood will be published in the March *Journal* meanwhile the whole of Bart's sympathises with his family and shares their sorrow at their great loss.

The Grosvenor

Once again about 400 couples took the floor at the annual nurses' dance at Grosvenor House on the 8th January of this year. Unfortunately Matron herself, the hostess for the evening, was still ill after her somewhat protracted illness and Miss Turnock received the guests in her place.

As ever, the night nurses disappeared from the festivities at one o'clock and the remaining half hour soon disappeared.

The Grosvenor has become an institution which is discussed by the hospital at large for six months of the year and eagerly awaited for the other six, a hospital equivalent of Ascot, or perhaps more appropriately, of Newmarket.

The Chef's Special

The recent implementation of the promised quantity before quality regime in the Hospital Refectory has proved a somewhat disappointing experiment since the emphasis seems to have been on the sacrifice of quality without any noticeable increase in quantity. Also with the introduction of this Morris menu several strange attitudes of mind have emerged from behind the counter. In one particular case the menu advertised a sweet described as " Jam Roll " which on investigation after purchase proved to be all roll and no jam. When this was pointed out to the proper authority, who was taken to be the lady who supervises the counterhands, she took the view that buying a lunch at Bart's was like a lucky dip, one took what one got!

These two ladies who guard the portions so vigilantly could surely be more sensibly employed serving their meagre portions out thereby saving two other workers' salaries and perhaps enabling the jam to be afforded for the " Chef's special Jam Roll."

A new subway

Anyone who tried to get out of the Little Britain Gate in the last few weeks will have found their way barred by an enormous burrowing operation being conducted by a fairly typical gang of British workmen. This is the beginning of the underground passage linking the main block with the East Wing and the new L-shaped block. There has already been constructed a tunnel beneath Little Britain and this new tunnel will connect with this, the work is expected to take several months. At the moment there is a maze of subterranean passages linking R.S.Q., Surgery, and the Main block and this new extension will enable the whole hospital to be reached without even going into the open. Quite a consideration on wet or snowy days.

'Patience'

Following the quite outstanding success of " The Gondoliers " last year, the Gilbert and Sullivan Society is presenting " Patience " at Gresham Hall on March 7th.

Attempts to find and book a suitable theatre for a stage performance have not proved fruitful, and so for the present their activity is to be confined to concert performances. These have, in fact, many advantages. They are convenient and relatively inexpensive ; they can be rehearsed and performed in four or five weeks ; and there are far fewer barriers to accurate and controlled singing.

We understand that the chorus is large and good, and that the orchestra excellent. Vic Major will be the narrator and with John Creightmore and George Hobday singing the two important parts of Bunthorne and Grosvenor, Sheila Heap as Patience, and a very good supporting cast, their performance may even surpass the very high standard set last year.

Admission is by programme, and these can be obtained from the cloakroom or from the Nurses Home. It starts at half-past eight, and those who went last year will agree that this will be an evening well spent.

View Day Ball

The Students' Union has now decided in view of the possible damage to the lawn at College Hall to hold the View Day Ball at the Park Lane Hotel on the 9th May, 1958.

Royal College of Physicians

Elected Censor—Dr. E. R. Cullinan.

Royal College of Surgeons of England

Sir Archibald McIndoe appointed Bradshaw Lecturer for 1958.

Mr. Norman Carpenter appointed Robert Jones Lecturer for 1958.

Baly Medal for 1957

Awarded to Prof. E. B. Verney.

Harveian Orator

Sir Geoffrey Keynes.

University of Cambridge

Dr. H. Lehmann, D.Sc.

NOTICES

Change of Address

MRS. HELEN HOPWOOD, St. Monica's Guest House, Sutton Road, Seaford, Sussex.

DR. M. E. PLUMB, R.S.Q., St. Helier Hospital, Carshalton, Surrey.

ANNOUNCEMENTS

Engagements

BONNER-MORGAN — BARNARD.—The engagement is announced between Robin Peter Bonner - Morgan and Barbara Mary Barnard.

CHALSTREY — BAYES.—The engagement is announced between Leonard John Chalstrey and Aileen Beatrice Bayes.

Births

WHITTINGDALE — NAPIER.—On December 30th, John Whittingdale to Margaret Esme Scott Napier.

CASSELLS.—On November 29th, to Irene, wife of Dr. J. M. Cassells, a daughter.

CRONK.—On December 16th, to Elizabeth, wife of Dr. P. G. Cronk, a son (Simon Gregson).

GALBRAITH.—On December 29th, to Joan, wife of H.-J. B. Galbraith, a sister (Kirstie) for Mary Anne and Janet.

GIBB.—On November 24th, to Mary, wife of Dr. W. E. Gibb, a son.

THORNE.—On December 4th, to Pamela, wife of Dr. Napier Thorne, a sister for Susan.

Deaths

ANDERSON.—On November 28th, at Calcutta, Lt.-Col. Frederick James Anderson, I.M.S. (Retd.), aged 71. Qualified 1911.

BEDFORD RUSSELL.—On December 30th, Harold George Bedford Russell, aged 71. Qualified 1911.

DUNHILL.—On December 22nd, Sir Thomas Dunhill, Assistant Director, Surgical Unit, 1920-1931. Associate Surgeon, 1931-35. Aged 81.

JAY.—On December 19th, Maurice Bernard Jay. Qualified 1922.

KRAMER.—On December 12th, Nathan Kramer. Qualified 1929.

NAPIER.—On December 15th, Lionel Everard Napier, aged 69. Qualified 1914.

TRUEMAN.—On December 25th, Raymond Shaw Trueman, aged 54. Qualified 1933.

CALENDAR

Sat. 8th. Medical and Surgical Units on duty.
Anaesthetist: Mr. G. H. Ellis.
Hockey: v. St. George's Hospital **H.**

Wed. 12th.—Soccer: v. Charing Cross and Royal Dental Hospital (L) **H.**

Sat. 15th.—Dr. G. Bourne and Mr. J. B. Hume on duty.
Anaesthetist: Mr. F. T. Evans.
Soccer: v. Normandy Company, Sandhurst. **A.**
Hockey: v. University College **H.**

Wed. 19th.—Soccer: v. St. Mary's Hospital **H.**

Sat. 22nd.—Dr. A. W. Spence and Mr. Naunton Morgan on duty.
Anaesthetist: Mr. R. A. Bowen.
Soccer: v. Caledonians **H.**
Hockey: v. Orpington **A.**

Wed. 26th.—
on duty.
Anaesthetist: Mr. R. W. Ballantine.
Hockey: v. St. Mary's Hospital **A.**
Soccer: v. Trinity College, Cambs. **A.**

Sat. 1st.—Dr. R. Bodley Scott and Mr. R. Corbett

A BART'S SUCCESS

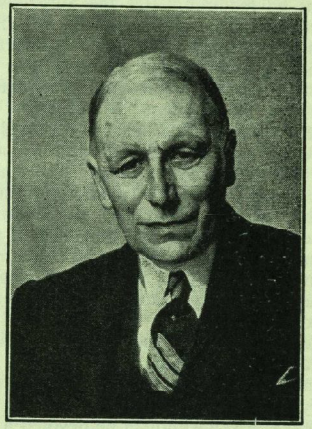
The Department of Medical Photography of St. Bartholomew's Hospital was successful in winning the award for the best colour print at the Exhibition of Medical Photography held by the Medical Group of the Royal Photography Society.

SIR THOMAS DUNHILL

Sir Thomas Dunhill named his Hampstead home TRAGOWEL after his birthplace in Australia, and there he died on Sunday, December 22nd, 1957, a few days after his 81st birthday. He had been in failing health for a long time, and it is unfortunate that because he found visits to town so much of a strain he very rarely came to the Hospital, and therefore his characteristic smile of recognition, his slightly stooping figure, and his alert enquiring and attentive mind, are unfamiliar to the present generation of Bart's men. He retired from the active staff and was made Consulting Surgeon in 1935, and although he returned from time to time to operate in his own theatre until the beginning of the War, it is nearly twenty years since he came at all frequently to the Hospital, and there have been great changes in its population during that period. His own close attachment to St. Bartholomew's was maintained till the end, and his criticisms and comments on what he read about current events in the *Journal* and in the Minutes of the Medical Council showed how anxious he was for the well-being of the Hospital.

He had had a distinguished career as a student in Melbourne, and his pioneer work on the surgery of toxic goitre had won him fame which had spread far beyond his native land long before he left home to go to France in 1914. By the end of the War he was one of the Consultant Surgeons to the British Expeditionary Force, and his outstanding military service was rewarded by the C.M.G. in 1919. Yet his first appearance at the Hospital was characteristically unobtrusive. One Saturday afternoon in 1920 Sister Stanley before going off duty warned her Blue Belt that later on a short, rather shy man might put his head round the door; and so when just this very thing happened she greeted him with "Mr. Dunhill, Sir?"—to which he replied "Yes, Nurse, may I go round your ward?" They shook hands, he accepted her welcome and the new prefix to his name, and his work at St. Bartholomew's had started.

In spite of his natural talent and his great achievements in surgery he was never known to seek for himself either position or prestige—on the contrary he showed more than once his willingness to accept a status lower than that to which he was entitled. He was 43 years of age when he left Melbourne, and considering his reputation he might quite justifiably have asked for the rank of full surgeon as a condition of his accepting the



invitation to join the Staff. He was content, however, to accept the position of Assistant Director of the Surgical Professorial Unit, and the Hospital owes him a deep debt of gratitude for his generous and unselfish decision which brought incalculable benefit to the practice of surgery in the Hospital, and to the training of the large number of young surgeons and future general practitioners who came under his influence.

Professor George Cask and his Assistant Director were almost of the same age, and so in order to avoid the disorganization which would be occasioned by their simultaneous retirement in 1935 they agreed, again thanks to Dunhill's unselfishness, that he should vacate his position in 1931 and assume the title of Associate Surgeon to the Surgical Unit so that another Assistant Director could be appointed. It thus came about that Sir Thomas was never full surgeon to St. Bartholomew's, and it was only when he was appointed Consulting Surgeon that he was accorded a rank which did him justice. To an outsider this would appear strange treatment of a great surgeon, yet those who knew Sir Thomas well realized he was speaking quite truthfully when he said, as he frequently did, that he loved Bart's and that he owed a lot to the hospital.

It is beyond all shadow of doubt that Bart's owed a lot to him. The Physicians were glad to be able to rely upon him for help not only with goitres but with all manner of medical complaints for which surgery might be required. But the Surgeons also called him into consultation for his clinical acumen and his wise judgment as well as for his surgical skill. The younger men were eager to learn from him both craftsmanship and the management of patients. The patients themselves trusted him completely, for every one of them felt that he or she was individually of supreme importance to him. This intimate personal relationship he established with patients of all classes ; the anxiety of a difficult case cost him his peace of mind and his sleep, but he never rested till either the patient was out of danger or he had lost the fight, and only then would he relax.

He formed the most delightful friendly contacts with students also, taking a pride in knowing their names and something about everybody on the firm and in the Out-Patient Class. Although he devoted a great deal of thought to medical education, and was at endless pains to prepare his material, he was never fond of teaching, and anything like a formal lecture or demonstration he dreaded. Men learned from him by watching him at work, and the tiny " temporary " theatre in which he operated on Thursday afternoons was usually overcrowded with visitors from near and far who always received a warm welcome, but also risked a sharp rebuke if they stood around, as surgeons so often do, with their hands in their pockets, their gowns wide open at the back, and (worst of all) talking in a corner while he was intent on some difficult job.

His large private practice came from many sources, through Australian friends, and from several of the well known Consultant Physicians some of whom he had known before he came to practise here. His first thyroidectomy for Graves's disease in London was done in 1915 on a very ill patient under the care of Sir Hector Mackenzie, and she is alive and well today. He operated on many of Lord Dawson's patients and it was through this association that Dunhill was appointed to the Royal Household, a privilege which he valued above all others.

It was of the first importance to him that everything he did should be done correctly, not only in surgery but in everything else as well. He was fond of fishing and shooting, but he went to schools to find out from experts all there was to be known about the right way to handle a rod and a gun. The same attention to detail was to be noticed in his everyday behaviour, in his dress, in his gardening of which he was extremely fond and in which he was an expert, and throughout his home—the furniture, the pictures, and the food and wine at his table—particularly in the little courtesies which meant so much to him.

It was a pity that this anxiety to achieve perfection in his environment tended to make his latter days unnecessarily lonely. When he moved from Harley Street to the edge of Hampstead Heath he couldn't bear to let his friends visit him till the house and garden, which had to be greatly altered to please him, had been made presentable. By this time he was beginning to find entertaining a severe physical and mental strain, and thus, although he enjoyed the selfless devotion of his own household, he lacked the companionship and the conversation of many of his friends who would have been happy to call when they were in his neighbourhood but hesitated to do so lest their unexpected appearance might upset him.

At Bart's we honour the memory of a great surgeon whose influence upon the work of the Hospital will long outlive him. Those of us who knew him intimately realize that we have lost a wise counsellor and a true friend whose words and whose actions will be recalled day by day as we continue to practise what we learned from him.

J.P.R.

A REMINISCENCE

Rather more than 30 years ago (it was in 1926 to be precise) I was at the extreme end of what was otherwise a very distinguished tail ; in fact I was the third assistant in the surgical professorial unit. How distinguished the rest of that tail was can be appreciated by the fact that the second assistant was Jim Ross, the first assistant was Geoffrey Keynes, the assistant director was Thomas Dunhill and at the head was the professor and very benevolent dictator, George Gask. To have used any of these Christian names would have been highly irreverent and quite definitely frowned upon. My job involved clinical work and research. Amongst my clinical duties was to organise an out-patient fracture clinic, which we believed at the time was the first in London. The idea of a fracture surgeon, or any other kind of departmental surgeon, was not then held very highly by the Professor nor for that matter, by any other general surgeon at Bart's. Nevertheless the need to improve the treatment and after care of fractures was recognised, and it was decided that I should be sent to Amsterdam to learn what I could from that Anglophile, and great gentleman, Professor Noordenbos, whose reputation stood high in these matters.

I have always thought that Thomas Dunhill was the guiding spirit in that enterprise, for after I had been two weeks in Holland he persuaded Geoffrey Keynes to accompany him to the continent to see how the young man was getting on and to take him out for a day at the Hague. What a memorable day it was. I met them at the railway station after their overnight journey from Harwich and we spent the morning in the operating theatres of a famous gastrectomist. Unfortunately for us we did not see what would then have been somewhat of a surgical treat: the perfect gastrectomy. What was never to be forgotten was the little byplay between Thomas Dunhill and the surgeon who, having removed a gall bladder the only offence of which was to have been associated with some " periduodenite ", was only persuaded from immediately closing up by Dunhill's insistent " Just to please me, won't you look at his appendix ? " a plea that after much banter was allowed to reveal a very nice example of chronic appendicitis. This was followed by other operations of great variety in an atmosphere of aesthetic charm ; an operating theatre of pastel shades and the rhythm of a string quartette.

The whole morning was an object lesson of technical showmanship of the first order and of courteous observation and discussion by a man of equal brilliance and greater clinical judgment. Gone from my mind is the name of the hotel at which we lunched ; for years I kept the menu until Hitler destroyed it in 1942, but I shall never forget the Chambertin which the three of us drank: a nectar to tired bodies but a warming solvent of senior dignity and of a young man's trepidation. Neither can I remember exactly what we talked about ; the " blushing stomach " we had done with before lunch. Thomas Campion, William Blake and Jan Vermeer are names I associate with Geoffrey Keynes at that time. I had had a connection with the Temple Church ; and Campion, poet, musician and doctor, had practised his arts somewhere near it in Fleet Street but whether he was a Bart's man I never knew. At the Hague that day I have little doubt that we all thought of his:

" Tune thy music to thy heart
Sing thy joy with thanks and so thy sorrow
Though devotion needs not art
Sometimes of the poor the rich may borrow."

Of William Blake I could only have spoken to Keynes with bated breath for already he was as well known for his erudition on that subject as he was becoming known in surgery. I would only have been able to recite " To Mercy, Pity, Peace and Love " and that was scarcely more appropriate to the occasion than " Little Lamb who made thee." Certainly about Jan Vermeer and Rembrandt I was to learn much from the arguments of Dunhill and Keynes that afternoon as we went round the Mauritzhuis. It was Dunhill who pointed out the erased figures in the foreground of the " View of Delft " and the anatomical errors of Rembrandt's " Anatomy Lesson." Whether Keynes ever did write the book on Vermeer that he planned then, I do not know. The intention was to have one with reproductions of every one of Vermeer's known paintings (not a great number as is well known). I believe Keynes was overtaken in this enterprise by Thomas Bodkin: otherwise the sad story of the " Supper at Emmaus " might have been different. He will doubtless smile at this but I have felt that Keynes' donnishness was finely mellowed by Dunhill's gentle wit and forthright clarity and perception. Some of us (including J.P.R.), who were surgical assistants at that time, formed a club which was dedicated with no false modesty to " The enquiring mind " ; a quality so well found in the character of Tom Dunhill whose passing one has heard of with such sadness.

SIR ERNEST KENNAWAY

Although not a Bart's man, Sir Ernest Kennaway has been a familiar figure in the hospital for the past ten years. After his retirement from the chair of Experimental Pathology and Directorship of the Research Institute at the Cancer Hospital in 1946, he was invited to continue his work here, and occupied the laboratory used before the war by the late Dr. Mervyn Gordon on the top floor of the Pathology Department. Here he worked with great determination despite his physical disabilities and several periods of illness until a short time before his death in Stanmore ward on January 1st.

Sir Ernest Laurence Kennaway, D.M., D.Sc., F.R.S., F.R.C.P., was born in 1881 of a well-known Devonshire family, and received his medical education at Oxford and the Middlesex Hospital. From an early stage in his subsequent career the whole of his life was devoted to cancer research, and he achieved world-wide fame as the leader of a group of workers including Cook, Hieger and Mayneord, who in 1932 identified the carcinogenic substances in tar, and produced experimental tumours with synthetic compounds of this nature. This was perhaps the most important discovery ever made in this field, and many subsequent advances have been based on it.

His study of chemical carcinogenesis continued until the end of his life, and his work at Bart's was concerned largely with the detection of carcinogenic substances in smoke. It was he who directed attention to the presence of arsenic (as a residue of a spray used during cultivation) in tobacco. He examined the solid matter in the air of the City for carcinogenic hydrocarbons. Recently he had been investigating the possibility that the high incidence of gastric carcinoma in Iceland (a country which he visited not long ago) may be connected with the heavy consumption of smoked meat and fish ; a very peculiar and not altogether agreeable smell emanating recently from his laboratory was that of Icelandic smoked fish undergoing extraction. With Lady Kennaway, who was his constant helper in all but actual bench work, he also pursued his studies of the epidemiology of cancer. He would not have regarded any account of himself as complete which did not include a reference to his militant rationalism : he lost no opportunity even in the columns of this journal for scathing comments on matters connected with revealed religion. We have lost a very distinguished guest, whom it will be to the Hospital's credit to have entertained during his latter years.

L.P.G.

H. G. BEDFORD RUSSELL

H. G. Bedford Russell, "B.R." to his colleagues at Bart's and elsewhere, died in Oxfordshire on December 30th, 1957, after a long and painful illness which he bore with characteristic bravery and fortitude. He continued to work to within a few weeks of his death.

Born in Australia in 1886, and educated at Geelong College, he came to England to study medicine at Sidney Sussex College, Cambridge, and St. Bartholomew's, where he remained to practice surgery and become a member of the staff of the Throat Department on the retirement of Mr. Harmer in 1928. He became head of the combined Ear, Nose, and Throat Department after the resignation of Mr. Sydney Scott in the early part of the last war, retired in 1947, but remained as an Emeritus Surgeon for a further five years. Qualifying in 1911, he served with distinction throughout the first World War and gained the F.R.C.S. after his return in 1919. He was mentioned in dispatches and gained the French Croix de Guerre. For some years after this he was on the staff of the Queens Hospital, Sidcup, working with Gillies and others on facial injuries. He then became a member of the staff of Golden Square Hospital. He was Secretary to the Section of Laryngology of the Royal Society of Medicine from 1932-34, under the presidency of another Bart's man, Musgrave Woodman, and was instrumental in getting both Dr. Ferris Smith, and later Arther Proetz, to visit this country and demonstrate their operations and treatment of nasal disease. He made the treatment of chronic nasal sinusitis his chief interest but while registrar to Mr. Harmer he gained great experience in the treatment of cancer of the upper respiratory tract by X-rays and radium and had much to do with the tabulation and analysis of the cases at St. Bartholomew's Hospital on which Harmer founded his memorable Semon Lecture of 1931, on The Relative Value of Radio Therapy in the Treatment of Cancers of the Upper Air-Passages.

Socially B.R. was a cheerful, humorous and entertaining companion. Always a good athlete he made tennis one of his chief accomplishments but was also a first-class ski-runner. He was keen on country pursuits and shooting, and later became a keen gardener.

He leaves a widow and two sons, one married, and it must have been a keen satisfaction to him to become a grandfather some six months before his death.

F. C. W.

THE CHRISTMAS SHOWS

Each year Christmas brings the usual festivities, but for those who have the mixed fortune to spend their Christmas at Bart's, it brings the ward shows. The trend at other Hospitals seems to be towards more streamlined shows organised by a hard core of talented experts with the exclusion of shows put on by individual firms. Recently rumour has it that even within the conservative fortifications of Bart's the tradition of ward shows is menaced. How sad it would be were we to give way to this modern conception that everything should be centralised. Whilst we are forced to confess that some Hospitals are able by this method to put on a show that is of a higher overall standard, it should be remembered that nearly one hundred students performed this year. If only one show was produced only a very small proportion of this number would have the opportunity to take part. Further, although the patients forced to spend Christmas with us are not, understandably, very demonstrative, they do enjoy and appreciate the students' efforts. Let us not tamper with tradition.

Passing on to the Pot Pourri one found, as one might expect under the circumstances that the gulf between the best and the worst was great. One sympathises with the committee faced with the difficult task of sifting each show and selecting the parts suitable for the Cripplegate audience. Congratulations are due to Trevor Robinson who miraculously glued the mass into a whole in one rehearsal, and to Colin Dale and his able lieutenants who worked in the wings. Nor should the marathon feat of skill performed no less than five times by Dr. Scowen and Bert Cambridge pass unmentioned. They managed with the aid of grease paint and other mystic products to convert almost a hundred ragged medical students into characters as divergent as Tweedle Dum and King Arthur.

The Pot Pourri opened with the Dressers' production. If an "Oscar" is to be awarded for the cleverest title one need look no further. "You're in for Culture" would take the first prize for publicity too, by dint of a large banner suspended above the "colostomy." The script seems to have been a communal effort as does the production although there is a fair degree of agreement that Chris Craggs shouted the loudest. Mike Brown played the piano and the high-spots were three virile Shakespearian witches, and three hirsute debutantes energetically treating Sullivan in a manner designed to win an approving smile from Gilbert.

This was followed by "Malice in Wonderland" produced by the Midder and Gynae Clerks. The costumes and musical arrangement were very good indeed and Wendy Donaldson, abducted from her rightful year by fair means or foul, made a charming Alice. Brian Richards besides arranging the music also sang to his own guitar accompaniment despite a sore and skinless thumb.

The peaceful tones of the pseudo-R.L.S. gave way to the gentlemen of Kids and Specials, determined to live up to the title "Pantomonium." Ingenuity is limitless. One moment we were faced with John Owens labelled R. Crusoe (dressed more like an affable polar bear) and singing a dirge about his blighted nauseating island in the sun, to be followed by the first of several angry

young men in turn succeeded by George Wills as Simple Simon, who did not seem angry at all. Robin Bonner-Morgan was responsible for the production and Don Lane sang lustily as well as playing the piano.

Another contrast followed in the shape of the MOPS and SOPS contribution "Not my Pigeon." As the title suggests the producer remains anonymous, but Janice Swallow, Ian Hamilton and Ken Bowles admitted to writing some of the songs. The show seemed rather preoccupied with nurses but two Red Indians did appear for relief. Probationer Nurse Swallow offered a short recital on the desirability of large rugger forwards which should put the 1st XV pack on its toes and three "deb's delights" added a few more tears to the flood caused by the demise of the debs. Thus the interval arrived and a parched audience swept like a cloud of locusts to the bar. The first half was too long.

After the interval the finalists burst upon the stage with vigour, eminently hummable tunes and a considerable amount of skill. Two of Searle's St. Trinian horrors played by John Bench and Paul Johnston stopped the show each night, whilst the idea of dressing the whole cast, excluding the three charming ladies, in "quite unmentionable, well cut vegetable sacks" was brilliant. John Bench wrote nearly all the songs, Dave Rowlands played the piano and Arthur Tabor produced, what must have a very strong claim to be the best show this year.

The clerks found themselves uncomfortably sandwiched between the two best shows of the evening. Their theme did not stray far from the Hospital as the title "1123 and All That," will reveal to the perceptive. They painted a picture of dissolute nurses and dissipated students following hard in the footsteps of Rahere. The producer was Paul Cassell and Daphne Humphreys played the piano.

Finally to the "House." With three experienced entertainers of the calibre of Nancy Watts, John Creightmore and Des Mulcahy, excellent costumes and uninhibited performances from the whole cast this could hardly fail to be a success. We were not to be disappointed. "Deadly Knightshade" bubbled along full of witty songs well performed and surely a fine model for any aspiring young producer. It would be iniquitous to select any particular part for special mention but one feels bound to single out the strongly moving finale saying farewell to the senior members of the staff who are leaving us this year. David Stainsby once more proved his virtuosity at the piano and John Creightmore is to be congratulated on producing such a splendid show.

As always after the final performance the cast adjourned for their party, success being ensured by a toxic punch, and to prove that they do not know when they have had enough the songs were all sung again but of course in a less formal manner.

ABERNETHIAN SOCIETY

JANUARY, 1958

Committee

President:—J. HEDLEY-WHYTE
Secretary: J. D. PARKES
Treasurer:—J. LLOYD-WILLIAMSON
Committee Members:—
J. PRICE, J. HAMILTON, M. BESSER
Ex-officio:—C. STEPHENSON
Pre-clinical Representative:—
Miss J. ANGELL JAMES

Meetings in February

Tuesday, February 4th:—"Liver damage and Personality Change." W. H. J. SUMMERSKILL, D.M., M.R.C.P.

Tuesday, February 11th:—Dr. E. F. SCOWEN, M.D., F.R.C.P.

Thursday, February 20th:—Clinico-Pathological Conference. Professor J. W. S. Blacklock in the Chair.
Students will present their analysis of cases.

SMOG

by R. E. WALLER

The study of atmospheric pollution at St. Bartholomew's Hospital is by no means an innovation. As long ago as 1881 W. J. Russell, who was Lecturer on Chemistry, began a study of this subject on behalf of the Meteorological Council[1] He designed his own apparatus and during the years 1883-1885 he made a number of experiments to determine the extent of atmospheric pollution at the hospital, St. John's Wood, and Hackney. Seventy years later the subject was again taken up here, this time on behalf of the Medical Research Council. Many factors had changed in the interval. Cars and buses were polluting the streets instead of horses, and new fuels such as oil, gas, and electricity had come into use for heating purposes, but the problem remained of similar magnitude. Despite the alleged passing of the London "pea-souper" we were strongly reminded of the harmful and even lethal effects of atmospheric pollution in the smog episode of December, 1952. In the 1880's coal fires were undoubtedly the largest source of atmospheric pollution in London, and they still are today, at least as far as black smoke is concerned. Great advances have been made in large scale heating and power installations and in all modern buildings these operate smokelessly, but relatively little change has taken place in small scale domestic heating. The advantages gained by the disappearance of coal fires in all but the living rooms of most homes have been offset by the increased number of houses built in and around London.

The differences between town and country fog are not generally appreciated. Country fogs consist simply of a suspension of water droplets in the air. On clear winter nights the ground cools rapidly by radiation, and the temperature in the lower atmosphere may fall sufficiently for water to condense out. In some conditions it does so in the form of droplets which are small enough to stay in suspension as fog. Each droplet forms round a minute nucleus of hygroscopic material, such as common salt. These nuclei are very numerous, and although many of them originate from the sea, they are to be found far inland. Droplets of this kind scatter light, therefore the fog appears white and it is difficult to see objects clearly through it. The formation of this type of fog depends on the existence of certain atmospheric conditions rather than on the presence of particular numbers of nuclei. Amongst other things, the wind must remain low for fog to persist.

Wet fogs occur in towns too; in heavily built up areas however the temperature is generally a little higher than in open country and often when there is fog in rural areas it may be absent in adjacent towns. Wet fog is in fact rare in Central London where the night temperature is often several degrees higher than in outlying districts, and in the City it has only persisted into daylight hours on three or four occasions during the past three years.

The haze, so often called "fog," which shrouds London on winter evenings is merely an accumulation of smoke and other pollutants, and its occurrence is unrelated to the formation of wet fog. Similar meteorological conditions are required for the accumulation of smoke as for the formation of fog, but the timing is different. Whenever the wind speed becomes negligible in London during the winter, smoke accumulates, but the maximum concentrations reached are related to the rate of emission of smoke. This is highest in the early morning and in the evening when coal fires are being freshly lit. Any smoke "fog" which collects under these conditions tends to disperse after midnight when fires die out. Wet fog is most likely to form in the middle of the night when temperatures fall to minimum values. In urban areas this may lead to periods of smoke "fog" during the daytime alternating with periods of wet fog at night. Sometimes these conditions overlap, but in Central London it is rare for wet fog to occur at times of maximum pollution, though such a coincidence may have been a special feature of the 1952 smog. When wet fog and smoke do occur together the smoke particles are in general separate from the fog droplets. The vast majority of smoke particles consist of aggregates of carbon and tarry hydrocarbons. They can be seen under the electron microscope as irregularly shaped particles having

diameters well under one micron. There may be as many as half a million of these particles per cubic centimetre of air at times of peak pollution. Their dull black surface makes them excellent absorbers of light, so that a high concentration during the daytime leads to semi-darkness and it becomes difficult to see objects more than 50 yards or so away. Visibility is however unlikely to be reduced as much by smoke alone as by wet fog.

It has been estimated[2] that about 1,000 tons of smoke are emitted daily into the atmosphere over Greater London in mid-winter. This is accompanied by some 2,000 tons of suplhur dioxide and although this gas has no material effect on visibility it accumulates when the air is calm and may reach levels at which its characteristic smell is noticeable. A small amount of sulphuric acid is also emitted and as this persists in the air as small droplets which scatter light, it contributes to the general reduction in visibility. Acid droplets can be detected by collecting samples on slides treated with indicators and examining them under the microscope. At all times there are just a few strongly acid droplets having diameters of the order of several microns and each of these contains a solid particle. In addition there are many acid droplets of sub-micron size. There may be as much as 0.2 milligrams of sulphuric acid per cubic metre of air at times of peak pollution which compares with a maximum of about 10 milligrams of black smoke per cubic metre of air. When wet fog is present some sulphur dioxide may dissolve in the water droplets, and it is possible that this is oxidised to sulphuric acid. If high pollution accompanied the wet fog the concentration of sulphuric acid might rise well beyond the figure quoted above, and this could have happened in the 1952 smog. Any effect of this kind would however be offset by the tendency for sulphuric acid droplets to absorb further water from the air and become large enough to fall out under gravity. This phenomenon has been demonstrated by placing indicator papers on the roof of the hospital at times when pollution is very high and the relative humidity is increasing; on several occasions a "shower" of acid droplets has been observed as fog formed or just before rain. This process may account for some of the corrosion which occurs on exposed stonework in the City.

Efforts are now being made in London and other large towns to prohibit the emission of black smoke and so remove the most frequent cause of visibility reduction. Black smoke is a sign of inefficient combustion and is avoidable. Combustion is much easier to control in large furnaces than in domestic fires and with mechanical stoking or careful hand firing it is possible to operate large furnaces smokelessly even on soft coal, but no amount of care will prevent smoke from domestic coal fires. The solution to this problem lies in the use of smokeless fuels such as coke or anthracite. The City has already been declared a smokeless zone, and the small percentage of domestic premises within it made this a relatively easy task. As it is surrounded by several hundred square miles of residential area, the benefits are however not immediately apparent. In ordinary atmospheric conditions smoke from other parts is always blowing over the City, but when there is absolutely no wind the differences are remarkable. On two occasions during recent years (4th January, 1956, and 3rd December, 1957) a great "wall" of smoke has built up in residential areas around the City whilst within it the air has remained clear for several hours. Ultimately, the smoke has drifted in, but observations of this kind illustrate the value of smokeless zones if extended over a wide enough area. At the same time it should however be pointed out that "invisible" pollutants such as sulphur dioxide are unlikely to be decreased in smokeless zones, since most alternative fuels contain as much sulphur as does coal. Fuel oil contains considerably more sulphur and the net result might be a slight increase in the concentration of sulphur dioxide in some areas. This may also be accompanied by an increase in the sulphuric acid content of the air. It is not yet clear whether smoke, sulphur dioxide, sulphuric acid or some other pollutant is responsible for the acute effects on health observed at times of high pollution, but each of these substances can act as an irritant if the concentration is high enough. While there must still be some reasonable doubt that all health problems will be solved by the setting up of smokeless zones, few would deny that the abolition of smoke is a valuable step in the fight against the evil of air pollution.

REFERENCES

1 William James Russell (1830-1909) and *Investigations on London Fog*
John R. Brown and John L. Thornton, *Annals of Science, 11* 331. (1955)

2 Know your fog. A. R. Meetham, *Weather, 10* 103. (1955)

MISS A. E. TURNER

ex-SISTER F.F.1

Miss A. E. Turner, who recently retired from her post as Sister to the Orthopaedic Department, had the unique honour of being the first Sister in charge of the Orthopaedic ward of this hospital.

Since the time of Percival Pott, Bart's can claim a long line of General Surgeon's interested in skeletal surgery, culminating in Howard Marsh and Gordon Watson. When Miss Turner entered St. Bartholomew's Hospital in 1924 as a junior nurse, she worked on Sir Charles Gordon Watson's wards; this may well have influenced her future choice of work.

In 1929 she was appointed Night Sister and later, when a ward was allotted to the Orthopaedic Department, she was first appointed nurse in charge as a "Pink", later becoming Sister Kenton. This ward was also unique as the back ward housed women, the front ward men with children's beds in both sides. The majority of the work was concerned with deformities and diseases of the bones and joints. Fractures were still treated by the general surgeons.

Although a small department, it flourished and many famous Orthopaedic Surgeons of today received their training there.

I think of Miss Turner as one of the "old school", and I do so with respect and pride as will all those who have worked with her. One certainly "worked with" Miss Turner. She welded together all members of the "House"—she never called it the ward—as a team working for the welfare of the patients. She was of the era when nursing care was the essential part of the treatment of so many diseases and making a patient comfortable when encased in plaster or suspended from one bit of Orthopaedic gadgetry to another, was a difficult everyday nursing problem which Miss Turner was never weary of tackling and solving.

Students do not usually hold an In-patient appointment in Orthopaedics, but the Orthopaedic ward was well patronised by the hospital's sportsmen, especially the Rugby teams with their injured joints and fractures, and it was in this way that many of us first met Miss Turner and learned to appreciate her kindness and that of her staff.

For many years she attended and assisted at almost all operations on her patients, but as her duties became more onerous and Orthopaedic surgery expanded, as it did with the outbreak of the last war, she was unwillingly forced to curtail this interest.

At the beginning of the last war, Miss Turner moved with her "House" to St. Albans and became Sister in charge of the main male Orthopaedic ward, F.F.1, at Hill End. This ward of 70 beds was usually fully occupied by soldiers from Dunkirk, by airmen from the Battle of Britain, or by air-raid casualties from the London bombing raids, and Miss Turner's "House" became a hive of Orthopaedic industry demanding long hours and constant vigilance. At this stage Orthopaedics had embraced the large-scale treatment of fractures and emerged as that part of general surgery responsible for the skeletal system.

During her time at Bart's, Miss Turner saw the establishment of Orthopaedic Surgery as a speciality and in this development she played an important part. As I write this, I am aware that she will certainly disagree with me if she suspects that I am placing her in the limelight. Nevertheless, all of us who were privileged to have worked with her are greatly in her debt and wish her a long and happy retirement in her beautiful country home. A larger band of people will also remember her with gratitude and affection. They were the most important people in the world to her because they were her patients.

G.J.H.

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WESTWARD HO—THE WAGON

by R. C. KING

When I discussed, with the late Professor Hopwood, the potentialities of a visit to the United States, he made the remark that such an event would, in all probability, rank as one of the more notable occasions in my life, adding, "but if you go without your family you will be making one of your greatest mistakes." He was of course, quite right, but it was nonetheless, with a certain amount of trepidation that we set out with three small children on the 3,600 mile journey from London for a year's stay in Ann Arbor. The ocean crossing itself was pleasant enough, but the "Mauretania" docked in New York a few hours after the survivors of the "Andrea Doria" had been landed and the resultant chaos no doubt accounted in large part for our initial unfavourable impressions. In the midst of a raging thunderstorm we were among the last to leave the ship. The temperature was 96° F and the customs authorities proceeded to open each and every article of our carefully corded luggage. To add to our troubles the travel agency did not fulfil its promise of dealing with our trunks and their representative, who should have met us with our rail tickets had returned to his office. However, the expenditure of the first of our precious dollars on the purchase of iced drinks and American flags for the junior members of the party had a remarkable effect on morale and despite some initial confusion we arrived at the New York Central Railroad Station in time to catch "The Wolverine" to Ann Arbor.

The size of the country together with the relatively small population and the high tempo of living combine to account for many of the differences which impress the visitor to the "States." Americans work hard and play hard, and travel long distances in the interests of both. Air travel is therefore a necessity, trains are equipped for greater comfort over longer distances and both cars and roads are built for speed. Turnpikes and express ways employ every known device to hurry the traffic along and it is now possible to drive from Chicago to New York (a distance of 850 miles) without encountering a single traffic light. (A friend of mine was pursued by the Police for 110 miles along such a road before the patrol car could succeed in passing him.) Road-side services are geared to the needs of the impatient motorist and there are drive-in restaurants, banks, and cinemas, where one can have a meal, cash a cheque or watch a film without leaving the car. In Wyoming we even saw a drive-in Church. Gas stations are models of efficiency, tipping is unknown, and the low price of petrol is accentuated by the "gas war" at present in progress between the larger petroleum companies. The cars themselves are beautifully made, comparatively cheap and stand up well to the rough handling they receive. Although the casualty rates on the road are enormous, the standard of driving is high. Two major factors contributing to the annual total of 40,000 deaths are excessive speeding and driving under the influence of alcohol, while the comparative youth of many of the drivers must also be of some relevance. In many states the minimum age at which driving is permitted is 15—16 years, and in Florida and South Carolina it is as low as fourteen. Many other everyday features reflect the higher speed of living and the sparsity of the population. Super Markets have replaced the traditional grocer's store; greengrocers, fishmongers and bakers shops are rarely seen whilst the majority of the food is canned, frozen, or wrapped. Large shopping centres sited on the outskirts of residential communities abolish parking problems and make it possible to do all the family shopping in the course of one expedition. There is less tendency for the population to be grouped round commercial centres, straggling ribbon development is the rule and the towns and villages by and large lack the compactness and character of their English counterparts. The political and judicial structures appear less stable and more corruptible than in this country while it is easy to appreciate the admiration evoked in the foreign visitor by the British Police Force.

Two of the most frequently asked questions since our return have concerned family and finance. In particular how did the children react to America and how much money did we spend. The Fulbright authorities very rightly advised that at least 4,200 dollars would be necessary for the maintenance of a family of five over a twelve month period. In fact we spent exactly 5,000 dollars during a thirteen month stay. One fifth of this was contributed by my wife who worked for two six hour evening periods each week as a registered nurse in a local private hospital. In order that she could work it was essential that she should go on her own immigrant visa rather than as an exchange visitor, and the initial cost of such a visa (26 dollars) in this country was amply repaid. The cost of living was definitely higher than in England, but not to the expected extent, despite the fact that Ann Arbor is reputed to be the most expensive town in the United States. Details of our expenditure are given below:

26.7.56 to 24.8.57

	Dollars
Rent (including lighting and heating) ...	1270
House Keeping	1120
Milk	200
Car	705
Health Insurance (Blue Cross) ...	111
Telephone	70
Capital expenditure	1000
Miscellaneous	524
Total	5000

Most of the items are self explanatory. The Blue Cross subscription insured against hospitalization costs but did not cover either Doctors or Dentists fees. The seventy dollars expended on the telephone included the cost of a call from Ann Arbor to Pembroke (sixteen dollars) which incidentally was put through without any prior notice and within fifteen minutes of first being requested. Capital expenditure covered such items as clothes, household articles, camping equipment etc., and was somewhat heavier than had been anticipated. The temperature in Michigan varies from sub-zero in the winter to 90—100° F in the summer and we had to purchase rather more clothes for the children than had been expected. We had very few luxuries and would, I am sure, have been most unhappy with less than 5,000 dollars. The University Apartment was new and comfortably furnished and its situation, three miles outside Ann Arbor made a car a necessity. For 450 dollars we bought a 1952 six cylinder Chevrolet and twelve months and twelve thousand miles later it was sold to a fellow Englishman for 275 dollars. This loss of 175 dollars is included in the total expense of the car given above, other items being 64 dollars for insurance, 166 dollars for maintenance and 300 dollars for gas and oil. A day spent in Detroit touring the second hand car lots was a most entertaining experience. Such statements as "I don't care if I don't make any money on the deal as long as I make a friend" or "This belonged to an elderly widow who only drove it on very fine days", etc., etc., became very familiar. We eventually decided that it was safer to buy either from a genuine owner-driver or from a local garage proprictor with some reputation attached to the car.

America made little impression on Susan aged five months, despite the fact that her first spoken word was "Hi!". She slept in car, train or boat with equal indifference and was remarkedly tolerant of the many changes of scene. The boys aged six and four enjoyed every moment of their travels. The "Mauretania" was completely safe as far as they were concerned, although the boat deck of the "Saxonia," on which we returned, was a source of some anxiety until the rule was established that when standing by the rail both feet should be firmly planted on the deck. They went "trick and treat" at Hallow'een, skated and tobogganed in the winter and caught pollywogs in the spring, while the spacious North Campus of the University provided a wonderful playground in the summer. Christopher attended a local infant school which was like all American Schools, free, but he unfortunately repeated his previous year's work in England, as the commencing school age is six. His accent and clothes initially singled him out as an English boy, but both soon underwent a remarkable change and by the time he requested that his last course at breakfast should be a vitamin tablet we realized that the metamorphosis was complete. Both he and David attended Sunday school which was very sensibly arranged to take place at the same time as morning service. A babies' crêche completed the facilities to ensure that the whole family could attend Church together. The standard of schools varies from place to place but we were certainly fortunate in Ann Arbor. I was very amused at a question asked by a ten year old girl in Detroit after I had given her class a short

talk on "England." She said "Would you mind saying a few words in your own language?"

This is not quite as amusing as it sounds, because surprisingly enough, there is a remarkable difference both in actual vocabulary and the usage of words common to both languages. In the world of clothes for instance, braces become suspenders, waistcoat becomes vest, trousers pants, and a bowler hat a derby. Around the house the ground floor is called the first floor, the settee the davenport while the verandah is the porch and the toilet is variously known as the biffy,

The Campus in Winter

biffer or john (There is a society in New York which has as its members men with the Christian (given) name of John, whose aim in life is to prevent the use of their name for such a lowly purpose). In the car the bonnet becomes the hood, the boot the trunk, the silencer the muffler and the exhaust pipe the tail pipe. A saloon is called a sedan while on the road the tarmac is the pavement and the pavement the sidewalk. Even the baby may be confused for her pram is called a buggy, her push chair a stroller, her cradle a bassinet while her dummy (which heaven forbid she should use) a "Pacifier." To gumshoe means to creep, ornery means awkward, while presently means at the moment. With very little effort we were able to compile a list of 400 words in common use in the States which are either spoken with a different meaning or not used at all in this country. Small wonder that Anglo-American relations become at times a little strained—we often don't speak the same language.

No visit to America would be complete without a "trip out West". We were fortunate in having enough time and money for such a purpose and in early June we set out with a car load of children and equipment for the Rockies. Two days spent on the sandy shores of Lake Michigan enabled us to perfect our camp drill and we then moved on by boat 80 miles across the lake to Milwaukee. In Wisconsin we camped at Devil's Lake, an old volcanic crater, and from there visited The Dells, a 12½ mile rocky gorge with towering sandstone cliffs and fantastic rock formations, through which flows the Wisconsin River. We crossed the Mississippi into Minnesota and the Sioux River into South Dakota, the capital of which, Sioux Falls, has a modest population of 52,000 and yet is the largest town in five neighbouring sttates which together cover an area of 476,000 square miles. Such is the vastness of the West. Between the White and Cheyenne Rivers in South Dakota lies one of the most spectacular examples of weathering and erosion in the world — the Badlands. An area of 123,000 acres characterized by irregular ravines and fantastic ridges, it derives its name from the security it once provided for the outlaws of bygone days.

Travelling further west it was but a few hours drive to the Black Hills — yesterday's land of buffalo and boom town, cattle drives and rustlers, Hickock, Custer and Indian Wars. It was here that America's last gold rush wrote a chapter of recent Western history studded with names like Wild Bill, Calamity Jane, Deadwood Dick and Potatoe Creek Johnny. It was here, too, that we visited the Shrine of Democracy — the Mount Rushmore National Memorial, where the carved heads of Washington, Jefferson, Lincoln and Roosevelt rise to a height of 70 feet as a tribute to the conception and preservation of individual American freedom. The largest remaining herd of American bison roams the Custer State Park through which passed en route to the Big Horns, the first real Rocky Mountain Range. On through Powder River Pass and Ten Sleep Canyon to Cody, Buffalo Bill's own town and so to the last lap of our journey over the Buffalo Bill Highway, "the most scenic 50 miles in the world," we came to the Eastern Entrance of Yellowstone Park—1,853 miles and eight days from Ann Arbor.

Yellowstone, established by Act of Congress in 1872, is one of the 29 National Parks administered by the Government for the purpose of conserving the scenery, the national and historic objects and the wild life. In 1955, 1,368,515 tourists visited its 3,471 square miles. Elevations ranged from 5,000 to 11,360 feet and the nights are always cold. The natural features include over 200 geysers, hot pools, and terraces, canyons and water falls and large numbers of wild animals such as bison, moose, wapiti, deer, prong horns, big horns, grizzly and black bears. While we were there we forsook our tents for log cabins and very glad we were that we had done so when, lying in bed at night, we heard the coyotes howling in the distance and the bears muzzling round the cabin doors. Best known of the geysers is Old Faithful, which derives its name from its regular eruptions approximately every 64 minutes. After premonitary cannonading between 10,000 and 12,000 gallons of boiling water are discharged 180 feet into the air, while clouds of steam rise to 1,000 feet or more. A most amazing sight. Another remarkable feature of the park is the Grand Canyon of the Yellowstone River, 24 miles in length and 800 to 1,200 feet in depth. It is the predominant yellow colour of the gorge which is thought to have been responsible for the name of the river and the 308 feet high Lower Falls seen against such a background provide one of the most colourful scenes in existence. We stayed five days in Yellowstone. We would have stayed five weeks, but reluctantly we turned south and followed the Snake River to the Teton range and Jackson Hole country which, together form a landscape of matchless grandeur and beauty, said to be unlike any other in America. There was a blueness about the snow-capped mountains such as we had not seen before, while the valleys below were carpeted with wild buckwheat, yellow bells, balsam root and larkspur—it was springtime in the Rockies. Once again, however, Old Father Time grew impatient and we moved further South to the Mormon country of Utah and Salt Lake City. After the coolness of the mountains the heat of the valley was unbearable, but true to tourist tradition we bathed in the Great Salt Lake with its 28% salt content. Paying a quick visit to the Mormon's Temple Square we then moved East over barren semi-desert country where the water courses had long since dried out and where the only vegetation was sagebrush, greasewood, salt bush and juniper. A night's stop at the Dinosaur National Park and then on into Colorado, the mountain State of the Union, where 52 of the country's 64 named peaks, with elevations of over 14,000 feet, are to be found and where the road itself ascends to a height of over 12,000 feet and runs for more than 15 miles above timber line. Trail Ridge road crosses the Continental Divide twice on its way through the Rocky Mountain National Park and spectacular panoramas of majestic peaks and awe-inspiring canyons extend in every direction. Reluctantly we left the Rockies through Estes Park and Big Thompson Canyon and set out on the long trek back across the plain states. By contrast, Eastern Colorado, Nebraska and Iowa were flat and uninteresting, while Illinois and Indiana were but little better. And so back to Michigan, the Water Wonderland with its 11,000 lakes to Ann Arbor and home. In 29 days we had travelled 4,734 miles and visited 13 states. We had gone from sea level to 12,000 feet and back, we had camped in temperatures ranging from 30° to 104° F. In short, we had had a wonderful holiday and the cost—just 340 dollars.

Although Mr. Rupert Corbett has described in detail in a previous issue of the *Journal* (April, 1956) the organisation of the University Hospital, the reader may well be asking, "But why no mention of American medicine. Was he not impressed?" Of course I was more than impressed by much that I saw and I had the good fortune to spend a year with Dr. Marvin Pollard in what must be one of the most progressive gastro-enterological units in the world. Differences there must be between British and American medicine, differences which result in the main from a more stable financial background and the more positive attitude of the average American citizen towards health and disease. Adequate funds allow for the organisation of comprehensive research programmes, specialisation is the rule, while every form of investigation and treatment is readily available—at a price. "Fight Cancer with a Check-up and a Cheque" is a popular American Cancer Society slogan, and the response is such that large-scale screening projects have been established (particularly in relation to cancer of the uterus) to the mutual benefit of the general public and medical research. Some degree of morbid anxiety must inevitably result from such campaigns, but as a general rule the public are merely health conscious rather than hypochondriacal, cancer conscious rather than cancerophobic. Naturally the advantages of the Welfare State are missed, and to the poor and uninsured the threat of ill-health is a constant dread. Illness can be an expensive experience with hospital beds costing 20-25 dollars a day, and blood at 25 dollars a bottle, but in a country where the average factory worker earns £26 a week it seems only right that the cost of medical services should be in proportion.

We journeyed to America with three small English children; we returned with three Americans, complete with Davy Crockett suits and genuine frontier accents. It was a successful family venture, and to those who say "Was it worth it?" the answer is an unqualified "Yes". To those who say "Would you like to stay there?" the answer is "No, not yet". We enjoyed America, the people, the country and the medicine, but we were not unhappy at the thought of returning home again to England.

* * *

A CHAPTER OF INCIDENTS

by T. C. LITTLER-JONES

Nearly 60 years ago whilst on duty as House Surgeon I admitted to the out-patient department an old lady who was obviously a tramp. This lady was very ill and on examination proved to have a very bad throat which was causing much distress. Before she could be admitted to a ward she collapsed and died.

Two days later I had a very sore throat and immediately sent a swab to the Path. Lab. and awaited their report. As luck would have it on that very day the pathologist was struck down with influenza and the slide was never made. At tea time of the same day a doctor colleague of mine suggested that a weekend in the country at his father's house at Barnes might set me once more on my feet. I accepted the invitation gladly and we both set off to Barnes. However at 1 a.m. on the following morning I was finding breathing increasingly difficult and became very frightened.

The local physician was then called and he very indignant at the late hour poohpoohed the whole thing saying it was only a "hospital throat" and would recover with gargling.

By 1.30 a.m. I was really terrified and begged to be taken back to Bart's and hence a brougham was sent for, to arrive 45 mins. later. The jarvey kept to the South Bank of the Thames for most of the way, crossed over Westminster Bridge and along the Embankment. On reaching Ludgate Circus the jarvey announced that the horse was done for which was not surprising since it had travelled 11 miles from Barnes without any respite, I meanwhile was hanging from the brougham window struggling for my breath and dribbling copiously.

The jarvey led the horse up Ludgate Hill whilst my friend and a Peeler who had been impressed with the urgency of the case pushed the brougham from behind. Round the corner by Hope Brothers and along Old Bailey wound this strange procession, over Holborn and on till the gates of Bart's were reached.

As we crossed the square Laidlaw Maxwell was sent for and all preparations were made for an emergency tracheotomy. My friend laid me on a bench seized a paraffin lamp and the operation commenced. It was here that my friend disgraced himself for the first and only time when he fainted as I was opened up and the lamp crashed to the floor.

Owing to the time and haste in which the operation was performed no proper tracheotomy tube was available so a makeshift rubber tube was used. This tube was the cause of 60 years of inconvenience since the rubber scarred the epithelial lining of my trachea giving rise to endless throat troubles. This however was a small price to pay for my life since I had literally stopped breathing when laid on the bench and death was not far off.

Nor was I the only one more dead than alive since my friend, the jarvey, and the horse were dropping with exhaustion following their frantic efforts of the night.

Some weeks later the toxic side effects of the Corynebacterium diphtheriae began to become apparent, my heart began to race, I was unable to focus properly and I became paralysed from the waist down. In consequence I was ordered to the Channel Isles where the atmosphere is supposed to be more suitable for invalids and tickets were booked on the first daylight trip of the S.S. Stella which was some weeks ahead. I soon tired of waiting and persuaded my doctor to change the passage to one a week sooner and by night. The S.S. Stella sank on her first daylight trip that year and many people lost their lives; I had escaped a premature end for the second time in a few months.

This was not the only occasion that the sea nearly claimed me for its own for many years later it tried again. At this time I was a surgeon in the R.N.V.R. and appointed to the Hospital Ship Rohilla and late in 1915 we were steaming towards Zeebruge at 5.0 a.m. when we were struck by a terrific gale. After some hours we were blown onto a very rocky shore and the ship broke in two. At this time I was lying on my berth trying to get some rest dressed only in a very short shirt. Suddenly the berth above me fell down pinning me in a cage and all the lights went out. Eventually I managed to escape but in doing so dislocated a tendon at the back of my heel, the flexor hallucis longus, and also cut my bare feet severely on the broken glass.

After much delay I with three naval nurses was taken off in a very small rowing boat still dressed only in my shirt. On reaching the shore we discovered that we were aground off Whitby Head and I discovered a link with Bart's of today. One gentleman who was at the scene of operations offered me the loan of a suit of clothes which I gratefully accepted. I met his son in the square at Bart's some 40 years later whom I discovered was now Senior Surgeon to the Hospital and who was then but a student. It was Mr. Hume's father who lent me the suit.

Now after a long and I hope useful life as a surgeon I have once more retired to the Channel Isles to spend the rest of the time I borrowed on that first occasion 60 years ago in the 'atmosphere so suitable for invalids'.

A CASE OF LYMPHOGRANULOMA VENEREUM

by M. W. SLEIGHT

Lymphogranuloma venereum is becoming common in this country on account of the large number of immigrants, chiefly from the West Indies, where it is endemic. In the case described below, the patient presented with a swinging pyrexia and leucopenia as is seen in typhoid fever. In a review of the disease, such a presentation is not described by Rajam and Rangiah, though it is mentioned by Topley and Wilson, and also by Horder, who states that it is more commonly seen in infections by the associated virus Psittacosis.

Case History

The patient was a Jamaican, aged 44, who had been in England for four years. He presented with a temperature of 104° F., and a four-day history of headaches and abdominal pain. He had been seen two days previously when he was not so ill and the temperature was 100° F.

The headaches were severe, constant, and situated in the frontal region. There was no photophobia or visual disturbance. The abdominal pain was moderately severe, colicky in character and was centered on the umbilicus, radiating to both hypochondria and the suprapubic region. It was associated with excruciating pain in the testes. The patient had been constipated since the onset of his symptoms, though the bowels had been quite regular beforehand. The pain was only relieved by eructation.

In the systematic history, there were no abnormal symptoms. In particular, he had had no urinary symptoms and no urethral discharge.

He had been treated three times in the past for gonorrhoea and at the time was having treatment for syphilis. In addition, there was a possible past history of malaria.

On admission T.P.R. was 104° : 88 : 22. There was tenderness in the right hypochondrium and supra-pubic region. There were no localising signs. The blood count on admission was:—

Hb. 107%. White cell count 2,200. Polys. 77%. Lymphs 24%. Monos 3%. Eos. 1%. E.S.R. 22mm. per hr.

As can be seen in fig. 1, the temperature was hectic and intermittent. Two days after admission, there was a slight generalised lymphadenopathy, rather more marked in the inguinal region. A possible scar was noted in the right groin.

Though there was no neck rigidity initially, slight resistance to neck flexion developed after about a week.

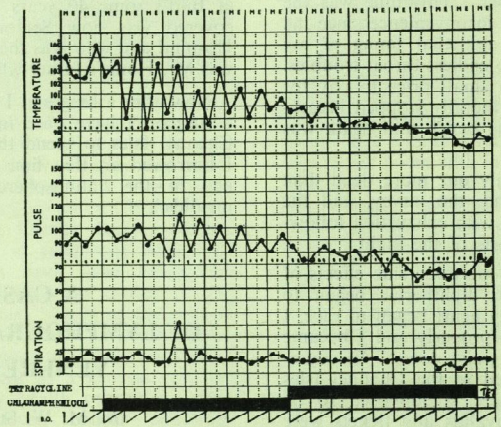

Fig. 1

The differential diagnosis at this stage included malaria, amoebiasis, typhoid fever, and the Venereal Diseases. A test of quinine was negative, the Widal and W.R. reactions were negative. No cysts or amoebae were found in the stools. However, the Frei test and L.G.V. complement fixation reaction were both positive: the latter to a titre of 1:64. Proctoscopy revealed pus on the rectual mucosa which contained many leucocytes on microscopy.

On the third day he was given an empirical course of chloramphenical, during which the temperature began to subside over a period of about one week. After L.G.V. had been diagnosed, this was changed to tetracycline.

Discussion

Usually L.G.V. runs a course in three stages. It begins with a lesion on the genitalia, though it is often so mild as to pass unnoticed. About a week later a mild pyrexia develops with swollen inguinal glands which suppurate and may break down. Later, fibrosis occurs and strictures form, e.g., in the rectum, and elephantiasis develops in those areas drained by the affected lymph glands.

However, instead of a mild pyrexia, a severe systemic reaction may develop in the second stage, as in the case described, and L.G.V. must be considered in the differential diagnosis of such a P.U.O.

Summary

A case of Lymphogranuloma Venereum is described exhibiting a typhoid state. Diagnosis was based on a positive Frei test, a positive L.G.V. complement fixation reaction, and the demonstration of pus cells on the rectal mucosa.

I would like to record my gratitude to Dr. N. G. Hulbert for his help and encouragement in the preparation of this article, and for his permission to publish the case.

A TRANSLATION OF DE CIRCULATIONE SANGUINIS

by K. J. FRANKLIN

At the suggestion of the Editor of the *British Medical Journal* and of others (1-3), and with the goodwill of my colleagues in our Department of Physiology, I have since summer, 1957, set out to re-translate into English the two anatomical essays addressed by Harvey in 1649 to John Riolan, Jr., Professor of Anatomy and Dean in the University of Paris. The two essays are often called *De circulatione sanguinis*. I have also re-translated the series of letters printed in Harvey's *Opera omnia*, 1766. As these new versions will appear before long from the press which published the similar version of *Exercitatio anatomica de motu cordis et sanguinis in animalibus*, 1628, all Harvey's circulatory writings will henceforth be available in comparable *format*, and simultaneously in both languages, and it is my hope that these new books may prove of service to Harvey's memory and to the advancement of his science of physiology.

My translation of *De motu cordis* last year owed much to being accompanied in publication by the colour reproduction of the Royal College of Physicians' oil painting of Harvey. The generosity of Professor John F. Fulton, F.R.C.P., made the illustration possible, and the College subvented the book's appearance. To both parties my publishers and I are greatly indebted.

The illustration which I have chosen for the present paper seems to me to suggest, with an elegance which Harvey himself would have appreciated, that gentleman's links with the court, art and science. It is a reproduction of an oil-painting by William Dobson (1610-1646) of Charles, Prince of Wales, at the age of 12, and it was painted to the order of King Charles I and presented to Harvey, in whose and whose family's possession it remained a long time before it eventually started on its way to the National Portrait Gallery of Scotland, where now it is.

Physiology was considerably advanced in pre-Harveian days by Galen (A.D. 130 to *c.* 200) and by Vesal (1514-1564), but could not really prosper before the recognition of the blood movement and the acceptance of recourse to properly conducted experiment as the proper criterion of the science; it also had to wait upon adequate advances in anatomical knowledge and nomenclature. Its emergence was therefore slow, and I am personally unable to understand the attraction Jean Fernel (1497-1558) had for the late Sir Charles Sherrington. For Fernel was a leading physician, imbued with the scholarship of the renaissance but lacking the experimental method, and being therefore a very good example of those against whom Harvey had all his life to contend.

In 1544 Fernel's book, *De naturali parte medicinae Libri septem*, reappeared in revised and modified form as the first of the three parts of his *Medicine*, and with its title changed to *Physiologia*. The natural part of medicine included anatomy, which was to physiology as geography was to history, i.e., it described the theatre in which the action took place. The subsequent section on physiology was little influenced by its anatomical prelude, and Fernel stated that one passed from what one could see and feel to what was known only by meditation. The result was the second separate treatise on physiology to appear (the first being Galen's *De usu partium*), but it is of no particular interest, and Charles Singer calls *Ars medica, succincte et perspicue explicata*, second edition Hamburg, 1617, "the first formal treatise using the word Physiology in the modern sense" (note by Professor Singer in copy presented by him to the present writer). The second book in it is entitled "De physiologia", and the author was Duncan Liddel (1561-1613) of Aberdeen. His words are, however, of small import beside those written in 1649 in the first of Harvey's two essays to Riolan, which included the following passage. "The contemplation of those things which are normal is physiology, and it is the first thing to be learned by medical men. For that which is normal is right and serves as a criterion for both itself and the abnormal. By defining in its light departures from it and unnatural reactions, pathology becomes more clearly obvious for the future, and from pathology the practice and art of therapeusis, and opportunities for discovering multiple new remedies, derive". It was, indeed, this passage which decided me that I ought to continue translating Harvey's *De circulatione sanguinis*, and so led to the book which I have in hand.

Jean Riolan had been born in Paris in 1577 and had published a number of works in the early part of the century and in 1618. In 1613 he was appointed Regius Professor of Anatomy and of Botany, and later he became Chief Physician to Queen Marie de Medicis, a post he retained to her death. He went with her on her journeys and was in England for several years, thereby presumably getting opportunities of meeting Harvey and seeing his experiments. He died on February 19th, 1657, aged 77. His *Encheiridium anatomicum et pathologicum*, 1649, to which Harvey replied by the two essays, is an elegant little work which, however, was too bound up with traditional medicine to be able to please the discoverer of the circulation, who wrote "For the rest, Riolan, I congratulate both myself and yourself, myself because of the significance with which you have invested the circulation, yourself on a learned, polished and concise book of unsurpassed elegance, for the gift of which to me I thank you most fully, the deserved praises of which I both should and would like to recount; I confess, however, that I am unequal to so great a task".

The second essay by Harvey, "in which many objections to the circuit of the blood are refuted", says that "It is now many [*i.e.*, 21] years ago, learned Riolan, since with the assistance of the press I published a part of my work. Since that birthday of the circuit of the blood there has of a truth been scarcely a day, or even the smallest interval of time passing, in which I have not heard both good and ill report of the circulation which I discovered. Some tear the as yet tender infant to bits with their wranglings, as undeserving of birth: others by contrast consider that the offspring ought to be nurtured, and cherish it and protect it by their writings. The former oppose it with strong dislike, the latter defend it vociferously. These think that by means of experiments, observations, and my own visual experiments I have established the circuit of the blood against the whole strength and force of arguments; the others that it is scarcely as yet sufficiently elucidated, and not yet freed from objections. There are moreover those who cry out that I have striven after the empty glory of vivisections, and they disparage and ridicule with childish levity the frogs, snakes, flies, and other lower animals which I have brought on to my stage. Nor do they abstain from scurrilous language".

"To return scurrility with scurrility, however", went on Harvey, "I judge unworthy in a philosopher and searcher after truth. I think it will be better and wiser to tone down these many indications of bad manners by the light of true and trustworthy indications. It is unavoidable that dogs bark and vomit their surfeit, or cynics are numbered among the assembled philosophers, but one must take care that they do not bite, or kill with their savage madness, or gnaw with a canine tooth the very bones and foundations of

truth. While I resolved with myself that censurers, mummers, and stain-defiled writers of disapprobations should never be read (as being men from who nothing sound or remarkable except scurrility was to be expected), I judged them even less worthy of answer. Let them enjoy their evil nature: I think they will scarcely ever have well-disposed readers: and the good God does not give to the wicked that which is most outstanding and most to be desired, namely, wisdom. Let them continue", he concluded, "with their scurrility until it irks if it does not shame them, and finally tires them out".

Fig. 2

After many pages of addition to the circulatory knowledge adduced in his 1628 book, Harvey went on to describe very succinctly some of the variations observed. "For what is more remarkable than the way in which our body reacts differently in every affection, appetite, hope, or fear, and the countenance itself changes, and the blood appears to be escaping hither or thither? The eyes redden with anger and the pupil is constricted. In bashfulness, the cheeks are lavish with blushes; in fear, disgrace, and shame, the face is pale but the ears are red as if about to hear ill; in adolescents touched with desire, how quickly is the penis filled with blood, erected and extended? But what is most worthy of observation by physicians and most useful, why do blood-letting and the exhibition of cupping-glasses, and compression and artificial constriction of the artery taking the blood-flow to a part (especially while the change is actually being made) assuage and remove all pain as by a charm?".

The letters are as follows. First, a short one written to Caspar Hoffmann in 1636 and published at Nuremberg. Hoffmann had been born in that city in 1572, and after studying medicine in Leipzig in 1592 and Strassburg in 1594, had gone with a grant from Altdorf to Padua to work there under Girolamo Fabrizi of Acquapendente. From Padua he had gone on to Basel, where he had taken his Doctorate in 1605. He had returned to Germany in the next year, and in due course had become Professor of Medicine in Altdorf, where he died on November 3rd, 1648, after being paralysed for some years. He was a marked devotee of traditional medicine and opposed modern views, including those of

Harvey, who was with Lord Arundel's embassy in Nuremberg in 1636, and wrote to Hoffmann offering a demonstration. This was probably given on November 12th or 13th, and traditionally convinced all except Hoffmann, who went on offering objections until Harvey at length threw down his scalpel and walked out of the theatre. The letter shows well Harvey's marked capacity to combine frank statement with gentleness of manners. " If, however, you are unwilling for that, and also averse to deciding for yourself by means of dissections, at least, I adjure you, refrain from despising the industry of others or turning it into a fault, and do not refuse to trust an honest man, who is also not unskilled or mentally deranged, in respect of something which he has tested so often over so many years ".

The other letters from Harvey number eight, and range in time from 1651 to 1657; they also vary considerably in interest. The first was to Paul Marquand Schlegel of Hamburg; the second, fourth and seventh were to Dr. Giovanni Nardi, of Florence; the third to Dr. Robert Morison, of Paris; the fifth and sixth to Johann Daniel Horst, Chief Physician of Hesse-Darmstadt; and the eighth was to Jan Vlackveld, of Haarlem. Schlegel had been born in Hamburg in 1605, and had later taken up science and medicine against the wishes of his father, a prosperous local merchant. In 1631 he had undertaken a scientific journey which, in the event, lasted for some years, and during it he visited Holland, England, France and Italy. He graduated in 1636 and returned to Germany, where he became Professor of Botany, Anatomy and Surgery in Jena. He died in 1653. Dr. Giovanni Nardi was a Florentine medical and literary friend of Harvey. Robert Morison (1620-1683) was M.A., Ph.D.(Aberdeen) at 20 but, after bearing arms in the royalist cause, went to Paris and later became a physician and botanist and got to know Charles II, whom he accompanied to England at the Restoration, and by whom he was appointed his senior physician, King's Botanist, and superintendent of all the royal gardens. The rest of his career was botanical and medical, in Oxford. Johann Daniel Horst was born at Giessen in 1616 and he became Professor and Court Physician there in 1637: he died in 1685. Jan Vlackveld was a physician who lived in Haarlem in the middle of the seventeenth century.

A considerable amount of extra evidence about the circulation is contained in the letters, and indeed a Librarian friend thinks that in some ways they are more like personal tutorials about special points, they and the two anatomical essays forming in that way a remarkable addition to *De motu cordis*.

We are sometimes apt to forget that Harvey was fifty years old when he produced this book on the movement of the heart and blood, and that he had had a strenuous time over many years fighting for the acceptance of the ideas which he had promulgated. In his 1653 letter he told Nardi that there was no need for him to plead advancing years, for he (*i.e.*, Harvey) was himself almost eighty and his physical powers tottering. In his January, 1654-5, letter to Horst, Harvey said that to look at small vessels he needed two things he no longer possessed, namely, sharp-sighted eyes and a mind free from other cares. In his July 13th, 1655, letter to the same scientist, he wrote, " My now too long a tale of years causes me to repress from sheer weariness any desire to explore new subtleties, and after long labours my mind is too fond of peace and quiet to let myself become too deeply involved in an arduous discussion of recent discoveries ". His letter of October, 1655, to Nardi, spoke of enlivening his rather inactive old age, and his spirit which scorned everyday trifles, by good light literature such as Nardi himself wrote. Finally, in the letter which he wrote to Vlackveld in Haarlem in April, 1657, shortly before his death, Harvey said, " It is useless for you to spur me on and for me to gird myself for some new research when I am not only ripe in years but also—let me admit—a little weary. It seems to me, indeed, that I am entitled to ask for an honourable discharge ".

I trust that the extra details about Harvey and his work may be of interest and pleasure to his successors, meeting more than three centuries later to advance his science in the way that he in particular introduced, and in a region particularly associated with certain scenes of his own labours.

Acknowledgments, etc.

To my Bart's colleagues go my best thanks for having made my new translation, and hence this paper, possible. I wish also to thank our Bart's Librarian, and those of the Wellcome Historical Medical Library and of the Royal College of Surgeons of England, and our College Archivist (Mrs. Gweneth Whitteridge, F.S.A.), very much for much help freely given.

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REFERENCES

1. *Brit. med. J.* (1957), i, 1293.
2. Leake, C. D. (1957). Personal communication.
3. Chauvois, Louis (1957). Personal communication, and *Discovery*, September, 404.
4. Harvey, W. (1957). *Exercitatio anatomica de motu cordis et sanguinis in animalibus*, 1628, translated by K. J. Franklin and published for the Royal College of Physicians by Blackwell Scientific Publications, Oxford.
5. *Idem in the press. De circulatione sanguinis*, etc. Translated by K. J. Franklin. Blackwell Scientific Publications, Oxford.
6. *Idem* (1766). *Opera omnia: a Collegio Medicorum Londinensi edita.*
7. Franklin, K. J. (1949). " A short history of physiology." London: Staples Press, Ltd. New York: Staples Press, Inc.
8. Liddel, Duncan (1617). *Ars medica, succincte et perspicue explicata*, 2nd Edn. Hamburgi. Ex Bibliopolo Froebeniano.
9. Riolan, J., Jr. (1649). *Encheiridium anatomicum et pathologicum. Lugduni Batavor. Ex Officina Adriani Wyngaerden.*
10. Power, D'Arcy (1917). "A revised chapter in the life of Dr. William Harvey, 1636." *Proc. R. Soc. Med.* (Historical Section), x, 33.
11. " Biographisches Lexikon der hervorragenden Ärzte aller Zeiten und Völker ", (1931) 3.
12. " Allgemeines Gelehrten-Lexicon Dritter Theil M-R " (1761). Leipzig, in Johann Friedrich Gleditschens Buchhandlung.
13. "Allgemeine Deutsche Biographie" (1890), **31**, Leipzig: Verlag von Duncker und Humblot.
14. Boulger, G. S. (1894). *Art.* " Morison, Robert (1620-1683) ", in D.N.B., ed Sidney Lee, **39**, 61-63. London: Smith, Elder & Co.

Fig. (*Courtesy of the Trustees of the National Galleries of Scotland.*) Reproduction of oil-painting of Charles, Prince of Wales, aged 12. Painted by William Dobson (1610-1646) to the order of Charles I and presented to William Harvey, M.D.

A note offered to members of the Physiological Society on the occasion of their meeting in St. Bartholomew's Hospital Medical College on February 21-22, 1958.

LETTERS TO THE EDITOR

Sir,

"NIGGERS IN THE WOODPILE"

My distinguished namesake has produced another of his wise and helpful articles, showing that combination of specialised knowledge and general experience which I like to think is characteristic of Bart's and himself.

May I, though, point out that this particular phrase is not now verba grata across the Atlantic—perhaps because it is colourful? A very distinguished American physician, addressing a well-known British Society late last year about a disease which bears his own name, emphasised that its cause was still unknown. " In fact," gentlemen," said he, " we still have not spotted the burglar in the woodpile."

Colourful phrases need careful use.

Yours, etc.,
W. A. BOURNE.

48, Wilbury Road,
Hove, 3, Sussex.

Sir,

THE GRAMOPHONE SOCIETY

Sir,—The question of the foundation of a Gramophone Society within the Hospital has been raised at recent meetings of the Students' Union Council. Most members are agreed that the adoption of the plans there presented would give rise to the troublesome and, fortunately, rare condition of ectopia musical.

Would it not be a wiser plan to use Union funds for the extension of the Burrows Memorial equipment at College Hall?

The potentialities of Long playing records are still only appreciated by the few people who have taken the trouble and not inconsiderable expense to instal amplifiers and so on, of the same order of fidelity, with regard to uniformity of frequency response, as those used by the manufacturers of the records.

I therefore suggest that the Union should set up a sub-committee to investigate the problems of installing such equipment in the recreation room at College Hall and to advise on the limitations which should be placed upon the use of this in order to prevent annoyance to residents in the Hall.

It should be possible to provide very useful equipment including fool-proof record player, 10-15 watt amplifier with pre-amplifier and " Steep Cut " filter together with a two unit Loudspeaker system and provision for the noise to be heard in the so called gramophone room only—for about £75.

The unit once installed could be adapted for reception of Frequency Modulated B.B.C. programmes (V.H.F.) by any one of a number of the student body at little cost.

Yours sincerely,
CHARLES STEPHENSON.

Abernethian Room,
St. Bartholomew's Hospital.

SPORTS NEWS

VIEWPOINT

Yet another game can now be played at Charterhouse, this time Badminton. A court has recently been marked out in the gym, and a net acquired. Mr. K. Bowles who was largely responsible is to be thanked.

Several cup games have been played during the last month.

It is quite a coincidence that for most of them Bart's were drawn against, and I regret to say lost to St. Thomas's. Still on the subject of cup games. It seemed a pity, even allowing for the fact that Rugger is not a game for children, that an element of undue viciousness was to be observed in both cup games.

Although not really in our field, the organisers of the various club Balls held recently are to be congratulated on their excellence. It is to be hoped that they proved financial as well as social successes.

Once again a party of fortunate, and much envied people has departed for the snows of the Austrian Alps and Ski-ing, this at Zürs. May this admirable expedition be made for many years to come.

CUP MATCH

Bart's v. St. Thomas's

Played at Richmond on Tuesday, January 14th. St. Thomas's won by 3 points (a try) to nil.

The result of this match was a great disappointment, after last year's successful run in the cup. Injuries meant that the Hospital were unable to field two of their more talented players, but as St. Thomas's were similarly affected, no excuse can be made on that account. What then was the cause of a half-hearted effort from a team that had promised well, and achieved some notable victories earlier in the season. It is always difficult to analyse the reason for any team's unexpected failure, but the impression gained on the touch-line was of a half-pace friendly match, without any traditional gusto associated with cup ties. Sufficient to say that St. Thomas's deserved to win. They moved quicker about the field, and were always ready to pounce on mistakes by the opposition, a virtue invaluable in cup matches, and which led to their only score. Much has been written in the daily press about the rugged, and impenetrable defence of both sides. This now seems to be an accepted feature of cup matches, but the old aphorism still holds that attack is the best form of defence. Failure to observe this may have been the main factor contributing to Bart's defeat.

Of the individual performances Britz, although maybe not the purist's idea of a perfect full-back, was hardworked and essentially capable, and McMaster was the most dangerous of the backs. B. Richards at scrum-half threw a long but sometimes floating pass, and did some good work in defence. R. R. Davies attempted little in direct running, being content usually to employ the kick ahead. Unfortunately these kicks were seldom diagonal enough to allow the wings to run on to, and often the St. Thomas's full-back was able to field and clear unmolested. In the pack Mackenzie, although short of match practice, covered a great deal of ground and was often prominent in the loose. L. R. Thomas was the most successful Bart's forward in the line-out, and Hamilton emerged from his hooking duel with honours about even.

Play began with R. R. Davies kicking off in cold but dry weather. From the ensuing line-out a Bart's forward was penalised for offside and St. Thomas's proceeded to encamp themselves in the Bart's half, a position they were to maintain almost continuously in the first half. St. Thomas's pressed continuously for the first quarter of an hour but the defence and Britz especially were equal to it. One or two stray passes were eagerly seized by the St. Thomas's wing forwards and only splendid covering by the pack kept them out. Bart's showed what they could do only spasmodically in the form of loose rushes, but to often ineptuosity cost them the ground gained. After a period of heavy St. Thomas's pressure they achieved the decisive try. Quick breaking by the St. Thomas's pack forced B. Richards into a hurried pass to R. R. Davies; he was caught in possession in the Bart's 25 and the ball went loose. It was kicked on by a St. Thomas's centre and although Britz fell on it he was unable to hold it and the St. Thomas's fly-half and captain scored half way out. The kick narrowly failed, and immediately Bart's swept into the St. Thomas's half with the help of a good break by Stephens. Half time arrived with Bart's at last playing with fire and spirit, and with hopes of a revival in the second half.

This revival did not however materialize. Although there were a series of scrums in front of the St. Thomas's posts the final finesse to beat a solid defence was lacking. McMaster was twice tackled into touch after good handling movements, but then St. Thomas's forced their way back and encamped in the Bart's half. They almost scored on two more occasions and only last-ditch tackles by Halls and McMaster saved the line. Bart's managed one final period of pressure, and won a penalty 35 yards out. Stephens was given the unenviable responsibility, but his kick fell short. This was the final effort, and the game ended with a series of brisk St. Thomas's three-quarter movements.

Team:

M. Britz, A. B. M. McMaster, J. Stevens, J. C. Neely, G. J. Halls; R. R. Davies, B. Richards; B. Lofts, J. Hamilton, D. A. Richards, J. Pennington, L. R. Thomas (Capt.), J. C. Mackenzie, W. P. Boladz. R. P. Davies.

1st X Vv. Strand. At Chislehurst. December 28th. Won 6–0.

After the dismal defeat of the previous week by K.C.S. Old Boys, the 1st XV gained a comfortable but rather surprising win over Stroud at Chislehurst. Victory was surprising since the Christmas festivities had barely finished and nearly half the side were involved in the Pot-Pourri on the previous evening. However due to a highly commendable and vigorous display by the forwards in which Pennington, D. A. Richards and Mackenzies were outstanding, Stroud never looked like scoring and only a series of mistakes by the Hospital near their opponents' line prevented the score from being nearly doubled or even trebled.

Play began with Bart's exerting early pressure and establishing a foothold around the Stroud '25'. After missing an earlier one, J. Stevens kicked an excellent penalty from 35 yards out after a quarter of an hour's play. Ten minutes later, he kicked another penalty from a similar position. From then on, with some fine hooking by P. Smith, Bart's saw a fair amount of the ball and should have scored on at least two occasions. Once when Mackenzie broke clear after a run by R. P. Davies only for him to kick when he came up to the full-back and again when Martin was seemingly clear of his opposite number for him to be caught by one of the covering forwards.

After the interval, Bart's continued to hold the upper hand, both in the set scrums and line-outs, but Stroud defended well and their fly-half made many relieving touch-kicks.

Davies had another good game and his defensive covering behind his three-quarter line was often noticeable and most helpful. B. Richards was back in his old form and besides throwing out a steady stream of long accurate passes, made several breaks around the base of the scrum.

Team:

A. P. Ross; J. Martin, J. Neely, J. Stevens, J. Plant; R. R. Davies, B. Richards, D. A. Richards, P. Smith, B. Lofts; J. Penniugton, C. C. H. Dale; R. P. Davies, W. P. Boladz, J. C. Mackenzie (Capt.).

1st XV v. Taunton. Away. Saturday, January 11th. Lost 3–0.

In the last game before their 1st round Hospitals cup match the 1stXV lost narrowly to Taunton by a try to nil. Bart's found that the exceptionally muddy ground, a strong wind, and a heavy Taunton side, prevented them from playing any sort of open Rugby. It was hoped that with L. Thomas back after six weeks absence due to a knee injury, the return of Neely to the centre, and the movement of Halls to the wing, some much needed scoring power would be restored to the side. However this was not to be, and the Taunton defence proved capable of stifling almost immediately any move Bart's were able to initiate.

With the wind and driving rain behind them, Taunton kicked off, and soon established a foothold in the Bart's half. Although Thomas jumped well in the line-out, Bart's were often out-scrummaged, and the three-quarters did not see much of the ball. The decisive score came after twenty minutes, when a fumble on the Hospital's line presented an opposing forward with an easy chance, and he dived for an unconverted try.

After the interval, the Bart's pack played better, and with more life. Eventually the heavier Taunton pack again established a slight superiority both in the set scrums, and the line-outs. Stephens and Neely were again pillars of strength in defence, but the three-quarter line very rarely looked like scoring. The side as a whole seemed to lack fire, and will have to produce much more lively and attacking football if they are to beat St. Thomas's next week in the cup match.

Team:

M. Britz; A. B. M. McMaster, J. C. Neely, J. Stevens, G. J. Halls; R. R. Davies, B. Richards; B. Lofts, J. Hamilton, M. Harries, L. R. Thomas (Capt), J. Pennington; P. D. Moynagh, W. P. Boladz, R. P. Davies.

1st XV v. Cheltenham. Home on January 18th. Lost 3–13.

After their disappointing display in the Cup match, the 1st XV were unable to shake off the morning blues in this game against Cheltenham, who had made the journey up to London primarily for the International but also to visit Chislehurst for the first time since the war.

With McMaster moved into the centre and Mackenzie unable to play, the Hospital strove hard to beat their opponents for the first time. However, although Bart's played well in the tight and gained the edge in the lineout through good work by Thomas and Pennington, Cheltenham always held the upper hand outside the scrum, and their fly-half and wing three-quarters were often outstanding. After an all-out attack in the first fifteen minutes, Pennington managed to kick an excellent penalty for Bart's but as the game progressed, the opposition's superiority outside the scrum brought them two tries in the first half.

After the interval Bart's were unable to score any further points (despite one or two determined breaks by McMaster in the centre). Ten minutes from the close, Cheltenham added a further goal from an excellent try by their wing three-quarter. Towards the end, the Bart's pack were slowing down considerably, bringing back memories of the Cup match of the previous week. It is indeed a great pity that the Captain, Mick Phillips, was neither able to play in this game, nor to train his three-quarters in the way in which he led them so well last season. It is earnestly hoped that next year will see a faster and more lively pack, supported by a back division bent on playing attacking and at the same time constructive football.

Team:

A. P. Ross; G. J. Halls, A. B. M. McMaster, J. Stevens, J. Plant; R. R. Davies, B. Richards; D. A. Richards, J. W. Hamilton, B. Lofts; L. R. Thomas (Capt.), J. Pennington; P. D. Maynagh, W. P. Boladz, R. P. Davies.

ASSOCIATION FOOTBALL

1st XI v. Royal Dental & Charing Cross Hospitals. Played at Cohndale on 15th January. Result: Draw 2—2.

After winning the toss, Bart's took command of the game and it seemed only a matter of time before a goal came. Fifteen minutes of continuous pressure roused Charing Cross and play switched

into the other half, with the scoresheet clear. Mercer in Bart's goal had a lot of work to do at this stage, being well supported by a strong, quick tackling defence. As half time approached play became scrappy, and a defensive error let in the Charing Cross centre-forward who drew the advancing Mercer and shot past him into the net.

Trailing 1—0, Bart's began the second half as they had done the first, but after ten minutes the Charing Cross left-winger broke away and scored with a strong cross shot.

Soon after this, following good work by Marsh and Williams, Andan centred to Watkinson who made the score 2—1.

Charing Cross were obviously tiring on the rather heavy ground and most of the play was well in their half, but the equaliser only came a few minutes from the final whistle. Prosser took the ball in mid-field and sent a glorious 40 yards pass to Savage on the left-wing, who cut in and crashed the ball against the crossbar with the goalkeeper beaten, Watkinson pushing the re-bound into the net.

This was a game where much good football was played and a lot of work done, but too often the final pass or shot went astray. If this finishing can be brought up to the standard of the rest of the play, matches such as this will be won before half-time.

Team :
J. Mercer ; R. Kennedy, M. Noble ; C. Juniper (Capt.), G. Haig, D. Prosser ; A. Andan, M. Williams, B. Marsh, P. Watkinson, P. Savage.

2nd XI. Played Saturday, 11th January. Won 8—2.

A very one-sided game about which little need be said, since slack marking by O.C's allowed the Bart's forwards to combine well and always seem to be numerically superior. Mention must be made of the remarkable performance of Gould in scoring be said since slack marking by O.C's allowed the of the field. Haig in an unaccustomed position in goal was only obliged to bring off one fine save. O.C's scored twice through defensive errors. The other scorers for Bart's were Bousfield (2) and Prosser.

Team :
G. Haig ; M. Noble, R. Gallop ; M. Williams, D. Prosser, G. Alabi ; T. O. Johnson, D. Bousfield, A. Gould, J. Kuur.

MEN'S HOCKEY

1st Round Interhospitals Cup v. St. Thomas's Hospital. Lost 1—6.

Judging from the score, the cup match was not a resounding success, but it would be most unreasonable to call it a dismal failure. Both sides played hard fast hockey. Goodwin and Defrates both battled stoutly against a very fast attack. Doherty, in goal, was his usual robust self and stopped many more goals than he let through. The forwards were unhappy partly because they had not played together a great deal, and partly because the Thomas's left-back, a Kenya Olympic player was fully capable of intercepting all but the best passes. Both Drinkwater and Anderson had a few quick shots at goal which were either well saved or went wide of the post. Roles, on the left wing had unfortunately taken a nasty blow on the knee two days before, and thus lacked his customary speed. Mackenzie-Ross at centre-half repeatedly intercepted passes intended for the Thomas's attack and in turn fed our attack very competently.

We scored in the last few minutes of the game when Anderson received a crisp pass from Roles, in the circle and flicked the ball past the goalkeeper into the left-hand corner of the net.

We were unlucky to meet what must be the best side in the competition, so early on but I think everyone thought it a good game and a fair result, especially after our memorable defeat of the same hospital last year.

Team :
R. P. Doherty ; C. S. Goodwin, M. Defrates ; D. S. Wright, K. Mackenzie-Ross, D. Godwin ; N. C. Roles (Capt.), P. Drinkwater, A. S. Anderson, R. B. Church, D. M. C. Glover.

1st. XI v. Old Cranleighans. Won 6—4.

Another enjoyable game in which a lively set of forwards showed their goal-scoring capabilities, and were admirably backed up by a stolid and hard working defence. Again the experiment of Anderson at inside proved a great success, and he was well supported by Glover at centre and Church on the wing. Stark, playing his first game of the season in goal, showed his usual coolness and good judgement.

1st XI v. Hampstead 2nd XI. Won 5—3.

This was a splendid game. Against such charming opponents, no one could fail to enjoy themselves. Having just played a fast cup match, Bart's were quicker on to the ball than our opponents. The forwards repeatedly snapped up the loose ball and consequently had more chances to score. Glover used his speed on the wing to its best advantage and we scored several times from his accurate cross passes. Church, playing for the first time at centre-forward, used his energy to provide many openings for Anderson trying out at inside right. Accurate cross-passing from backs and halves to the two insides, provided a basis for a solid and co-ordinated attack.

1st XI v. University College Hospital. Lost 3—9.

This was one of those days which come after a period of success, when nothing goes right. It was a miserably cold day, and the whole side were sluggish and ice bound mentally and physically. U.C.H. had an admirable set of fast and lively forwards, and a stolid hard-hitting defence which kept our forwards completely under control. It was unfortunate that this should be our last match before Christmas, for it left a very nasty taste in our mouths, which I hope will be removed rapidly over the holiday.

RIFLE CLUB

The Rifle Club has embarked on what is probably its most extensive post-war programme.

Following the large increase in membership during the 1956-57 season teams are competing in the United Hospitals Winter Smallbore League for the Lloyd Cup, the London University pistol and "Standing and Kneeling" leagues, and in the U.H. Tyro Team Leagues. This last competition is designed for less experienced members and both Clinical and Pre-clinical teams have been entered. The running of the Pre-clinical team has been left entirely to the Junior Secretary and Pre-clinical committee member. This provides an opportunity for the Charterhouse members to obtain experience in club administration and competitive shooting at this stage.

Although at present it is not possible to give detailed results, it is gratifying to note that the Lloyd Cup team lies third and has prospects of improving this position before the end of the season. The Pre-clinical teams heads its division by a good margin.

Besides team shooting, the Monthly Spoon competitions—which are open to any member of the College and run on a handicap basis—are in full swing. Results to date are:—

Month	Spoon	Medal
November	Miss A. M. Holloway	C. J. Griffiths
December	Miss A. M. Holloway	J. D. Hobday

Miss Holloway is to be congratulated on her performance, for the winner of the spoon one month has to show considerable improvement on previous scores to win twice in succession.

The social aspect of the Club's activities has included two shoulder-to-shoulder matches and an informal party is being held at the end of January in College Hall for members and their guests.

Members are now to be seen at the Hospital and at Charterhouse wearing the Club tie. The Club wishes to thank the President, Mr. H. Jackson-Burrows, who has recently given the stock of ties to the Club in order that a fund may be set up to replace this stock when it becomes depleted.

GOLF CLUB

Support and interest in the club has increased considerably during the past season. Several new members, some complete beginners, joined us, and in enthusiasm for playing in all kinds of weather probably put most of the senior players to shame.

The team played a very full programme of matches, with one almost every week from March to October. Of those we won against, The Staff, The Middlesex, The London, and King's College Hospital; and lost against, Mr. Hankey's team, King's College, St. Mary's, University College, The City Police, The Westminster, and Imperial College; and drew against Dr. Picton Thomas's team.

The two regular fixtures to which we always look forward, those against the Staff at Denham, and against Mr. Hankey's team at Tandridge, were again great successes. This year we added to them one against a team of registrars under Dr. Picto Thomas, which we hope will also join the regular list.

We would like to say how pleased we were to have that fine golfer Dr. Phil Fransden with us on several occasions. He played most excellently in winning his match for the registrars with a round of 75.

During the season the following gentlemen represented the club; A. Galbraith, C. Stephenson, M. Scorer, R. Hughes, Dr. P. Thomas, Dr. P. Fransden, Dr. D. Mulcahy, D. Rhys-Philips, F. Abercrombie, J. Sugden, A. Fuge, P. Drinkwater, D. Richards, D. Dick, R. Cleave, F. Strang, and T. Matthews, I. Hamilton, and T. Silverstone.

The Autumn meeting.

This was played on the High course at Moor Park on October 9th. The Girling Ball cup was won on handicap by Dr. Desmond Mulcahy, with Dr. Phil Fransden, and Charles Stephenson as runners-up.

For the coming year we are pleased to have secured the services of the following gentlemen. President: Mr. John Beattie. Vice-Presidents: Mr. George T. Hankey, O.B.E., T.D., Dr. G. W. Hayward, Dr P. F. Borrie.

At the Annual General Meeting on October 24th the following officers were elected for next season. Captain: C. G. Stephenson. Secretary: G. F. Abercrombie. Treasurer: K. J. Sugden. Honours colours were awarded to C. Stephenson. Colours were awarded to F. Abercrombie, J. Sugden, P. Drinkwater and A. Fuge.

Cup Match

On December 4th the first round of the hospitals cup was played against St. George's at home. The conditions were not ideal, and it became dark very early. Attempting to play Golf under such conditions, must be one of the greater follies of youth. However "All's well . . ." and by winning 4—1 we qualified to play Guy's in the next round. Team: Galbraith, Stephenson, Aber-Drinkwater, A. Fuge and Dr. D. Mulcahy.

SQUASH

Both teams have recently played cup matches, in the Interhospitals Senior, and Junior cup competitions respectively.

1st V. v. Guy's. Played Friday, 17th January. (Away).

Having received a bye in the 1st round, the team were unfortunate in being drawn against an exceedingly strong Guy's side in the 2nd round. Bart's lost the match 5—0, but will almost certainly have the consolation of knowing that they lost to the eventual winners.

Team:

B. Duff, C. Hindson, G. Randle, D. Godwin and D. Lyon.

2nd V v. St. Thomas's 2nd Side. Played Monday, 13th January. (Home).

The 2nd team were also drawn against tough opposition for their 2nd round match in the Junior Cup. St. Thomas's had already beaten them both last season and this. However, this time the result

was convincingly reversed, and Bart's won 4—1. There is every reason to hope that the 2nd V will do well in the competition this year.

Team :
J. Sugden, D. Lyon, K. Bowles, T. Seaton, K. Nouri.

FENCING CLUB

Despite the usual paucity of experienced Fencers on whom to call, the club is having one of it's more successful, and certainly its most active season for some years. It is pleasing to be able to record that a number of Fencers who only took up the sport after coming to the hospital, are starting to reap their reward for several years hard practice.

With an eye to the future, it has been a considerable relief to the senior members of the club, that more than the usual number of newcomers have outstayed idle curiosity, and we are very pleased to have them.

Match results so far are as follows.

At Home. 3 Foil and Sabre v. Guy's.

Both matches were won 6—3. This is a match we always enjoy, and this year we surprised ourselves a little in winning with both weapons.

Team :
McGrath, Sugden, Lyon, Townsend.

Away. 4 Foil v. Westminster. Drawn 8—8.

Another regular fixture. This was the first of several occasions when the presence of the secretary, John Parker, absent through illness, would have strengthened the team considerably.

Team :
McGrath, Sugden, Shaw, Thompson.

At Home. 4 Foil v. Middlesex.

Lost 9—7. As usual a close match. We hope to reverse the result when we fight the return.

Team :
McGrath, Sugden, Thompson, Lyon.

Away. Foil v. L.S.E.

Won 7—5. This was a new, and entertaining fixture. Unfortunately they were a man short, which made the normally complicated order of fighting even more difficult to work out. We hope this will become a regular fixture.

Team :
McGrath, Sugden, Parker, Thompson.

At Home. 3 Foil and Sabre v. Mary's.

Foil match won 5—4, and Sabre match lost 4—5. This was another new fixture or at least one resumed after several years lapse. We hope that again will be a regular event in future.

Team :
McGrath, Sugden, Parker, Townsend.

At Home. 3 Foil and Sabre v. London.

Foil match lost 7—2. Sabre match lost 9—0. The London have one of the strongest teams in the university this year, and we are not ashamed of this defeat.

Team :
Sugden, Thompson, Lyon.

At Home. 4 Foil v. Westminster.

Won 10—6. We also fought a second team 3 Foil match, which we lost 7—2. This was a welcome inovation, because one of the unfortunate things about Fencing is the smallness of a team. It means that it may be a couple of years before new members get a chance to fight in a match. We hope that future officials of the club will continue to arrange occasional matches for such members.

1st Team :
McGrath, Sugden, Shaw, Thompson.

2nd Team :
Lewis, Cohen, Mrs. Stephenson.

BOOK REVIEWS

THE DIAGNOSIS AND TREATMENT OF INFECTIONS *by* D. Geraint James, M.A., M.D. (Cantab.), M.R.C.P. (London). Blackwell Scientific Publications, Oxford. 1957, 234 + viii pp. Price 30s.

Dr. James has divided his book into three sections. The first contains an account of the properties and actions of the drugs used in chemotherapy, with observations on more general problems such as the development of resistance, toxic reactions and causes of therapeutic failure. The second section surveys in eight chapters micro-organisms causing disease. Fungi, protozoa, ricksettsiae and viruses are included as well as bacteria, so that considerable ground is covered. In the final section infections are dealt with as they present in the various systems of the body.

Dr. James' aim has been to bring together clinical and laboratory medicine and he is to be congratulated on the way in which he has been able to compress so much information into a relatively small book. The compression has been at the expense of nearly all references, and with only a few words available, many of the statements are somewhat dogmatic. This book is not recommended for students at the start of their clinical course, but for those with a grounding in bacteriology and experience of chemotherapy it will provide a reference book covering a wide field.

R. A. SHOOTER.

GYNAECOLOGY : A HANDBOOK FOR NURSES (3rd Edition) *by* Gladys H. Dodds. Published by Faber. Price 18s.

This is not a book about gynaecological nursing, but about gynaecology and obstetrics for nurses, and this purpose it fulfills well. The third edition has been quite extensively revised, and the new chapter on obstetrics is especially successful. The style remains an outstanding characteristic—lucid, unaffected, and easy to read.

W. E. HECTOR.

RECENT PAPERS BY BART'S MEN

ABRAHAMS, *Sir* Adolphe. Diet and clothing in winter. *Practitioner*, 179, 1957, pp. 685-688.

——, (and LINNELL, W. H.). Oral depot therapy with a new long acting dexamphetamine salt. *Lancet*, Dec. 28, 1957, pp. 1317-1318.

*ASTON, J. N. An adaptor for extracting McLaughlin's nails. *J. Bone Jt. Surg.*, 39B, 1957, p. 755.

*BACKHOUSE, K. M., (and HEWER, H. R.). Delayed implantation in the Grey Seal, Halichoerus grypus (Fab.). *Nature*, 178, 1956, p. 550.

*——. A note on Spring pupping in the Grey Seal (Halichoerus grypus Fab.). *Proc. Zool. Soc. Lond.*, 128, 1957, pp. 593-594.

*BETT, W. R. Bernard Sachs (1858-1944) of Tay-Sachs' disease. *Med. Press*, 239, 1958, pp. 41-42.

*——. Blood pressure: Von Basch and Riva Rocci. *N.A.P.T. Bulletin*, Dec., 1957. p. 179.

*——. Edward Emily (1617-57): first Harveian Orator; Samuel Herbert Habershon (1875-1915), Gladstone's physician. *Med. Press*, 238, 1957, p. 463.

*——. From "Dosimetric granules" to tridione. *Chem. & Drugg.*, 168, 1957, p. 409.

*——. John Benjamin Murphy (1857-1916) of "Murphy's Button". *Med. Press*, 238, 1957, p. 605.

*——. Joseph Babinski (1857-1932) and "Babinski's sign"; Axel Munthe (1857-1949) of San Michele. *Med. Press*, 238, 1957, pp. 495-496.

*——. Sigard Adolphus Knopf (1857-1940): tuberculosis fighter and Osler's friend; Theodore Escherich (1857-1911) of *Escherichia coli*; Adolf Guodi (1857-1920) anatomist and rhino-laryngologist. *Med. Press*, 238, 1957, pp. 516-517.

*——. Sir Archibald Edward Garrod (1857-1936). *Med. Press*, 238, 1957, p. 568.

*——. Sydney Young (1857-1937). *Nature*, 180, 1957, p. 1451.

BOURNE, Geoffrey. Paradoxical electrocardiogram in coronary exercise test. *Lancet*, Dec. 28, 1957, p. 1320.

——. The diagnosis of coronary disease with especial reference to symptoms. *J. Ind. Med Prof.*, 4, 1957, pp. 1874-1876, 1893.

*BROWN, J. R. (and CROTON, I. M.) An experimental method for the determination of the "clo" value of clothing assemblies. *J. Textile Institute*, 48, 1957, pp. 1379-1388.

BURROWS, H. Jackson. Slipped upper femoral epiphysis: characteristics of a hundred cases. *J. Bone Jt. Surg.*, 39B, 1957, pp. 641-658.

*CAPPS, F. C. W. Benign tumours of the larynx. *J. Laryngol. Otol.*, 71, 1957, pp. 709-717.

COOK, Josephine and others. Acquisition of staph. aureus by newborn babies in a hospital maternity department. *Brit. med. J.*, Jan. 11, 1958, pp. 74-76.

*CRAWHALL, J. C., (ARNSTEIN, M. R. V. and ——). The biosynthesis of penicillin 6. A study of the mechanism of the formation of the thiazolidine-β-Lactam rings, using tritium-labelled cystine. *Biochem. J.*, 67, 1957, pp. 180-187.

*DARMADY, E. H., and others. Sterilisation of syringes by infra-red radiation. *J. clin. Path.*, 10, 1957, pp. 291-306.

*DAY, George. Ten years of creative group therapy. *Perspectives in biol. & med.*, 1, 1957, pp. 119-123.

DE MOWBRAY, R. R. Endocrine crises. *Med. Press*, 238, 1957, pp. 447-52.

——. The pre-operative and post-operative care of patients receiving cortisone or other steroid therapy. *Postgrad. med. J.*, 33, 1957, pp. 632-639.

DORMER, A. E. Bacterial endocarditis; survey of patients treated between 1945 and 1956. *Brit. med. J.*, Jan. 11, 1958, pp. 63-69.

FLAVELL, Geoffrey. Hammans. *The Cornhill*. No. 1006, Winter, 1955/56, pp. 292-299.

——. The surgery of the heart. I. *N.A.P.T. Bulletin*, Dec., 1957, pp. 173-175.

FLETCHER, C. M., and others. Prophylactic use of oxytetracycline for exacerbations of chronic bronchitis. *Brit. med. J.*, Nov. 30, 1957, pp. 1272-1275.

*GALBRAITH, H.-J. B., and NICOL, C. S., Lymphogranuloma venereum. *Brit. med. J.*, Dec. 14, 1957, pp. 1402-1405.

GLENISTER, T. W. Some history and lore relating to teratogenesis. II. *Char. Cross Hosp. Gaz.*, 55, 1957, pp. 203-211.

*HANKEY, G. T., (SEWARD, G. R. and ——). Cherubism. *Oral. Surg., oral Med., oral Path.*, 10, 1957, pp. 952-974.

*HARPER, R. A. Kemp. Radiology and the hormonal aspects of breast cancer. *Brit. J. Radiol.*, 30, 1957, pp. 582-589.

*HOWELL, Trevor. Rupture of the right ventricle. *Geriatrics*, 12, 1957, pp. 711-712.

HUNT, John H. Peripheral vascular disease in general practice. *Practitioner*, 179, 1957, pp. 712-717.

*HUNTER, Richard A., and MACALPINE, Ida. A note on William Harvey's "Nan Gunter" (1616). *J. Hist. Med.*, 12, 1957, pp. 512-515.

INNES, G. S. *See* JONES, Arthur, and INNES, G. S.

*JONES, Arthur, and INNES, G. S. Cerebrospinal irradiation for medulloblastoma. *Brit. J. Radiol.*, 30, 1957, pp. 590-592.

KENNAWAY, *Sir* Ernest. Some points on nursing from a patient's point of view. *Brit. med. J.*, Dec. 21, 1957, p. 1485.

*KNOX, R., (and SKINNER, G. B.). Semi-solid agar media for culture and drug sensitivity tests of tubercle bacilli from sputum. *J. clin. Path.*, 10, 1957, pp. 307-310.

KOK, D'Almero (with HAYHOE, F. G. J.). Medullary aplasia in chronic myeloid leukaemia during busulphan therapy. *Brit. med J.*, Dec. 21, 1957, pp. 1468-1471.

LAWTHER, Patrick J. *See* WALLER, R. E., and LAWTHER, Patrick J.

*LEHMANN, H., (AGER, J. A. M., and ——). Intra-erythrocytic haemoglobin crystals. *J. clin. Path.*, 10, 1957, pp. 336-338.

*——. (and others). The blood groups and haemoglobin of the Gorkhas of Nepal. *Amer. J. phys. Anthrop.*, 15, 1957, pp. 163-169.

——. *See also* MOURANT, A. E., (and others).

LEVITT, W. M. Radiation nephritis. *Brit. J. Urol.*, 29, 1957, pp. 381-382.

MACALPINE, Ida. See HUNTER, Richard A., and MACALPINE, Ida.

MENDEL, Dennis (with J. Grayson). Observations on the intrahepatic flow interactions of the hepatic artery and portal vein. *J. Physiol.*, 139, 1957, pp. 167-177.

*MOURANT, A. E., (and others). The blood group of the Western Walsers. *Vox Sanguinis*, 2, 1957, pp. 159-174.

MOURANT, A. E., (and others). Blood groups of a Greek community with high sickling frequency. *Lancet*, Dec. 28, 1957, pp. 1333-1334.

——. *See also* LEHMANN, H., (and others).

NICOL, C. S. *See* GALBRAITH, H.-J. B., and NICOL, C. S.

*NICOL, W. D. Tranquillisers. *Med. Press.*, 238, 1957, pp. 484-488.

*OSWALD, Neville. Chronic bronchitis: some clinical pathologic and bacteriologic aspects. *Amer. Rev. Tuberc.*, 75, 1957, pp. 340-342.

PARRISH, J. A. *See* COOK, Josephine, and others.

*POPERT, A. J., (and others). The clinical course and corticosteroid excretion of patients with rheumatoid arthritis during long-term treatment with corticotropin. *Brit. med. J.*, Nov. 30, pp. 1257-1262.

——, (and DAVIS, P. S.). Surgery during long-term treatment with adrenocortical hormones. *Lancet*, Jan. 4, 1958, pp. 21-24.

*PRANKERD, T. A. J. Inborn errors of metabolism in red cells of congenital hemolytic anemias. *Amer. J. Med.*, May, 1957, pp. 724-729.

*——, (and others). Abnormalities of phospholipids in red cells of patients with paroxysmal nocturnal haemoglobinuria. *Brit. med. J.*, Nov. 30, 1957, pp. 1276-1277.

*——, (and others). Abnormal patterns of marrow activity. *Clin. Sci.*, 16, 1957, pp. 633-638.

*——, (and HARRIS, E. J.). Diffusion and permeation of cations in human and dog erythrocytes. *J. gen. Physiol.*, 41, 1957, pp. 197-218.

*——, (and others). The relationship of abnormal red cells to the normal spleen. *Clin. Sci.*, 16, 1957, pp. 223-230.

RICKHAM, P. P. Surgery of newborn infants: social, administrative and medical aspects. *Brit. J. Clin. Pract.*, 11, 1957, pp. 816-821.

——. Intestinal obstruction in the neonatal period. *Brit. J. Clin. Pract.*, 11, 1957, pp. 833-841.

——. Surgery of congenital malformations of the central nervous system. *Brit. J. Clin. Pract.*, 11, 1957, pp. 847-850.

*ROBB-SMITH, A. H. T. Harvey at Oxford. *Oxford Med. Sch. Gaz.*, 9, 1956, pp. 70-76.

——. The reticulin riddle. *J. Mt. Sinai Hosp.*, 24, 1957, pp. 1155-1164.

SARMA, Vishnu. Hydrocephalus. *J. Ind. Med. Prof.*, 4, 1957, pp. 1880-1887.

SHOOTER, R. A. *See* COOK, Josephine, and others.

SPENCE, A. W. Cortisone and hydrocortisone. *Practitioner*, 180, 1958, pp. 22-30.

*THOMPSON, Vernon C. Intercostal drainage of empyema. In, C. Rob. and R. Smith, *Eds. Operative Surgery*, v. 3, pp. 51-55.

*——. Rib resection for empyema. In, C. Rob and R. Smith, *Eds. Operative Surgery*, v. 3, pp. 56-61.

*——, (and others). The results of thoracoplasty in the treatment of pulmonary tuberculosis. *Thorax*, 12, 1957, pp. 241-252.

*VARTAN, C. K. Discussion on prevention of eclampsia. *Proc. roy. Soc. Med.*, 50, 1957, pp. 793-798.

VERNEY, E. B. Renal excretion of water and salt. *Lancet*, Dec. 21, 1957, pp. 1237-1242; 1295-1298.

WALLER, R. E., and LAWTHER, P. J. Further observations on London fog. *Brit. med. J.*, Dec. 21, 1957, pp. 1473-1475.

*WEBER, F. Parkes. The definition of the term "Cushing's Syndrome". *Med. Press*, 238, 1957, pp. 461-463.

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

ADDITIONAL NOTICES

Lecture on General Practice

The next lecture will be given on the 25th March at 12.0 in the main lecture theatre when Dr. J. Michael Roberts will talk on "The Surprise of General Practice".

Journal Staff

Mr. John Milward has been appointed Assistant Editor.

Mr. John Sugden has been appointed Sports Editor.

Change of Address

Mr. W. Etherington Wilson to
Cumbria,
270a, Dartmouth Road,
Paignton.

EXAMINATION RESULTS

ROYAL COLLEGE OF SURGEONS

The following Candidates were successful in the Primary Fellowship Examination of the Faculty of Anaesthetists in December 1957 :—

Hicks, J. P. N. Keil, A. McL.

UNIVERSITY OF CAMBRIDGE

D.SC. DEGREE, DECEMBER, 1957

Lehmann, H.

Final M.B. Examination. Michaelmas Term, 1957

Pass

Chalstrey, L. J. Goodwin, C. S. Grant, N. J. C.
Leaver, S. A. Mather, B. S. Tidmarsh, D.

Supplementary Pass List

Part I. Pathology & Pharmacology

Birkett, D. A. Carr, C. J. Faber, V. C.
Gibson, T. W. Harcourt, R. B. Haslam, M. T.
Hedley-Whyte, J. Humphreys, Y. P. Matthews, T. S.
Mitchell, R. J. Rice, J. C. Richards, B.
Robinson, T. W. E. Roles, N. C. Savage, D. C. L.
Stark, J. E. Whitworth, A.

Part II. Medicine

Bower, H. P. H. Parker, J. D. J.

Part II. Surgery

Part II. Midwifery

Bower, H. P. H.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXII **MARCH 1958** **No. 3**

EDITORIAL

THERE ARE few occasions which arouse more public interest than any incident which involves risk to human life. This is presumably the major factor in subconscious minds, at any rate of those that watch men pitting their skill and luck in order to stay alive in hazardous activities of all descriptions. This is an instinctive fascination which is with us from our earliest years, for even as children watching the dangerous antics of the circus acrobat was enormously thrilling; imagine also the dulness of a man doing those selfsame antics but a few feet from the ground. This morbid interest is further heightened by the half hope that perhaps something may happen and a further spectacle of human disintegration would be manifest for one's complete satisfaction.

There is no doubt that those people who revel in public carnage are themselves prime examples of human disintegration, whose very personalities have failed to transcend above the mentality of the bestial and who have had the misfortune to have been born but 1,500 years too late to join the orgies of the arena at the Coliseum. It is indeed sad that the newspapers and the television authorities now pander to these primeval emotions and prostitute their service to society at large.

Some months ago this whole issue was raised in the question of the attitude and behaviour of reporters after the murder of some unfortunate Dutch girl, and the Press authorities quickly leapt to their own defence maintaining that they had a duty to report these cases to the public, and that they endeavoured to do this with as little embarrassment and grief to those intimately concerned as possible. They, however, made no observations on the desirability of not offending the general conscience and of causing grief, embarrassment and horror to the general body of the community. They apparently regard themselves only as fact-revealers and not guardians of the integrity of the community as a whole.

The next example of their lack of discretion was the publication of a group of extremely personal photographs of a man fighting for his life in an oxygen tent following the Munich air disaster. However much this man was a public hero and however much the German authorities encouraged these photographers, it was lacking in tact and courtesy to the relations and in consideration for the public good. Doctors are not all anxious to become film stars, in fact most are unphotogenic, and when a valiant attempt is being made on the part of the patient, the nurses and the medical staff to maintain that infinitely precious thing, life, then there is no place for reporters and cameramen in that hospital.

The most recent discussion at great length in the daily press of the relative merits, the history, and the personal comments on A.I.D. and A.I.H. have once again affronted the general sense of what should, and should not, be discussed in the daily press. One of the members of the House of Lords in the recent debate on the legal position of artificial insemination pointed out that no child is now immune from knowledge of these hideous perversions of society creeping into its life at an age when it is scarcely able to comprehend the natural modes of behaviour. Surely the press could report these matters with more finesse and without playing to the Sunday Paper gallery.

The television authorities until recently have manifested wisdom and restraint in the programmes which they have elected to show, but in common with the more weighty journals representing the national interests of the profession one can but deplore the showing of the series on operations and the like

on the BBC. To the average layman these can constitute no more than just a good programme with a rather different twist; he is shown a patient before and after he has had medical treatment which is a cliché more used on the other channel as a means of selling their wares. Any attempt at explaining the basic and fundamental principles of disease and treatment is bound to fail owing to the limited time available, the limitations of the medium and the average cortical activity of the man in the street. Hence, only misunderstandings can arise, since the programmes are either too little on each subject or too much, e.g., the value of the film on mitral valvotomy was negligible since even to those who knew what was to happen nothing was apparent.

Those authorities which are responsible for the public well-being should seriously reassess their obligations to society and act as guardians of the public conscience, not as suppliers of the basest of the public wants. Human nature is frail and easily malleable, and such powerful influences should not contribute to further misunderstanding in regard to medicine or to the further degradation of mankind.

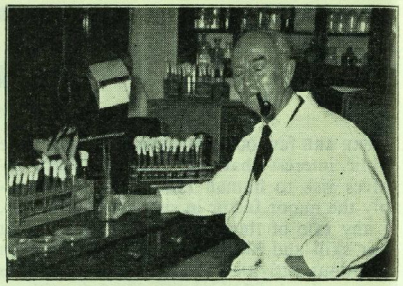
Wrong Notice

IN the last issue of the *Journal* the engagement between Dr. John Whittingdale to Miss Margaret Scott-Napier appeared in the notices of recent "Births." This was unfortunately due to some confusion which occurred in the production of the February *Journal*.

We would like to apologise to Dr. Whittingdale and his fiancée for any embarrassment this may have caused and any misplaced congratulations they may have received.

Mr. Norman Capener

Mr. Norman Capener has been appointed Robert Jones Lecturer for 1958, by the Council of the Royal College of Surgeons. This appointment coincides with the first year in which Mr. Capener is President of the British Orthopaedic Association. Mr. Capener left the Surgical Professorial Unit in 1926 and took charge of orthopaedics in 1931. Older Bart's men will recognise him as the writer of the reminiscence on Sir Thomas Dunhill in the last issue of the *Journal*.



Asleep or just thinking?

University of London

Dr. C. F. HARRIS has been elected Chairman of the Academic Council for 1957-8.

Dr. J. P. QUILLIAM has been appointed Reader in Pharmacology.

View Day Ball

Tickets for the View Day Ball can now be bought from Miss Oxburrow, or members of the Ball Committee. The ball is to be held at the Park Lane Hotel on 9th May.

NOTICES

Twelfth Decennial Club (1925-1935)

The Annual Dinner of the Twelfth Decennial Club is to be held at the Naval and Military Club, 94 Piccadilly, W.1., on Friday, May 2nd.

Will any member who does not receive notification or any eligible non-member who would like to attend the Dinner please get in touch with W. D. Coltart at 58 Harley House, N.W.1.

Eleventh Decennial Club

Eleventh Decennial Club Dinner, Friday, April 18th, 1958, at Simpsons' in the Strand. Dr. Laurence Holmes will be in the Chair. Anyone who has not had a card or still wishes to join the Club (January, 1915—December, 1925) write to F. C. W. Capps, 16 Park Square East, N.W.1.

Change of Address

Mr. T. B. Boulton to The Royal Berkshire Hospital, Reading, Berks.

Dr. P. G. Cronk from Moffiatts Close, Winchester, to 69 London Road, Gloucester.

Dr. F. Friend from 278, Hale Lane, Edgware to 92, Stanley Avenue, St. Albans, Herts.

Dr. W. Mel Thomson from Prernaydena, Tasmania, to 268 Sandy Bay Road, Hobart, Tasmania.

Mr. F. G. Ward from 11, Glebe Road, Staines to Nutbourne, Riverside Road, Staines.

Lecture on General Practice

The next lecture on General Practice will be held at 12 noon on Tuesday, March 25th. It is to be given by Dr. J. Michael Roberts on "The Surprise of General Practice."

ANNOUNCEMENTS

Engagements

GABRIEL—RATCLIFFE.—The engagement is announced between Dr. David W. Gabriel and Dr. Diana Ratcliffe.

MILLARD—TROUGHTON.—The engagement is announced between Dr. Frederick John Clayton Millard and Dr. R. E. Troughton.

SHERE—TALBOT.—The engagement is announced between Stanley Shere and Marion Talbot.

WOOD—ADDISON. — The engagement is announced between Christopher Bryan Somerset Wood and Mary Margaret Addison.

Marriages

GILLIES—CLAYTON.—On November 5th, at St. Marylebone, Sir Harold Gillies to Dr. Marjorie E. Clayton.

VEARCOMBE—BENDIXSON. — On December 7th at St. Bartholomew's the Great. Captain Colin Alexander Vearncombe to Theresa Mary Bendixson.

WELCH—REAM.—On February 12th, Raymond Hatfield Welch to Vera Ream.

Births

BARCLAY-HOBBS.—On January 12th, in Perth, Western Australia, to Diana, wife of Mr. John Barclay-Hobbs, a daughter (Jennifer Joy).

BEASLEY.—On January 25th, to Valerie, wife of Dr. Reginald Beasley, a daughter.

DOSSETOR.—On December 8th, 1957 at the Royal Victoria Hospital, Montreal to John and Margaret Dossetor, a daughter Frances Mary).

MASON.—On February 18th, to Marion, wife of Dr. Seymour Mason, a son (Alan Trevor).

MERCER.—On December 13th, to Pamela, wife of Dr. Michael Mercer, a brother for Nigel (Nicholas William).

PAYNE.—On January 24th, to Audrey, wife of Dr. John C. R. Payne, a brother for John and William.

POWELL.—On February 1st, to Janet, wife of Dr. F. J. Powell, a daughter.

ROBINS.—On November 23rd, to Shirley, wife of Mr. Robert Robins, a son (Michael George).

RUSSELL-SMITH.—On January 15th, to Dorothy, wife of Dr. Roy Russell-Smith, a son.

SHEPPARD.—On January 30th, to Patricia, wife of Surg.-Lieut.-Comdr. James G. H. Sheppard, G.M., R.N., a son (John Dominic Marius), a brother for Helen, Joanna, Mary and Peter.

TAYLOR.—On September 27th, to Andree, wife of Dr. W. Norman Taylor, at the Jericho Nursing Home, Ibadan, Nigeria, a daughter.

Deaths

ADAMS.—On January 27th, George Basil Doyne Adams, aged 80. Qualified 1903.

BOKENHAM.—On February 15th, Thomas Brandon Bokenham. Qualified 1896.

BOSTOCK.—On January 14th, Arthur Hastings Bostock, aged 81. Qualified 1900.

GAMES.—On February 20th, John David Bowen Games. Qualified 1930.

GREY. On December 12th, Sir Charles George Grey, Bt., aged 77. Qualified 1907.

LEA-WILSON.—On December 11th, Basil Hugh Campbell, Lieut.-Col., R.A.M.C., (retired), aged 72. Qualified 1911.

MALIM.—On February 6th, Jeffrey Wentworth Malim. Qualified 1900.

OBERMER. — On January 12th, Edgar Obermer. Qualified 1923.

PASRICHA.—On January 11th, Lieut.-Col. Chiranji Lal Pasricha, aged 60. Qualified 1920.

RUSSELL.—On December 30th, Harold George Bedford Russell, aged 71. Qualified 1912.

STANSFELD.—On January 28th, Rex Stansfeld, aged 69. Qualified 1913.

WROUGHTON.—On December 31st, Col. Arthur Oliver Bird Wroughton, aged 85. Qualified 1898.

MEDICAL STAFF

Department of Obstetrics and Gynaecology
Senior Registrar (Chief Assistant)
Mr. Peter Jackson 1.4.58 (replacing Gourlay).
Registrar
Mr. B. Measday 1.4.58 (replacing Jackson).

Department of Radiotherapy
Registrar
Mr. H. Horwitz 24.2.58 (returned from U.S.A. and replacing Johnson).
Senior House Officer
Miss A. E. Jacques 1.4.58 (replacing Banerjee).

Department of Pathology
Temporary Senior Registrar
Mr. Brian S. Jones 1.3.58 (replacing Worssam).
Senior House Officer
Mr. P. H. N. Wood 1.2.58 (replacing Huntsman).

Department of Psychological Medicine
Associate Chief Assistant
Dr. J. J. Flood.

CALENDAR

MARCH

Sat. 22nd.—Dr. Geoffrey Bourne on duty.
Mr. J. B. Hume on duty.
Mr. F. T. Evans on duty.
Rugger: 1st XV v. Nottingham **A.**
Soccer: 1st XI v. Swiss Mercantile College **H.**
Hockey: 1st XI v. Kings College Hospital **H.**
Wed. 26th.—Soccer: 1st XI v. Westminster College **H.**
Sat. 29th.—Dr. A. W. Spence on duty.
Mr. C. Naunton Morgan on duty.
Mr. R. A. Bowen on duty.
Rugger: 1st XV v. Notingham **A.**
Soccer: 1st XI v. Old Parkonians **H.**
Hockey: 1st XI v. Past Bart's **H.**

APRIL

Fri. 4th.—Rugger: 1st XV v. Treorchy **A.**
Sat. 5th. Dr. R. Bodley Scott on duty.
Mr. R. S. Corbett on duty.
Mr. R. W. Ballantine on duty.
Hockey: 1st XI v. Bexleyheath **A.**
Mon. 7th.—Rugger: 1st XV v. Tredegar. **A.**
Thurs. 10th.—Abernethian Society Meeting.
Sat. 12th.—Dr. E. R. Cullinan on duty.
Mr. J. P. Hosford on duty.
Mr. C. Langton Hewer on duty
Rugger: Inter Firm Sevens.
Sat. 19th.—Medical Unit on duty.
Surgical Unit on duty.
Mr. G. H. Ellis on duty.

GENERAL PRACTICE AND THE MEDICAL COLLEGE

by D. F. ELLISON NASH

The first ten years of almost complete nationalisation of the medical profession have produced many changes in general medical practice and in the relationship between the hospital consultants and the family doctors. Many of us regret the degree of separation which has occurred, and I think it is true to say that in the last three or four years the tide has turned, and by means of organised courses general practitioners are again coming into close contact with a variety of consultants. Soon after World War II in the face of the oncoming nationalisation, and largely due to the inspiration of Bart's men who were in general practice, the College of General Practitioners came into being. Many medical schools adopted a policy of sending their students on attachment to general practitioners for varying periods of one to four weeks in order to give them an insight into the family doctor's work, his problems and his requirements. Although numerous Bart's students have from time to time had the privilege of residing with family doctors in this way it has not been possible to include such a period as part of the essential curriculum. Before the introduction of the compulsory pre-registration year after graduation it was possible for men and women recently qualified to go immediately into general practice as locums or assistants and see for themselves the type of life, the challenge and the opportunities which family practice provides. Now this is no longer possible, and yet during the first year after qualification a student may find himself faced with decisions on his future career with absolutely no knowledge of general practice. Some of us feel that a compulsory period in general practice after qualification would be of tremendous value, given adequate supervision; in fact the Medical Act which makes provision for pre-registration stipulates that six months work in a health centre may be counted as one of the approved appointments. Unfortunately such opportunities do not exist and for many men the first taste of family practice is while undertaking National Service and having the care of service men's families. The profession as a whole is much more aware of the social factors in the aetiology of, or recovery from disease and consequently throughout his clinical training a student is reminded by his teachers of the need to consider the home, the work and the family background in dealing with patients. Organised teaching in social medicine provides additional information, and the student who graduates today is I feel sure much better prepared for general practice than the students of fifteen to twenty years ago.

Recognising however that a need for preparation for general practice exists the Medical College has recently appointed Dr. G. F. Abercrombie as Adviser in General Practice. This appointment has been made by the generosity of a concern outside the College, and the Adviser is at present attending the College on Thursday afternoons to see students by appointment (through the Sub-Dean's office).

It is hoped that men and women who are already out in house posts or holding other appointments will make use of this facility if they would like advice on any aspect of general practice such as the purchase of equipment, assistantship or partnership agreements, postgraduate study, etc.

Many years ago the former Registrar of the College (Mr. Willans) was responsible for the organisation of an agency which worked to the mutual benefit of established practitioners and graduates needing locum or assistant posts. It is not possible at present to re-establish such an agency, although from time to time it has been the privilege of the Dean to act informally in this way, and numerous requests are received from Bart's men anxious to find young assistants and partners. It is hoped that this service may also be extended under Dr. Abercrombie's guidance, and made more useful.

Finally, the Hospital consulting staff conducts half-day teaching sessions specially arranged for visiting groups of 20 general

practitioners as part of the programme for continuing education of National Health Service practitioners provided by the University of London. Bart's does not have "old boys" days or clinical week-ends as do many of the London Schools, and it would be interesting to know whether such functions would be popular. Most keen practitioners have their time fully occupied, but to spend perhaps a Saturday in London at the "old school" might be a justifiable recreation! We have much that is new, in buildings and in medical science to present to visitors. Very few of the old College glories remain: the smell of the students' cloakroom has gone for ever and the new palace is worth a visit; the notices outside the Library which until 1948 still advertised commissions in the disbanded Indian Medical Service have disappeared, but the distinctive noise of the lift in the path block will always recall memories of the trips to the great lunch-time assemblies where physicians and others displayed their intellectual plumage to a ready audience!

COUGH

by W. V. CRUDEN

AIR IS our most valuable possession, and breathing our most important activity. That something intangible is the most precious substance in life, and that an act which is almost unnoticed is our most vital necessity, is a paradox which is not always acknowledged. Yet we cannot stop breathing for much more than sixty seconds, and even the most expert apnoeist cannot hold his breath for more than about two minutes. If, after this brief moment of time, we fail to get air, life has gone. "God in Whose hands thy breath is" does indeed thus describe our dependance. What else can compete in urgency and value with this?

It is not surprising therefore that Nature takes such pains to safeguard this first essential of life. We are provided everywhere with abundance of fresh air. "Free as air" is our good fortune, for no charge can be made for it and no power-besotted dictator can control it. Not one, but three entrances are provided by which we can suck it in, and it is conducted down a perfectly designed passageway without the silghtest obstruction to its final destination in the alveolar membrane, where only a single layer of pavement epithelial cells separates it from the capillary wall with its circulating blood. Should the efficiency of this airway be threatened by obstructing or irritating material, two mechanical safeguards are at hand, the perpetual movements of the cilia and the temporary emergency of the cough reflex.

THE WORD

Primitive man, trying to invent words to express his meaning, could have had no difficulty about this subject. Coughing, we should imagine, was a familiar sound in the damp and draughty caves and huts in which he lived, and all that he had to do in his primitive talk was to imitate the sound of the cough, for his meaning to be understood. It is to be expected, therefore, that the word for cough should be onomatopoeic—an "echo" word. And so it is, for "cough" (why don't we spell it "kof"?) sounds like a cough, and its sister word "spit" is equally onomatopoeic, especially the last letter "t," which leaves one in no doubt that the offending plug of mucus has been well and truly ejected!

It is interesting to see how the word is translated in various languages, and how it still retains its "echo" character in lands far apart. Can we discover in these different words some national coughing characteristics, or in any way detect the prevalent type of cough from the sound of the word? Does the Welsh "Pesuch," for instance, mean that the people of Wales are more given to spitting than the English, or the Scotch "Host" (like the German "Husten") indicate a prevalent wheezy element? The Chinese word for cough is pronounced like "Cute," but the final "t" is apparently brief and muted, so that it hardly sounds at all. May not this word echo and resemble the polished and polite manners for which the Chinese have been noted, and show that they end their cough with as quiet and unobtrusive an expectoration as possible, in contradistinction to the final emphatic "t" of the blatant Englishman's "spit"? And what are we to think of the Turkish word for cough, which is apparently pronounced like "Urk-sur-Rik"? If this indeed be onomatopoeic, it would suggest that the Turk could learn a lesson in elegance from the "Cute" Chinese coughers! Finally, those with first-hand knowledge would surely agree that the Hindustani "Khasi" is a particularly appropriate echo word for the intonation of the Indian cough. (It is necessary to add, at this point, that the above pronunciations have been received at secondhand by the writer, who, however, believes them to be correct.)

Many English people like to add another onomatopoeia to the word "Cough," and so we hear of "hacking," "hawking," "whooping," "barking" and "husky" coughs. The curious adjective "tissicky" is reminiscent of the Latin "tussis." These various additional words are often of help in diagnosis.

THE MECHANISM

Efficient respiration depends upon an intact and untarnished alveolar membrane, free from any deposit which would obstruct the vital passage of the gases through it. For this reason the tiny cilia keep up their incessant metachronal waves, rippling like a cornfield in the wind, moving always towards the upper end of the trachea. Twenty times a second these minute structures whip the sides of the air passages, so that drops of dust and mucus trapped upon them are slowly and inexorably swept away from the fragile alveolar membrane up towards the mouth.

But this delicate and peripherally situated security mechanism is unable to deal with larger foreign bodies, plugs of mucus or irritant vapours which cause more severe and sudden threats to the patency of the airway and which demand quick removal. It is for this purpose that the cough reflex is used. This cough reflex can apparently only originate in the primary and secondary bronchi and is powerless to act in the lower and smaller air tubes. For these smaller tubes there is a preliminary mechanism. Reinberg has shown that the presence of a foreign body in the lower bronchi induces protective peristaltic movements whereby the invading fluid is propelled upwards to the primary and secondary bronchi, where it can be dealt with by the cough reflex and finally expelled. For obstructions in the lower tubes, therefore, there are two distinct events, an initial peristaltic movement followed by a final cough reflex.

The act of coughing is generated by impulses from the pharyngeal branches of the glossopharyngeal nerve and by laryngeal tracheal and bronchial branches of the vagus. There are three stages in the cough reflex, firstly a deep inspiration, secondly a temporary closure of the vocal cords, and thirdly a short and violent expiration. The depth of inspiration is related to the amount of expiratory effort required. When inspiration is ended the vocal cords are completely closed and do not open again until the expiratory movement is well under way. Pressure is thus built up below them and the expulsive blast has an explosive nature when they finally open. Sometimes the expiratory act is slightly prolonged, especially if there is a wheezy element present, and usually more than one cough is necessary to shift the offending object. Perhaps two coughs at a time is the average experience, but sometimes, especially with viscid mucus, many expiratory efforts are necessary, and at times (notably in Pertussis) the onset of the cough induces a whole spasm of quite uncontrollable coughs which may last for a truly remarkable time and even then be quite unproductive. Coughing, incidentally, causes an expiratory increase in the intrapleural pressure, and this pressure is propagated along the peripheral arteries (brachial and femoral) and produces a marked rise ("up to 150 mm. Hg.") in their recorded pressure.

Coughing by itself will eject small particles from the mouth. Larger masses of muco-pus and so forth are usually raised into the mouth and then expelled by the second and separate act of spitting. Whilst the milder forms of cough are to some extent under the control of the will, spitting is completely voluntary—a fact well known to hygienists in the days when "Penalty for Spitting—Forty Shillings" was widely advertised and did so much to help in eradicating T.B. When we remember that a wet bronchiectasis may produce as

much as two pints of purulent sputum within twenty-four hours we can appreciate the immense value of the cough reflex in keeping a clear airway and the importance of controlled expectoration in public hygiene. In passing, it may be mentioned as a curious fact that Physiology books have so very little — or nothing — to say about the subject of cough.

In *inflammation of the respiratory mucosa* from alveolus up to pharynx (including sinus drip) the rationale of coughing is obvious. But it is difficult to see what purpose can be served by those coughs occurring as the result of *pressure on the air passages* from neoplasms, glands, aneurysms and the like (unless, of course, there is associated obstructing matter in the lumen of the tubes), for these coughs are usually unproductive. Perhaps it is Nature's attempt to widen the air passage back into its normal lumen, but if so any such widening must be of a most transient duration and possible only whilst the local situation retains some degree of elasticity. The pressure persists and takes over its perpetual obstructing character as soon as the dilating cough ceases, so that any relief lasts only for the briefest time. So, too, with the cough due to the oddity of a long uvula, which flaps back in recumbency and irritates the pharynx. Coughing will momentarily lift it out of the way, but it falls back again as soon as the expiratory whiff has passed. *The cough which occurs with effort* in cases which are already dyspnoeic (heart failure, pericardial and pleural effusions, gross lung disease and so on) is also probably an attempt to widen the airway and remove fluid obstruction. Even if unproductive it seems to give slight ease, and certainly tends to hinder further harmful effort. *The "nervous" cough*, usually a mere clearing of the throat, is a curious psychological phenomenon exhibited on occasions by all types, from the robust Churchill making a Victory speech to the most timid curate's first pulpit appearance. It is probably in the nature of a preliminary "trial of strength," testing out the patency of the airway and one's ability to produce a noise, just as a pianist plays a few chords before starting off, or the tennis players have a "knock-up" before commencing the game. The little cough over, the speaker can go ahead with more assurance, for it says in effect, "All clear!" *Coughing due to polluted atmosphere* is usually a futile waste of time, because the noxious matter will probably be just as concentrated in the next breath as it was in the preceding one. The irritant reflex, however, is not to know this and in its endeavour to be rid of the annoyance may bring in a further security device in the form of a "nasal cough" or sneeze. In connection with these irritant coughs, "Avoid fogs, fugs and fags" is a useful slogan (but the writer feels that due acknowledgment should always be made when quoting this clarifying apophthegm!).

THE AUDIENCE

All the animal noises which we make are unpleasant to the ear and coughing is no exception. To say the least of it, it is a cacophonous interruption of life at the best of times. In a symphony concert even the most genteel cough is a positive crime ("right in the middle of that superb slow movement!") and will cause a number of irate young men to whip their heads round and "look back in anger" at the offender. Even in the home it can cause trouble, as Mrs. Bennet knew ' "Don't keep coughing so, Kitty, for heaven's sake! Have a little compassion on my nerves. You tear them to pieces." "Kitty has no discretion in her coughs," said her father. "She times them ill." "I do not cough for my own amusement," replied Kitty, fretfully.' How often has this kind of scene been repeated since the days of "Pride and Prejudice"? The most disturbing and dramatic of all coughs is, of course, a really fruity spasm of whooping cough. The child is caught up in uncontrollable and seemingly never-ending spasms, its little face congesting to the deepest redness; the distracted parent not knowing what on earth to do, the onlookers anxiously hurrying their own progeny out of the danger zone, and the doctor saying to himself, "Ah, ha! I know that sound!" Montgomery, of course, would have no nonsense about coughs. In his pep talk in Malta before the Sicily invasion, for instance, he began by saying that his audience had better get all their coughing over before he began talking, as he permitted no such interruptions. He would, however, allow a pause halfway through proceedings, so that anyone in need of coughing would be allowed to do so before the second half of his talk began. Seldom can any Commander have disciplined the bronchial tubes of his troops more rigorously than did Monty! No doubt others, without a field-marshal's authority, would like to take a similar line.

Although there is this antipathy between the cougher and his audience, there is a certain comradeship amongst coughers themselves. In a silent hospital ward at night, for instance, cough by one patient is very often followed by a "replying" cough from another who would probably have kept silent otherwise. The latter may, of course, have half-wanted to cough before but lacked the courage to break the silence of the night. But often the replying cough seems to be a sort of expression of sympathy—"All right, old chap. I, your fellow cougher, am still here," or a kind of rivalry, as if to say, "Ah yes, that cough of yours is all very well, but you just listen to mine—it's much more impressive (or gentlemanly, or effective) than your effort!" Sometimes, too, it is just mere imitation, or perhaps the other person's cough just produces the notion, "Ah yes . . . coughing . . . that's a good idea . . . here goes."

Some coughers get quite proud of their tussic ability and trumpet forth their prowess with considerable pride; others, in the olden days, used coughing and expectorating as a kind of pastime when there was nothing better to do. Martin Chuzzlewit found one such person in New York when Col. Diver introduced him to the famous Major Pawkins. The good Major was found sitting in front of a stove which was "garnished on either side with a great brass spittoon. Before it, swinging himself in a rocking chair, lounged a large gentleman with his hat on, who amused himself by spitting alternately into the spittoon on the right hand of the stove, and the spittoon on the left, and then working his way back again in the same order." The Major "was not aware of their approach until the Colonel, walking up to the stove, contributed his mite towards the support of the left-hand spittoon just as the Major . . . bore down upon it" (another example of the comradeship of coughers.) But fortunately such disgusting habits are disappearing with education. It is, for instance, most impressive to watch a well-trained Sanatorium patient expectorate into his sputum flask with the very minimum of fuss or noise, so that his neighbour is barely conscious of the fact that anything has happened until he sees the flask being unostentatiously returned to the hip pocket.

There are occasions on which a cough is a good way of attracting attention to oneself. Jeeves found this method useful in dealing with his young master Bertie Wooster. Thus Bertie says "I became aware of somebody coughing softly at my side like a respectful sheep trying to attract the attention of its shepherd," and found the faithful Jeeves standing quietly beside him. This method of announcing one's presence may be most useful, for if one becomes sufficiently skilled (and it may require some amount of practice to become near-perfect) the hearer is unable to tell whether the cough was a deliberate trespass upon his attention or a quite uncontrollable bronchial reflex. He is thus compelled to notice the cougher without at the same time taking definite umbrage at the noise—a useful start to the proceedings.

THE DIAGNOSIS

The clinician relies as much as possible on natural signs, and the sound of a cough may at times be sufficient (or almost sufficient) in itself to make a diagnosis without further examination (though the latter should *always* follow as confirmatory evidence). That is why careful recordings of certain absolutely typical coughs should be useful aids in teaching. The playing of the record frequently until it is quite familiar to the student, with preferably two or three different "specimens" of the cough in the same recording, would impress the sound on his mind, but it must be an accurate record. Perhaps this form of teaching is already in use. If not, why not?

The cough of *early measles* consists of one or two short, sharp coughs with a very juicy catarrhal character, almost suggestive of tiny bubbles in it. The cough is repeated frequently and there is often a nasal sniffle added between the little coughs which adds to the typical diagnostic catarrhal picture. Mother says, "She's got such a nasty cough and cold, doctor," as she leads the way upstairs. One look at the child with its watery eyes and reddened caruncles, and perhaps a few koplik spots in the mouth, will enable one to prophesy that the measles rash will be "out" in a day or so. But it is the cough which suggests the diagnosis before ever setting eyes on the child, especially in an epidemic.

Whooping Cough is the most spectacular and readily recognisable of coughs, and in its full-blown stage is diagnostic (though it must not be forgotten that a tendency to whoop when coughing may persist for some time after Pertussis is over and done with). But in the important early stages before the typical whoop has developed, it may be

strongly suspected. The child's cough consists of a series of short, sharp staccato expiratory efforts which give an impression that the little series is not under the patient's control and that the cough, once started, "takes charge" and continues through several quite uncontrollable little coughs until it has spent itself. It has, too, an accelerando character. It is this element of uncontrollability (starting early in the disease and gradually evolving into the prolonged spasms of the fully established disease) which is typical quite early on, and may even be observed when there are only three or four expiratory efforts. Even in the early days, too, there may be some evidence that the cough is induced by excitement, apprehension and so forth.

Pleurisy and acute Pleuro-Pneumonia are characterised by an obviously suppressed cough. The cough reflex compels action, but the pain caused by the cough movement is so severe that the patient holds it back as much as possible. The cough is obviously painful, curtailed, and not really sufficiently strong to be useful, and there is usually a catch in the breath immediately afterwards with a wince of pain shown in the face. These little, shortened, usually single or double coughs, are frequently repeated and are associated with tachypnoea and a respiratory excursion curtailed for the same painful reason. The mere sound of the cough and breathing of such cases is almost diagnostic.

Tracheitis and adjacent inflammation often follows colds and sore throats. It produces an annoying cough of harsh, loud and prolonged sound with a recognisable character which, however, is difficult to put into words. The cough is frequently repeated and notably worse in polluted atmospheres, especially smoke, so that the patient often gives up smoking for the time being. The patient's chief complaint is that he has a cough (and it is often described as "a beastly cough") which "won't clear up." It is his annoyance at its persistence (for it usually lasts several weeks) together with the character of the sound, which dominates the picture. One must, however, be on the watch for more serious causes.

The hysterical cough is a fortissimo bark which seems to say "just listen to that!" It usually has a somewhat annoying effect on the listener, who is inclined to say to himself "I'm sure there's no need for him to make all that noise." The cough is usually a single or twin effort, and its production and intensity are dependent upon the occasion. An audience, although preferable, is not always necessary, as some curious compensation seems to be gained by the cougher even when he performs in solitude. It ceases whenever he becomes wholly engrossed in something outside of himself. It is unproductive.

The brassy pressure cough and the husky laryngeal cough are also amongst the more readily recognisable sounds which should be mentioned. And it should be stated that all coughs tend to vary with day, season, posture, occasion, emotion and atmosphere. If one tried to characterise all the above with their one key adjective one might say that Measles is catarrhal, Pertussis compelling, Pleurisy painful, Tracheitis annoying (to the patient), Hysteria barking, Pressure brassy, Laryngeal husky. (It is hoped that these various descriptions will be amply criticised by more competent and experienced observers if disagreement is there.) All these types of coughing are very familiar to clinicians and others who frequently come in contact with them. Indeed, they become so obvious that a diagnosis might even be made in some cases over the telephone by "listening in" at the other end of the line for a moment or two to the cougher! But this is a dangerous doctrine and should certainly *never* be followed. Unless the eyes as well as the ears are used in diagnosis, most untoward results may ensue!

Perhaps one should add that listening to the cough should always be followed by looking at the spit. "Spot 'em by the sputum" is the slogan here. It is interesting to notice how a dry, loose, viscid or bubbly cough is reflected in the expectoration.

ZURS : 1958

by D. SAVAGE

AFTER a number of trials and tribulations the Club eventually left Victoria on January 18th with a full complement of 55 members. The journey out to Zürs was passed in the usual manner, everyone seeming to be continually either eating, drinking or sleeping. On Sunday morning we awoke in Austria to find less snow than last year, but more than enough to ski on. Most of the party had travelled out in their ski-ing kit, and many were on the slopes within a couple of hours of arrival.

From the first day it was possible to divide the party into two main groups. There were those who rose early, ate sparingly, waxed their skis and were not seen again till lunch, when they could be heard talking excitedly of their experiences on the Zürsersee, Hexenboden and Matloch. Then there were others who rose late, ate well, greased their faces and again were not to be seen till lunch, when they spoke drowsily of the Zürserhof sun loggia, the Flexner balcony, iced lagers and the afternoon's trip to Oberlech. But whatever one was doing the weather was perfect, cloudless blue skies, a broiling sun and masses of snow to admire from a deck chair or a pair of skis.

Towards the end of the two weeks the conditions became a bit icy and altogether more difficult, especially for the beginners. It was during this time that all our accidents occurred, two fractured legs, an injured hand, several sprains of various degrees and what has now come to be regarded as the property of one of the secretaries—a dislocated shoulder. This is the third year that this has happened. Is someone sticking pins into wax images of the Bart's Ski secretaries? Perhaps it will help in the election of next year's officers if it is pointed out that this year the secretary dislocated his shoulder twice—sufficient for next year? It was certainly apparent that the other secretary skied with far more abandon from then onwards. All praise to Joanna and Monica, the two physio-therapists who gave up so much of their "chocolate" time to put the halt and lame back on the slopes in as short a time as possible.

This year Zürs had added another lift to her slopes, a double chair lift. Once one had mastered the art of not trying to sit down too early or get off too late, it was much in demand. Nick Roles, who seems to be attracted to ski anchors, hoists and chair lifts like metal to a magnet, very nearly made the return journey down the Zürsersee suspended by his anorak. Once again the whole party took full advantage of the excellent Ski-school, whilst the beginners spent the first few days mastering the art of not swallowing too much snow on the nursery slopes, the remainder spent their time tearing up and down the Hexboden trying to beat yesterday's record and yet drink enough Gluwein on the way down.

Many of the party went to the Valuga not only for the ski-ing but also for the magnificent panorama which extends northwards to the Bavarian forests. One can see nearly as far as Munich, and in other directions Switzerland, Italy and Austria extend for miles, as far as the eye can see.

Whilst it is difficult to say how everyone's prowess for ski-ing improved, people seemed to make remarkable progress considering the difficult conditions. Most of the first-timers reached 4a and some 3b — this is great credit not only to the individual ski-ers, but to the ski school which lived up to its reputation. Some, notably David Weekes and David Savage, seemed to have the idea that skis were to enable one to get from the highest possible point in the straightest course and the fastest time, and whilst the ski instructor would vainly say "And now ve make ze slow traverse, so," they would hurtle past to end up in a cloud of snow a good hundred yards further on. Others had difficulty in coaxing their skis to move at all until suddenly hitting a patch of ice they would find how much easier it was to ski in a squat position. John Hedley-Whyte, dressed in Crimean P.O.W. outfit, and Sally Juniper in her 1899 ski trousers gave the party a dis-

tinguished air, added to by Hedley's frequent cries of "Gone away," which, since his normal quarry does not frequent the slopes of the South Tyrol, must have been addressed to his skis.

After skiing, tea-dances claimed most people, dancing a quick waltz in ski-boots is not only energetic but agonising for those ladies who change their boots for shoes. It was not surprising, therefore, that many retired to bed till "whoopee bag" parties, the bar, or dinner began, usually around about 7.30 p.m.

In the evenings there was always some form of "apres-ski" dance in one of the hotels. The Zürserhof put on a fancy dress ball in which one or two new girls appeared and were much in demand. On the following morning the photographs which had been taken were hastily bought up.

Suddenly it was time to go, the two weeks had flown by all too quickly. Looking around it seemed a different party to the one that had left Victoria. A few were returning, their limbs moulded into various shapes by Dr. Sepp Murr, but we all were coming back darker, fitter and, if not eager, at least better suited to face the London fogs, lectures and long-houred ward rounds.

Once again our thanks are due to Mr. Tuckwell and Mr. Nash for allowing us the time to ski, to those chiefs who let individual members come, and to Ernst and Hilda Skardarasy for all their helpfulness and concessions to us out in Zürs.

A CASE OF CAT-SCRATCH DISEASE FROM THE DUTY BOX

by M. B. McKERROW & M. S. WHITEHOUSE

THE PATIENTS who are seen in the Medical Duty Box represent an astonishingly broad cross-section of medical practice. Most come with trivial complaints; a few are seriously ill; many present social rather than medical problems, the unwanted misfits of urban life needing rehabilitation or sympathy rather than medicine. These are all in the daily task of the staff of the Box. But occasionally there appears a case which does not fit into any of the usual categories and may be by comparison a clinical rarity. One such case was that of M.H., a schoolgirl aged 15, who was referred by her doctor on account of unexplained lymphadenopathy and anorexia and was seen in the middle of November, 1957.

The story she gave was as follows. Two weeks before we saw her she had noticed an unaccustomed lassitude, loss of appetite and general malaise, not accompanied by fever or headache. At the same time a painful lump had appeared in her right armpit, followed two days later by tender swellings in her neck, especially on the right. She had stayed away from school for five days, but had not remained in bed. Her doctor had given her oral penicillin, but this was stopped after three days as it did not appear to be having any effect. One week before we saw her she had begun to feel rather better, but noticed a slight sore throat lasting for one day only. From then onwards her improvement had continued, and the lumps were no longer painful, although she was still aware of their presence.

On examination she appeared a generally fit girl. Her temperature and pulse were normal. In her right axilla was a mobile non-tender lymph node of about ¾-inch diameter. Both tonsillar nodes were palpable and there were several palpable nodes in the right posterior triangle of the neck. We found no enlargement of lymph nodes elsewhere, nor of her liver or spleen, and her tonsils were not inflamed. Three scratch-marks, each about one inch long, were noticed on the back of her right hand.

We asked her about these marks, and she told us that ten weeks previously she had bought a four-week-old kitten for 3s. 6d. and she was "always being scratched by it." The last scratch had occurred two days before the axillary lump had appeared. All the scratches had healed normally without suppuration.

Investigations

Investigations included chest X-ray, which showed no evidence of enlarged mediastinal glands or other abnormality; Hb 90%; white blood-cell count, 7,000 per cu. mm. with normal differential; E.S.R., 9 mm. in the first hour; Paul-Bunnell reaction, positive to a titre of 1:64. The Paul-Bunnell test was repeated with Barrett's modification one week later, and this gave a *negative* reaction for glandular fever. At the same time three further investigations were done. An intradermal antigen test for cat-scratch disease was positive, giving an erythematous papule of 12 mm. diameter after 48 hours; a Frei test for lymphogranuloma venereum and its control solution both gave negative results; a complement-fixation test for virus of the psittacosis-lymphogranulous venereum group was also negative.

Differential diagnosis

The three most likely diagnoses seemed to be (a) glandular fever, (b) inflammation of an axillary node secondary to a bacterial infection of the hand, and (c) cat-scratch disease.

The weakly positive Paul-Bunnell test had seemed to support glandular fever, but this had been discounted by the negative result when the test had been repeated with Barrett's modification, and by the absence of the characteristic cells in the blood. The second possibility—that of bacterial sepsis—could not be supported, we felt, because of the lack of local reaction to the scratches and their quick healing. Cat-scratch disease, however, was strongly supported by the history and by the positive skin test. The disease had taken a mild course, but we think the evidence of it sufficient to make a fairly confident diagnosis.

Subsequent course

The patient was observed for one month. For most of this time she had felt perfectly well, and at the end of it the cervical nodes were no longer palpable, but the axillary node, although smaller and rather firmer, was still definitely enlarged. The site of the cat-scratch intradermal test was still discernible as a slightly indurated purple macule 5 mm. in diameter.

The kitten was destroyed, much to its young mistress's chagrin, a few days after we had first seen her. Its fall from domestic grace owed nothing to its owner's illness, nor to its habit of scratching, but was due rather to its reluctance to accept some of the other conventions of domesticity.

THE DISEASE

It is not possible in a short article to present a full review of the literature which has already sprung up around this condition, or indeed to attempt more than a brief history of the disease and an account of some of its salient features.

Cat-scratch disease has only recently been generally recognised as an entity, although in France and America it had been gradually gaining recognition during the last twenty years. Among the pioneers in this field were Debré of Paris and Foshay of Cincinnati. Both independently had, since the early years of the 1930's, observed examples of a benign illness with sterile suppurative adenitis following the scratch or bite of a cat, but it was the similarity of their findings when compared at a meeting in 1947 which prompted a more widespread interest in the disease. The theory, now generally accepted, that the disease was a clinical entity was strongly supported by the work of Rose of New York, who in 1945 prepared a sterile solution of the pus which was found to act as a specific antigen when injected intradermally (Foshay, 1952). It was thus possible to use the pus to perform a skin test for cat-scratch disease in the same way as the pus from a bubo of lymphogranuloma venereum was used in the original technique of the Frei test.

The ultimate source of the disease is not known. It is caused almost certainly by a virus, and the cat is merely the vector, carrying the virus on claws or teeth while remaining healthy itself. But it is not known where in its wanderings the cat picks up the virus or indeed whether it is the only species to do so. Nor of course is it known whether the disease is a new or merely a newly-recognised entity. Perhaps the latter is the more likely alternative, and in this context we should remember that modern antibiotics, through their efficacy in the treatment of bacterial diseases, have thrown into relief many conditions caused by viruses, against which we have at present no comparable weapon.

The species susceptible to the disease are limited to man and the apes, and to these it has been transmitted experimentally, but attempts to infect cats and other animals have not succeeded.

Clinical features

There is great variation in the clinical features of the disease, as is shown in the analysis of 160 cases carried out in America by Daniels and MacMurray (1954) and by study of the cases so far published in this country. On the whole it is a disease of young people. In the American series referred to, one-third of the patients were under 10 years old, and two-thirds were under 30.

So diverse are its manifestations that one is hard put to it to describe a typical case. But the cardinal features for diagnosis are (1) a history of the scratch or bite occurring 1—7 weeks before the onset of symptoms, (2) lymphadenopathy within the lymph drainage area of the scratch, and (3) a positive cat-scratch intradermal test. Symptoms may include headache, nausea, lassitude, general malaise and aching of the limbs.

The incubation period appears to vary greatly, but, as in our case, one often cannot be sure which scratch caused the disease. Usually the illness begins within three weeks of the scratch, but incubation periods of seven weeks or more have been recorded.

The lymphadenopathy again is variable. In the earlier reports the walnut and golfball were quoted as objects of comparison by English and American writers respectively, but often the nodes are much smaller. They are not always tender, but a constant and characteristic feature is the absence of lymphangitis between the primary lesion and the inflamed glands. The nodes often suppurate, but this is by no means an invariable feature. They usually remain enlarged for at least six weeks and sometimes for as long as two years. In addition to the enlarged nodes in the lymph drainage area of the scratch, there is often a more widespread lymphadenopathy, but these nodes do not suppurate and they return more quickly to their normal size. The spleen seldom becomes palpable.

Fever occurs in 75% of cases (Daniels and MacMurray), and may be high (101-103°). A skin rash occurs occasionally, and is then usually a generalised macular or papular eruption, although examples of erythema nodosum have been reported.

Morbid anatomy

The pathological changes associated with the disease have been described by a number of authors, and most recently by Brand and Finkel (1956). The primary lesion shows a generalised infiltration of the corium by lymphocytes and polymorphonuclear leucocytes. In the earlier stages plasma cells and eosinophils are also prominent, and later histiocytes and multinucleated giant cells appear. The affected lymph nodes are enlarged and often adherent, and on section appear red and homogeneous or necrotic. Microscopically there are local infiltrations of polymorphonuclear leucocytes and plasma cells, followed by the formation of numerous foci of structureless necrosis surrounded mainly by epithelioid cells with occasional giant cells. The picture is often sufficiently typical for the diagnosis to be made from it.

The skin test

The principle of the skin test consists in injecting intradermally a sterilised solution of pus from a known case and noting any local reaction after 48 hours. The technique of preparation of the solution varies slightly in different laboratories, but that described by Bettley and Fairburn (1953) illustrates the general principle. The pus is diluted 1:10 and then sterilised by heating to 60°C. for two hours and reheating for one hour on the following day. 0.1 ml. of this solution is used for the injection, and a positive reaction consists of a firm intradermal papule, 5-10 mm. in diameter, usually with a ring of erythema around. The papule may last as long as eight weeks.

The specificity of the test and its freedom from false positives were investigated by Bettley and Fairburn when they injected the antigen into forty volunteers who kept cats but gave no history suggesting cat-scratch disease. Three of these cases showed positive reactions, and the remaining 37 were negative. Remembering that a positive reaction may be obtained many weeks or months after the illness, it seems reasonable to associate these reactors with past undiagnosed infection. The general reliability of the test seems therefore to be supported by this investigation.

It is usual, when testing for cat-scratch disease, to do also a skin test for lymphogranuloma venereum and a complement-fixation test for the psittacosis-lymphogranuloma venereum group of viruses. The early French workers had considered that the virus of cat-scratch disease belonged to this group of viruses, but the almost consistently negative result of these tests in cases of cat-scratch disease disproves any cross-specificity of its antigens with those of other members of the group.

Other differential diagnoses which have to be excluded clinically or by laboratory tests include infectious mononucleosis (glandular fever), tuberculous adenitis, the reticuloses, and of course bacterial infection with secondary adenitis.

Complications

Three complications, although rare, are worth mentioning. The most important is encephalitis, of which there were two examples in the 160 cases reviewed by Daniels and MacMurray. Both were mild cases and the patients made a complete recovery.

Hinden (1957) described the case of a girl of 14 in whom a widespread lymphadenopathy was associated with conjunctivitis and suppuration of the pre-auricular node. The cat-scratch skin test was positive, and it was thought that the virus might have been conveyed to the eye by the patient's fingers. Similar cases have been reported in America and France.

The third was the association with pneumonia reported by Sheldon and Smellie (1957). The patient, an adult, showed the local lesion, regional adenitis and a positive skin test. One week after the onset of the disease she developed a high fever and consolidation of the right lower lobe. No pathogens were grown from her sputum, blood culture was negative, and there was no definite response to antibiotics. The complement-fixation test for the psittacosis-lymphogranuloma group of viruses was positive to a titre of 1:32, but serial tests showed no change in this titre throughout the illness. One cannot be quite sure that it was the cat-scratch virus that caused this patient's pneumonia, but the authors of the paper were at great pains to exclude other possibilities, and therefore the association with cat-scratch disease is of great interest.

Conclusion

It will be seen from the description of our case and from the brief review of those of others that cat-scratch disease is protean in its manifestations and inconstant in its severity. It is a disease easy to suspect if one bears it in mind, but impossible to prove without laboratory help. It is a self-limiting disease and treatment is largely symptomatic.

The multiplicity of its features and uncertainty of its ultimate cause are reflected in the names that have been given to the disease. Cat-scratch fever, cat bite disease and cat-scratch disease are synonyms for the same condition, and they tell us little but its mode of transmission. The inconstancy of the fever has resulted in the third of these names being adopted in the recent English papers on the subject. An impressive title, to English ears at least, though no more informative, is that given to the disease by the French writers—"La maladie des griffes de chat."

Acknowledgments

We should like to thank Professor C. F. Barwell and Professor L. P. Garrod, who helped us with their advice. Professor Barwell and the Department of Bacteriology at the London Hospital kindly provided us with the solutions for the intradermal tests and performed the complement-fixation test.

Our thanks are also due to Dr. D. Weitzman for his permission to publish this case from the Medical Casualty Department.

REFERENCES

Debré R., Lamy, M., Jammet, M-L., Costil, L., Mozziconacci, P., (1950). *Bull Soc. méd. Hôp. Paris, 66,* 76.
Foshay, L. (1952). *Lancet, i,* 673.
Daniels, W. B., and MacMurray, F. G. (1954). *J. Amer. med. Ass., 154,* 1247.
Brand, T. A., and Finkel, K. C. (1956). *Brit. med. J., i,* 88.
Bettley, F. R., and Fairburn, E. A. (1953). *Lancet, i,* 520.
Hinden, E. (1957). *Brit. med. J., ii,* 444.
Sheldon, G. C., and Smellie, H. (1957). *Brit. med. J, ii,* 446.

MANY YEARS AGO!

TWENTY years ago I used to look after an old Bart's man who had qualified some 60 years before. When he was a dresser one member of the operating team had the onerous task of working the brass pump which delivered the fine carbolic spray over the field of operation. One day, seeing on his desk a copy of the Bart's Pharmacopeia issued in 1888, I begged him to give it to me. In many ways it differs little from the 1912 edition—but the number of people on the Staff was 28, and not one had managed to weather the time between the two editions.

A few names had been crossed out by my friend and the new boys' names written in their places, and amongst them were the names of Bowlby and Lockwood. The only hospital knight was Sir Dyce Duckworth, but one of the two consulting surgeons was Sir James Paget, Bt., who has survived in my memory as "about to trepan." Also on the staff at this time was Dr. Samuel Gee of linctus fame, who must be one of the only men to turn down a knighthood for a fur coat. The details of this are quite amusing and refer to when Gee had been treating the Prince of Wales. In consideration of his services to the Prince, the Lord Chamberlain rang Gee up at the hospital one Christmas time and enquired as to whether he would prefer a K.C.M.G. or a K.C.V.O. Gee immediately replied that although he appreciated the honour done him he would prefer a fur coat. The fur coat duly arrived and so Gee sacrificed his knighthood.

Dr. Norman Moore, the historian of Bart's, Dr. Brunton of the sphygmomanometer, and Matthews Duncan the Physician Accoucher to the hospital are all there as well. Until the advent of W. S. A. Griffiths, all the Physicians Accoucher to the hospital operated on the perineum, 'abdominal section' was performed when of gynaecological import by a surgeon.

The ENT Department was headed by Mr. Cumberbatch, who returned during the first World War to help with the Aural clinic and caused some alarm by grasping his reflecting mirror between his teeth.

The junior Assistant Surgeon was Mr. Bruce Clarke, whose closure of the abdomen was to give Sir Hulbert Waring such vast experience and masterly skill in the repair of incisional herniae.

There was none of the nonsensical and exigenous specialities such as dermatology, diagnostic radiology, orthopaedic and traumatic surgery, paediatrics, cardiology, neurology, pathology nor the most fanciful of them all, the chloroformist who has now blossomed into that medical butterfly, the anaesthetist. What a vast experience those physicians and surgeons must have had.

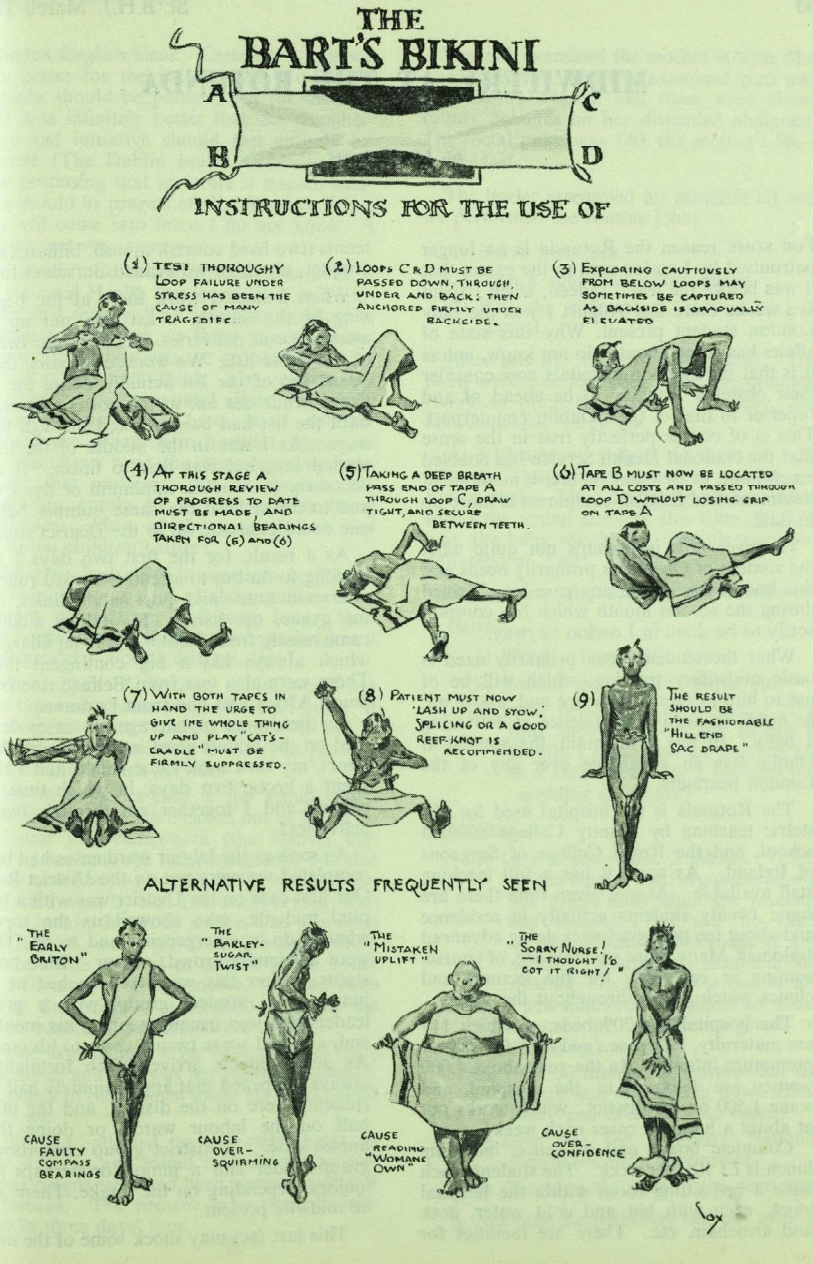
My old friend was in the I.M.S. and, of course, said what every other person who has been there since Clive said, "My boy, I was in the last batch of people who went to India whilst it was still worth going to. It has never been the same since." He had looked after several units, but always spoke of the Bengal Sappers and Miners. He became almost blind and then, shortly after the beginning of the last war, his hearing began to go. This was too much for the old man and he sent his nurse out to do some shopping and, while she was away, he cut his throat.

TO THE DUTY H.S.

Through some misunderstanding this gentleman returned to see me this morning bearing his casualty card and his x-ray in a Wet Film Frame.

I was delighted to see the yellow card of my old surgical firm and feel that he has established something of a record by getting out of Bart's with all this paraphernalia. However, I am returning it herewith and am instructing him to return again in two weeks time.

Yours sincerely, C. H. HOSKYN.



MIDWIFERY AT THE ROTUNDA

by M. HASLAM

FOR SOME reason the Rotunda is no longer patronised by London men to the extent that it was before the war. Indeed, when I spent five weeks there last August I was the only London student present. Why this state of affairs has come about I do not know, unless it is that the London hospitals now consider their obstetric teaching to be ahead of and superior to that of their Dublin counterpart. This is of course perfectly true in the sense that the National Health Service has enabled much more to be spent on lavish methods of treatment, and English equipment is more up to date.

However, this is perhaps not quite what the student of Obstetrics primarily needs and this knowledge can in any case be obtained during the second month which has compulsorily to be done in London anyway.

What the student does primarily need is basic midwifery training, which will be of use to him in general practice and, above all, he needs to acquire confidence at delivering a baby. In this, I maintain, the student at Dublin has an advantage over any of the London hospitals.

The Rotunda is the hospital used for obstetric teaching by Trinity College medical school, and the Royal College of Surgeons of Ireland. As such, it has a full teaching staff available. At any given time there are some twenty students actually in residence and about ten post-graduates doing advanced diplomas. Many more students are, of course, coming in each day for the lectures and clinics which go on throughout the year.

The hospital has 209 beds, of which 117 are maternity, 32 gynae., and 60 "for sick or premature infants." In the year about 4,000 women are delivered in the hospital, and some 1,500 on the district; which works out at about a hundred cases each week!

Complete board and residence, including lunch is £3 10s. per week. The students each have a bed-sitting room within the hospital block, each with hot and cold water, desk and armchair, etc. There are facilities for tennis (two hard courts), squash, billiards and croquet, of which we availed ourselves fully.

When I started work there at the beginning of the month, a list was put up for attendance at deliveries. There were twelve of us on the list. We worked in pairs, those at the top of the list actually doing the delivery, while the one at the bottom watched, until the list had been worked through both ways. As I was in the middle of the list I started last, but was first to finish. It was necessary to watch a minimum of five cases and to do at least the same number before one could graduate on to the District rota.

As a result, for the first two days I had nothing to do but to attend the ward rounds, afternoon ante- and post-natal clinics, and the gynae. op. lists. My fellow students came mostly from Dublin and from Glasgow, which always has a big contingent there. There were also two from Belfast, one from South Africa and one from Lausanne.

As there were on average ten cases delivered on the labour ward in each twenty-four hours, my turn soon came round and I then spent a hectic two days, in which time my partner and I together got through twelve deliveries!

As soon as the labour ward cases had been completed we were put on the District Rota. Our first case on the District was with a hospital midwife, who showed us the ropes: what to do in emergencies, and so on. They were a friendly crowd, of our "Blue belt" status. After this we were attached as the junior on a student group, with a group leader who was usually nearing his month's end, and had some twenty cases to his credit. As new students arrived each fortnight it always happened that approximately half the students were on the district, and the other half on the labour wards, or doing their nurses case. A district group comprised a group leader and a junior, or perhaps two juniors, depending on the intake. There was no midwife present.

This last fact may shock some of the more orthodox English ideas. Certainly I suppose it is better for the patient that a qualified midwife should be present, but for the student it is infinitely better that the responsibility and initiative should rest entirely on himself. (The Dublin health authorities are now proposing that in future a trained midwife should be present at all deliveries. When this will come into force I do not know. I suspect not very soon.)

It should also be remembered that there is no National Health Service in Eire, and midwives cost money. The tenement dwellers in Dublin are not rich, as there is a lot of unemployment. Nor was the procedure as hazardous as one might think. The mothers had all attended the ante-natal clinic where any abnormalities would have been spotted. These were delivered in hospital. The rules for admission were the same as over here, except that multipara got no special consideration purely by virtue of their being multipara. Most of the cases I saw had up to ten children before!

Also we had strict instructions to 'phone for help if any of a list of abnormalities were present, e.g., Delay: 2nd stage longer than two hours in a primigravida or one hour in a multigravida. Foetal distress, etc.

The subject of the cost of various drugs and types of treatment was brought home. It is something never taught at Bart's, but is certainly worth knowing if one is to practice outside the Health Service.

My first district case in the group was a typical one. We were called out at 2 a.m. to a house in Drumcondra (the district embraced not only the local tenements, but also some new housing estates to the north of the city) and went by car. There was myself, who was a junior, the group leader, who was from the R.C.S.I., and a girl from Glasgow, also a junior. The three of us arrived at the house at 2.20 after a bit of trouble. We had been given the address in English, and all the street names in the estate were in Irish.

The woman had been having pains since midnight, and this was her eighth pregnancy. A gaggle of old women made tea and chatted with us.

We had collected the ante-natal notes on our way out and found that six of her previous pregnancies had been normal, and one a forceps. The present baby was officially due in three days' time.

We each examined the mother in turn. She was an L.O.A. The Os (examined p.r.) was two fingers dilated, and there were about twenty fleabites on her distended abdomen. The foetal pulse was 140, the mother's 98—rather fast.

The leader assembled his obstetric kit and we performed the routine jobs:—

(1) Shave perineum.
(2) Give a soap and water enema.
(3) Boil the instruments, gloves, etc., in Dettol.

After this we settled down to wait. The pains were coming about every five minutes. Every so often we assessed the case, and betweenwhiles drank tea.

At 5.10 a.m we judged the os to be fully dilated. The pains were strong and we got her to push. The Glasgow girl was elected to do the actual delivery this time. At 5.30 a.m. the baby was born. The placenta was delivered at 5.40.

Our routine after delivery was as follows:

Baby—

(1) Weigh. It was 8lb. 2oz.
(2) Record temperature, pulse, etc.
(3) Instil two drops of Acetocid 20% into each eye. (In my month in Dublin I never saw an infected eye in a child, although I handled two syphlitic placentas.)

Mother—

(1) Give ergometrine, 2 tablets. (Even on the labour ward ergometrine was not given until after the placenta had separated. I saw no cases of postpartum haemorrhage of any severity; a supposed hazard of this method. In England in one month I saw nine retained placentas where ergometrine had been given on crowning.)
(2) Wait 30 minutes to ensure that the uterus was contracting down effectively and bleeding had ceased.
(3) Give her the necessary National Assistance form if required.
(4) Check on the state of the perineum.

In this case the perineum had not torn. If

a tear did occur a post-graduate was sent for and the suture done under his supervision.

We left the house at 6.30 a.m. and, on arriving back at the hospital filled in the details in the case book. For the next ten days one of us would be visiting the house to check that all was going well.

This too was quite a responsibility. One home I visited some five days after the birth was in a tenement block in the centre of the dock area. The tenement had two flats per floor on each staircase. Water was available from a tap at the head of each flight.

When I went into the bedroom it was to find no furniture except for the bed which was covered with some very dirty linen and newspaper, stained, and with some twenty flies of the Dublin summer breed—fat, slow, and self-satisfied ; bluebottles who did not even bother to get up when you entered the room—sitting on it.

The floor had no carpet—the walls no wallpaper. But even here over the bed was a picture of the " Sacred Heart," and by the door some Holy Water.

The baby was lying on the bed, swaddled. It cried as I undid its fastenings, and I found a nasty, raw weeping area under each axilla. I told the mother to bring the baby along to the clinic straight away. This she could not do as she had not yet been " churched," and was therefore unable to leave the house. Nor apparently had she friends who would do it for her. Under these circumstances I reported the case to the social almoner, and the C.C. (Clinical Clerk Dublin's equivalent of a houseman) went out himself to deal with it.

We did not only see normal cases on the district, but were also called out to abortions, threatened or inevitable.

One night at 2 a.m. we were called out to Finglas to see a woman aged 29. This was her fifth pregnancy. She was nine weeks pregnant. She had had a " show " at 7.30 p.m., and at 10.30 had passed some clots which she had not kept.

The C.C. had come with us and examined her. The Os was one finger dilated, and the C.C. decided to do a D. and C. then and there. This was done in the bedroom, with only sedation and a local. Ergot 0.5 mg. was given, the foetus baptised, and we left at 5.30 a.m., an eighteen-month-old child still asleep in the cot on the other side of the room!

Chloroform was used on the district when a " general " was required. This was necessitated by the presence of coal fires, preventing the use of ether. It struck me as being very effective and is, of course, used in England quite a lot in the country districts, in spite of its bad reputation.

After ten days on the district, in which time I conducted seven district cases, culminating in a particularly heavy 36 hours, our group was dissolved and we were given a rest. This meant that we were free to do as we liked for a few days, apart of course from the weekday hospital activities.

A bell rang in the daytime if an abnormal case was coming off and one was expected to watch or assist. Whilst I was there I had an opportunity of seeing some twenty forceps deliveries, though not the chance to apply them, as the post-graduates always snapped these cases up. I also saw a number of Breechs, a few twins and was lucky enough to see triplets born while I was there. Also one assisted at the Gynae. operations, two days per week, if not out on the district, and went to the afternoon out-patient clinics.

After a few days break I returned to the district fray, this time as a group leader, with two of the new entry with me. Within a week I had completed my required number of cases (20), and so with the knowledge that I still had a further month to do in London, I decided to retire and spend my last four days in Dublin virtually on holiday. Two of my Glasgow friends did the same. These people incidentally only do 13 normals, but do a further fortnight (making six weeks in all) specifically on abnormals, in Glasgow. This seems to me to be a good idea, because here one can qualify without ever attempting to apply forceps or deliver a breech.

We spent four happy days touring the Wicklow mountains, bathing at Bray and Howth, and visiting local beauty spots in a hired car (Morris Minor at £2 per day), which we obtained in Dublin. I too visited Carrickmines, where the all-Ireland croquet championships were being played, and was made an honorary member for the occasion!

Dublin has a lot to offer the student, and was to my mind a pleasant break from routine. At week-ends, and when not first or

second on call on the rota, one might visit the abbey theatre, watch the races or hurling at Croke Park; visit the zoo at Phoenix Park, and spend an evening in the gay cafés where many of us would rendezvous. The local cinema took hospital calls. And then there were the parties, the mad parties, with the students and their Dublin friends. Any excuse for a dance or a bottle party was invoked. Farewell parties (two per month), new arrival parties (also two a month) and so on.

I came away at the beginning of September with a deep sense of regret at losing so many good companions and leaving behind such pleasant people.

Perhaps one of the most interesting aspects for me was the gaining of an understanding of the orthodox catholic views on childbirth and related subjects. Also I had an opportunity of seeing many examples in the wards of tuberculous and hypertensive patients giving birth to healthy children with the utmost ease, thus showing the lack of any need to condone the half-hearted excuses for the wholesale removal of unborn children in England on these and similar pretexts.

A visit while in Dublin to the new Anatomy room and lecture theatre at Trinity are worth while. Also most of Cunningham's original dissections are to be found in the museum. Dublin also sports Guinness's brewery!

All things considered, I found my month in Dublin to have been eminently worth while. It did to my mind combine the experience gained on the district here with the other month at one of the outer London midder. hospitals, giving both district and ward work. Above all, it gave far more personal responsibility to the student, and showed him midwifery as he would know it, if like as not he does not finish up in a London consultantship, but rather as a G.P.

Bart's gives an excellent teaching on midwifery, and the communal student life, but with often as not only some five district cases per month. The outer hospitals give labour ward work, but not the facilities of a teaching hospital. A month at the Rotunda combines the best of both worlds, with a high prestige, and a chance to see life, if but for a short time, in another capital, in an environment outside the Health Service, where the cost of treatment and drugs can be seen first hand, and this valuable knowledge can be acquired.

SPORTS NEWS

VIEWPOINT

At the end of the sports news this month is included a list of the officers elected for the coming season by clubs playing Summer games. This has been done because on occasion it may be difficult for someone not playing a particular game to discover who in fact is responsible for the affairs of the club involved. It is hoped that this will prove of use to someone.

It will be observed that the Sports Calendar includes matches for part of April as well as for March. This will be the form the calendar will in future take, because it is almost inevitable that the *Journal* should only appear about the middle of the month, and this would seem to be the simplest way of ensuring that people not at Bart's are always informed of the activities taking place.

Unfortunately one of the disadvantages of playing a minor game is the considerable danger that either the opposition will not turn up for home matches, or not be expecting one for away matches. Recently only one instance is known of this happening to teams visiting Bart's, but it has happened several times to teams from Bart's ! Perhaps it is inevitable that this should be the case, but it would seem so easy to avoid.

SPORTS CALENDAR

Saturday, 1st
1st XV v. Old Milhillians **H.**
1st XI Soccer v. Trinity College, Cambs. **A.**
1st XI Hockey v. St. Mary's Hospital **A.**
Sunday, 2nd
1st XI Hockey v. The Bandits **H.**
Wednesday, 5th
1st XI Soccer v. Guy's Hospital **H.**
Saturday, 8th
1st XV v. Loughborough College **H.**
1st XI Soccer v. St. George's Hospital **H.**
1st XI Hockey v. Inland Revenue **A.**
Saturday, 15th
1st XV v. Aldershot Services **H.**
1st XI Soccer v. Middlesex Hospital **H.**
1st XI Hockey v. Oxted **A.**
Saturday, 22nd
1st XV v. Harlequin Wanderers **A.**
1st XI Soccer v. Swiss Mercantile College **H.**
1st XI Hockey v. King's College Hospital **H.**
Wednesday, 26th
1st XI Soccer v. Westminster College **H.**
Saturday, 29th
1st XV v. Nottingham **A.**
1st XI Soccer v. Old Parkonians **H.**
1st XI Hockey v. Past Bart's XI **H.**
Friday, April 4th
1st XV v. Treorchy **A.**
Saturday, 5th
1st XI Hockey v. Bexleyheath **H.**
Monday, 7th
1st XV v. Tredegar **A.**
Saturday, 12th
Inter-firms 7-a-sides **H.**

RUGGER

1st XV v. Streatham on Saturday, February 15th. Away. Lost 12—21.

Although they lost this high-scoring game, the 1st XV gave one of their best exhibitions of attacking rugby seen this season. With the return of the captain, R. M. Phillips, next week after four months off through injury, the prospects of our finishing off the season in grand style are thus considerably enhanced.

Despite the fact that one or two of the side were visibly affected by the previous night's Hockey Club Ball, Bart's began well and were soon ahead, Stevens kicking an easy penalty from in front of the posts. Streatham, stung into action, now launched several promising attacks, equalising with a similar penalty goal ten minutes later. They went further ahead when the Bart's covering failed and the Streatham three-quarters slipped through to score under the posts, a try which was converted. There followed some excellent attacking football by the Hospital, with Davies, McMaster and Bamford each making several penetrating runs. Despite these, Streatham were next to score when they kicked another simple penalty goal from thirty yards out. Stevens replied shortly afterwards with a further penalty for Bart's. Streatham scored another goal when an attempted drop-kick by a Hospital player was fielded, and the opposition immediately set up another attack, finally scoring under the posts.

After the interval, with Streatham now leading by 16 points to 6, Bart's started to attack from every quarter and newcomer Randle at wing forward twice came very near to scoring with determined runs. After ten minutes, Rees Davies scored a beautiful try wide out, after working a highly successful dummy scissors with McMaster. Five minutes later, Halls just managed to touch down in the corner before knocking over the corner flag. Neither try was converted.

With both sides now attacking hard there was much open play. The final score, however, came from Streatham who, winning the strike from the loose head, set up a movement on the blind side, which resulted in their fast left-winger to score under the posts. Though beaten in the line-outs, Bart's fought well in the loose and tight scrums, but the pack as a whole must cover and corner-flag much more rapidly if their opponents' short-passing movements are to be broken up.

Laurie Thomas led the side well, with good support from Randle, Pennington and Gibson forward, and Davies, McMaster and Halls outside the scrum. Altogether a satisfactory display.

Team:
M. Britz; J. Stevens, J. Bamford, A. B. M. McMaster, G. J. Halls; R. R. Davies, B. Richards; J. L. C. Dobson, J. W. Hamilton, B. Lofts; J. Pennington, W. P. Boladz; T. W. Gibson, L. R. Thomas (Capt.), G. Randle.

1st XV v. Old Blues on Saturday, February 22nd. Away. Won 6—5.

Recording their ninth win of the season, the 1st XV (with the return of the Captain, Mike Phillips after four months' lay-off through injury) were playing at full strength for the first time this season. It was most heartening to see genuine attempts at attacking football, the first try being the result of one of McMaster's breaks in the centre.

With the Old Blues kicking off amidst snow and sleet, Bart's soon settled down in the opposition half and, adapting themselves to the conditions much better than their opponents. By kicking ahead in the mud and following up quickly they made several dangerous raids on the Old Boys' line. After twenty minutes, following an excellent passing movement, this despite the appallingly greasy ball, McMaster made a fine break and Stevens was at hand to take the final pass. He dived over half-way out for an unconverted try. Ten minutes later, after a forward rush in which Randle, Hamilton and Thomas were prominent, Dobson touched down to put Bart's six points up at the interval.

With the snow still falling, the Hospital gained a foothold in the Old Boys' half early on in the second half. Several times Bart's should have scored, but always the final pass was dropped or carelessly thrown forward. A little later, after a scrum ten yards from the Hospital line, a defensive lapse let through a powerful Old Blues' centre three-quarter to score under the posts, making it 6—5. Bart's pressed hard for the rest of the game and first Davies, and then Halls nearly scored.

At the close, the Old Boys were still defending against a number of good foot-rushes by the Hospital.

As usual, Mackenzie held the opposing fly-half in tight rein, and Thomas led the forwards admirably. Hamilton hooked well and Davies continued his fine attacking play and kept his backs well supplied with the ball.

Team:
M. Britz; R. M. Phillips (Capt.), J. Stevens, A. B. M. McMaster, G. J. Halls; R. R. Davies, B. Richards; J. L. C. Dobson, J. W. Hamilton, B. Lofts; J. Pennington, W. P. Boladz; J. C. Mackenzie, L. R. Thomas, G. Randle.

MEN'S HOCKEY

1st XI v. National Provincial Bank on January 11th. Lost 1–3.

The quest for knowledge into the secrets and marvels of childbirth having deprived us of a treasurer and a fixture secretary, we took the field with a slightly depleted team on a fairly heavy pitch. Bart's started very quickly and had scored a rapid goal before two of the members of our team had appeared on the field. This was a duet between Anderson and Glover which left our opponents' defence gaping. It was not to last, however, for with the arrival of our missing members, the Bank got into their stride and by half time had equalised. The second half produced good hockey with our defence playing gallantly and saving many goals while the forwards produced several good movements but, alas, no goals. Our opponents scored twice during the second, half both goals coming from quickly taken free hits when marking was faulty. Gordon in goal had a field day and showed good judgement in coming out to save whilst the backs, Garrod and Defrates, broke up many attacks and hit the ball cleanly and hard.

Altogether a satisfactory result with the Bart's side playing intelligently and raising their game to suit their opponents.

1st XI v. University College on February 15th. Won 4—1.

This was certainly a good scalp. Playing on a fairly firm and fast pitch, the whole Bart's side really looked like business and the result shows the consequences of a side playing well together. The forwards excelled themselves in this game; taking advantage of some rather loose marking by our opponents, they used the through pass with devastating effect. Glover opened the scoring for us when he hit a very good shot, completely beating the goalkeeper, following an intelligent series of passes between our forwards. The half-time score was 1—0. In the second half, with the defence fully backing up the forwards' good play, keeping our opponents out of our goal, it was all our own. Glover, Anderson and Bonsfield added to our score, while University College managed to sneak a belated goal in the dying minutes of the game.

Team:
A. J. Gordon; M. Defrates, J. A. Garrod; N. C. Roles; D. S. Wright, D. Godwin, J. Bonsfield (1), P. J. Kingsley, D. N. C. Glover (2), A. S. Anderson (1), R. B. Church.

1st XI v. Orpington on February 22nd. Draw 2—2.

This game was played in the most unfavourable conditions, it being extremely cold and, snowing heavily. The ground was extremely heavy and one felt that everyone was hoping that someone would be courageous enough to cancel it! However, it was played somehow, and everyone in the end seemed to have enjoyed it. It was, of necessity, a slow game, a game of mis-hits and fluffed shots at goal, but both equally distributed between the two sides. They opened the scoring—rather to our amazement and annoyance—but we were soon fighting back and, following a very good run and shot by Church on the wing, one of their backs stopped a certain goal with his hand and we were awarded a penalty bully. Anderson took the bully and, true to form, scored a goal from it. Our next goal came from a free-hit, taken quickly by Roles, to MacKenzie-Ross on the edge of the circle. A quick pass to Anderson was neatly flicked past backs and goalkeeper. In the second half, Orpington scored again, and so we returned to the warmth of the pavilion with honours even.

Team:
A. J. Gordon, M. Defrates, J. A. Garrod; W. H. Pagan, K. MacKenzie-Ross, D. Godwin; J. Bonsfield, N. C. Roles, D. N. C. Blover, A. S. Anderson, R. B. Church.

1st XI v. St. Mary's on March 1st. Lost 2—5.

A curious match played on a fast, flat pitch at Teddington. The first half was nothing short of disastrous, Mary's scoring all five of their goals while we looked on in wonder and admiration. Craggs, in goal, weathered the onslaught well and succeeded in achieving the scalp of the Mary's energetic centre-forward when he came out from his goal with colours flying and, with the aid of a little beef, forcibly grounded his opponent with an effective "crash-tackle"! His efforts were unfortunately rewarded with a penalty bully—which he lost. Anderson managed to score a very fine goal in this half when he beat many opponents with clever dribbling. In the second half things were different. We got annoyed with ourselves and played very well as a result. Not only did we prevent Mary's from scoring again, but we had more of the play and once again Anderson produced one of those goals which leaves one's own side purring but one's opponents flabbergasted!

Team:
C. G. Craggs; M. Defrates, J. A. Garrod; W. H. Pagan, K. MacKenzie-Ross, D. S. Wright; J. Bonsfield, N. C. Roles, D. N. C. Glover, A. S. Anderson, R. B. Church.

WOMAN'S HOCKEY

Results of matches played during February:—
Feb. 1st.—v. Reading University. Lost 2—10.
Feb. 5th.—v. St. Mary's Hospital. Won 7—1. (Hospitals Cup Semi-Final.)
Feb. 12th.—v. Royal Holloway College. Lost 4—7.

Feb. 15th.—v. Wimbledon 2nd XI. Won 5—1.
Feb. 22nd.—v. Oxford University. Lost 4—5.

We are very fortunate in having been able to play all the matches arranged during the past months. None had to be cancelled on account of the weather as is usual at this time of the year.

The game against Reading University was our first for some time. Unfortunately our opponents literally ran away with the game, out-classing us in speed and team work.

On February 15th we played St. Mary's in the semi-final of the Hospitals Cup. Miss Chambers returned to the team on this occasion, and we were pleased to see she retained her old form. She scored three times despite the fact that she had not touched a stick since last season. Miss Hartley scored twice and showed limitless energy, in collecting the ball from back in the Bart's circle before taking it upfield. Miss Barraclough stopped many an attack by sound tackling followed by accurate passes to the forwards.

In the match against the Royal Holloway College, our main weakness lay in the half-backs, who were unable to intercept their opponents' passes. In the forwards, play was not too bad.

The match against Wimbledon was the best this season, despite the lack of sleep of those who had been to the Ball the night before. Miss Swallow played well on the left wing, and scored twice. The other scorers were Miss Chambers and Miss Hartley, both of whom sustained injuries during the match. The latter continued to play well despite her knocks and bruises. Of the other players, Miss Tomkins had a good game in goal. We were honoured during the match by the presence of the Vice-President, Dr. Blunt, and his family.

In the last match we played Oxford University in what might be termed adverse conditions. Snow, sleet and rain fell during the game, and the pitch was very muddy. This latter was frequently splattered about by the sticks to the discomfort of the players.

The following have played for the team:—

I. Tomkins, G. Tuft, G. Barraclough, B. Barnard, E. Knight, J. Swallow, J. Chambers, S. James, J. Hartley, and J. Arnold.

J. Angell James, M. Robertson, S. Cotton, V. Nash, I. Hall and A. Sinclair have also played.

RIFLE CLUB

Details of the summer full-bore programme are as follows:—

April

20th.—Club Practice. 200 and 500 yards.
27th.—Club Practice. 300, 500 and 600 yards.

May

4th.—Club Practice. 300, 500 and 600 yards. Spoon Competition. Highest aggregate over 300, 500, 600. 2ss. + 7.
10th.—London University Championship. 2ss. + 10 over 300, 500 and 600 yards. Concurrent Team Competition.
18th.—Club Prize Meeting
Staff v. Students Match
300 and 600 yards, 2ss. + 10.
31st.—Club Practice. 200, 500 and 600 yards.

June

1st.—United Hospitals Meeting
Armitage Cup Competition
2ss. + 7 over 200, 500 and 600 yards.
15th.—Club Practice. 200, 500 and 600 yards.
29th.—Club Practice. 200, 500 and 600 yards.

July

11th.—N.R.A. United Hospitals Cup. 2ss.+ 7 over 200, 500 and 600 yards.

Club equipment and rifles are kept at the Surrey Rifle Association Pavilion where meals and bar facilities are provided. Coaching is given to any member of the club who requires it during practice shoots. New members are particularly encouraged to attend the earlier practices when more time can be given to them.

At the Club Prize meeting the following trophies are to be competed for :—

The H. Waring Challenge Cup and Club Tankard for the highest aggregate score made by a student.
The Messrs. Benetfink Challenge Cup and Club Spoon, for the highest score in the handicap competition.
The Staff v. Students Challenge Cup.

In addition it is hoped to award prizes in kind for:—

(i) The highest score made by a member of the Staff.
(ii) The highest score made at each range other than those already gaining one of the major prizes.

The Club Donegall Badge will be awarded to the highest scorer in the Armitage Cup competition who does not already possess such an award.

Details of University and United Hopital Competitions may be obtained from the Hon. Secretary. Members are at all times entitled to use club equipment for Surrey Club or other competitions on days when there is no organised Hospital shoot.

RUGBY FIVES CLUB

Cambridge Tour

On the weekend of the 15th and 16th February the Rugby Fives Club took a team consisting of T. C. Hindson, D. A. Birkett, R. T. Haslam and K. Mackenzie-Ross, to play Clare College and Emmanuel College, Cambridge.

Results—

Bart's beat Emmanuel, 104 points to 69.
Bart's lost to Clare, 90 points to 120.

Barts R.R.C. v. Westminster Bank.

Wednesday, 12th February, Home.
Westminster Bank beat Bart's by 102 points to 82.

GOLF

On Wednesday, February 12th, Bart's played Guy's, the holders, in the first round proper of the Inter-hospitals competition. The match was played at their new course at Croham Hurst, which was in beautiful condition for the time of year, and which proved very enjoyable to play over. Not unexpectedly Bart's were well beaten, 5-0, for all their players were round in under 80, one or two in several strokes fewer. Such a standard at present we are unable to match. However we thoroughly enjoyed the game, and wish them success in future rounds.

FENCING

Since the last report was published two further matches have been played.

4 Foil v. King's College. Lost 9-7.

This is another new fixture this season. The match was fought at home, and we narrowly lost. Once again we hope that this match will pass on to the regular fixtures list.

Team:—B. McGrath, J. Parker, A. Thompson and J. Townsend.

3 Foil-Sabre v. St. Mary's.

This was the return of a match fought earlier in the season at Bart's. Once again the Foil match was won 5-4, and this time the Sabre match was also won 6-3.

Team:—B. McGrath, K. J. Sugden, J. Parker and A. Thompson.

CLUB OFFICERS

The following are the officers of clubs playing summer games for the coming season:—

Cricket Club
Captain: D. Abell.
Secretary: A. Garrod.

Athletics Club
Captain: C. Prys Roberts.
Secretary: R. Thompson.

Golf Club
Captain: C. Stephenson.
Secretary: F. G. Abercrombie.

Tennis Club
Captain: T. Cantrell.
Secretary: B. Duff.

Rowing Club
Captain: G. M. Besser.
Secretary: K. Bowles.

Shooting Club
Captain: P. Ellis.
Secretary: J. Hobday.

Women's Tennis Club
Captain: J. Swallow.
Secretary: E. Knight.

CRICKET CLUB

At the A.G.M. of the Cricket Club the following were awarded their colours for the 1957 season :—

Honours

D. Whitworth, R. M. Mitchell, A. Garrod, J. Stark.

Colours

W. Pagan, D. Abell, J. Harvey, B. Richards.

RECENT PAPERS BY BART'S MEN

*Adrian, *Lord*. Sherrington Memorial Lecture. The analysis of the nervous system. *Proc. roy. Soc. Med.*, 50., Dec., 1957, pp. 991-998.

*Archer, H. E., and others. The aetiology of primary hyperoxaluria. *Brit. med. J.*, Jan. 25, 1958, pp. 175-181.

*Bett, W. R. Giovanni Alfonso Borelli (1608-79). *Nature*, 181, Jan. 25, 1958, pp. 235-6.

*——. John Addison Fordyce (1858-1925) of Fordyce's "disease." *Med. Press*, 239, Feb. 12, 1958, p. 154.

*——. Lewis Linn McArthur (1858-1934). Originator of the grid-iron incision. *Med. Press*, 239, Jan. 22, 1958, p. 86.

*——. Paul Taenzer (1858-1919) of "Taenzer's Disease." *Med. Press*, 239, Feb. 5, 1958, p. 134.

*——. Washington Lemuel Atlee (1808-78): ovariotomist. *Med. Press*, 239, Feb. 19, 1958, pp. 175-6.

Bickford, J. A. R. Shadow and substance: some changes in the mental hospital. *Lancet*, Feb. 22, 1958, pp. 423-424.

*Birnstingl, M. A., and others. Two cases of perineal fistula following cowperitis. *J. Vener. Dis.*, 33, Dec., 1957, pp. 246-8.

*Burrows, H. Jackson. Biomechanics. *Chartered Mechanical Engineer*, Feb., 1958.

*Butler, H. The breeding cycle of the Senegal Galago *Galago senegalensis senegalensis*. *Proc. Zool. Soc. Lond.*, 129, 1957, pp. 147-149.

*——. Some reflections on man's history. *El Hakeim* [1957?].

Capps, F. C. W. "Abductor paralysis" in theory and practice since Semon. The Semon Lecture, 1957. *J. Laryngol. Otol.*, 72, *Jan.*, 1958, pp. 1-31.

Cholmeley, J. A., and others. Tuberculosis of the knee: results with chemotherapy between 1948 and 1956. *Tubercle*, 39, Feb., 1958, pp. 1-6.

*Daly, I. de Burgh. Intrinsic mechanisms of the lung. *Quart. J. exp. Physiol.*, 43, 1958, pp. 1-26.

——, *see also* Daly, M. de Burgh, and ——.

*Daly, M. de Burgh. The cardiovascular effects of anticholinesterases in the dog, with special reference to haemodynamic changes in the pulmonary circulation. *J. Physiol.*, 139, 1957, *pp.* 250-272.

*——. The effects of anticholinesterases on the bronchioles and pulmonary blood

vessels in the isolated perfused lungs of the blood. *Brit. J. Pharmacol.*, 12, 1957, pp. 504-512.

*——, and DALY, I. de Burgh. Observations on the changes in resistance of the pulmonary vascular bed in response to stimulation of the carotid sinus baroreceptors in the dog. *J. Physiol.*, 137, 1957, pp. 427-435.

*——. (and WRIGHT, P. G.). The effects of anticholinesterases upon pulmonary vascular resistance in the dog. *J. Physiol.*, 139, 1957, pp. 273-293.

*——, and others. The effects of stimulation of the carotid sinus baroreceptors upon the pulmonary arterial blood pressure in the cat. *J. Physiol.*, 137, 1957, pp. 447-459.

DE MOWBRAY, Robert R., *see* FOULDS, H. Priscilla S., and others.

DISCOMBE, George. The cost of clinical pathology: economy as an aid to efficiency. *Med. World*, 88, Feb., 1958, pp. 169-175.

DORMER, A. E., *see* ARCHER, H. E., and others.

*EVANS, *Sir* Charles Lovatt, and others. A histological study of the sweat glands of normal and dry-coated horses. *J. comp. Path.*, 67, 1957, pp. 397-405.

*——, and others. Physiological factors in the condition of "dry coat" in horses. *Vet. Record*, 69, 1957, pp. 1-9.

FINLAYSON, R. The vicissitudes of sputum cytology. *Med. Hist.*, 2, Jan., 1958, pp. 24-35.

FLAVELL, Geoffrey. The surgery of the heart. II. *N.A.P.T. Bulletin*, Feb., 1958, pp. 19-22.

FOULDS, H. Priscilla S, and others. Changes in serum-potassium level and in pH of arterial blood in respiratory acidosis. *Lancet*, 22, Feb., 1958, pp. 405-409.

*FRANKLIN, A. W. Care of the mongol baby. *Lancet*, Feb. 1, 1958, pp. 256-258.

——. The prognosis of bronchiectasis in childhood. *Arch. Dis. Childh.*, 33, Feb., 1958, pp. 19-23.

*FRASER, *Sir* Francis. Medical practice in a changing society. *Lancet*, Feb. 18, 1958, pp. 154-157.

FURNIVALL, M. A. Home invalid diets. *Practitioner*, 180, March, 1958, pp. 324-330.

*HADFIELD, Geoffrey. The application of physiological principles to hormone-dependent breast cancer. *Ann. roy. Coll. Surg. Engl.*, 22, Feb., 1958, pp. 73-106.

*HAVARD, C. W. H., and others. Thalassaemia minor in an Englishwoman. *Brit. med. J.*, Feb. 8, 1958, pp. 304-305.

HODGSON-JONES, I. S. Papulonecrotic tuberculides with miliary tuberculosis. *Proc. roy. Soc. Med.*, 50, Dec., 1957, p. 1019.

*HOWELL, Trevor. Loss of Babinski response in elderly hemiplegics. *Med. Press*, 239, Feb. 12, 1958, pp. 149-151.

——. Unexpected ulcers. *Practitioner*, 180, March, 1958, p. 343.

*HUBBLE, Douglas. The problems of puberty. *Brit. med. J.*, Jan. 25, 1958, pp. 191-193.

HUNTER, R. A., and THORNTON, J. L., Edward Octavius Hocken (1820-1845): life and writings of a forgotten man. *Med. Hist.*, 2, Jan., 1958, pp. 57-61.

JENKINS, J. S. The response of urinary 17-hydroxycorticoids to corticotrophin zinc as a test of adrenal cortical function. *J. Clin. Path.*, 11, Jan., 1958, pp. 78-81.

JOEKES, A. M., and others. Acute renal failure due to poisons and drugs. *Lancet*, Jan. 18, 1958, pp. 134-137.

——, and others. An early renal lesion in systematic lupus erythematosus. *Brit. J. Derm.*, 70, Feb., 1958, pp. 44-47.

KOK, D'Almero, (and Barkhan, P.). Acute renal failure associated with massive haemorrhage in a haemophiliac. *Brit. med. J.*, Feb. 22, 1958, pp. 434-435.

*LEHMANN, H., (with Bangham, A. D.). "Multiple" haemoglobins in the horse. *Nature*, 181, Jan. 25, 1958, pp. 267-268.

——, *see also* Havard C. W. H., and others.

*LEVITT, W. M. Radiation nephritis, *Brit. J. Urol.*, 29, Dec., 1957, pp. 381-382.

MEDVEL, V. C., (and Tickner, F. T.). Scurvy and the health of European crews in the Indian Ocean in the seventeenth century. *Med. Hist.*, 2, Jan., 1958, pp. 36-46.

MENDEL, David, *see* FOULDS, H. Priscilla S., and others.

MORGAN, C. Naunton. Discussion on major surgery in carcinoma of the rectum: restorative resection. *Proc. roy. Soc. Med.*, 50, Dec., 1957, pp. 1050-1052.

*POSEL, M. M., (and Kaye, Josse). Primary pulmonary haemosiderosis. *Medical Proceedings*, 4, Jan., 1958, pp. 17-20.

*RAVEN, Ronald W. Liver surgery in relation to diseases of the colon and rectum. *Proc. roy. Soc. Med.*, 50, Oct., 1957, pp. 775-786.

RICKHAM, P. P. Bilateral Wilms' tumour. *Brit. J. Surg.*, 44, March, 1957, pp. 492-495.

——. The surgery of premature infants. *Arch. Dis. Childh.*, 32, 1957, pp. 508-516.

ROSS, Sir James Paterson. Sir Thomas Dunhill (1876 1957). *Ann. roy. Coll. Surg. Engl.*, 22, Feb., 1958, pp. 144-146.

RUNDLE, F. F., (and Kettle, J. H.). Early detection of breast cancer: a fact finding metropolitan survey. *Med. J. Aust.*, Nov. 30, 1957, pp. 781-784.

*SCOTT, A The distribution and behaviour of cutaneous nerves in normal and abnormal skin. *Brit. J. Derm.*, 70, Jan., 1958, pp. 1-21.

SCOTT, R. Bodley, *see* HAVARD, C. W. H., and others.

SCOWEN, E. F., *see* ARCHER, H. E., and others.

SIEGLER, J. Leukoplakia of the larynx complicated by carcinoma. *J. Laryngol. Otol.*, 72, Jan., 1958, pp. 78-80.

*SIMMONS, P. H., (and Blanshard, M. S.). An assessment of buthalitone sodium. *Brit. med. J.*, Dec. 7, 1957, pp. 1347-50.

TODD, R. MacLaren. Acromegaly in a girl of 8 years. *Arch. Dis. Childh.*, 33, Feb., 1958, pp. 49-54.

*TUCKWELL, E. G., (with Rob, C.). Lumbar sympathetic ganglionectomy. *In* Rob, C., and Smith, R. *Operative surgery*, v.4, pp. 28-34.

*——, (with ——). Lumbordorsal sympathectomy and splanchnicectomy: presacral neurectomy. *In* Rob, C., and Smith, R. *Operative surgery*, v.4, pp. 20-27.

*——, (with ——). Sympathetic ganglion block. In Rob, C., and Smith, R. *Operative surgery*, v.4, pp. 5-7.

*——, (with ——). Upper thoracic sympathetic ganglionectomy. *In* Rob, C., and Smith, R. *Operative surgery*, v.4, pp. 8-19.

*WARD, R. Ogier. Thirteen days on service in France after Dunkirk. *J. Hon. Artillery Company*, Dec., 1957—Jan., 1958.

WATTS, R. W. E., *see* ARCHER, H. E., and others.

*WITTS, L. J., (with SPRAY, G. H.). Results of three years' experience with microbiological assay of vitamin B_{12} in serum. *Brit. med. J.*, Feb. 8, 1958, pp. 295-301.

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

EXAMINATION RESULTS

UNIVERSITY OF LONDON

M.D. EXAMINATION, DECEMBER 1957

Part I

Malpas, J. S. Martin, R. M.

SPECIAL FIRST EXAMINATION FOR MEDICAL DEGREES, DECEMBER 1957

Boladz, W. P. McPhail, L. M. Wilson, R. G.

The following General Certificate of Education Candidates have qualified for exemption from the First Medical :—

Balfour, A. J.
Blake-James, R. B.
Colin-Jones, D. G.
Dupré, P. C.
Hutchinson, D. B. A.
Latham, D.
Perry, P. M.
Ratcliffe, R. M. H.
Sandhu, M. S.
Walton, J. O.
Barber, S. E.
Bolton, J. C.
Dacie, I. E.
Fonseka, Y.
Innes, G. R.
Marsh, A. R.
Phillips, J. D.
Robinson, L.
Scriven, P. C.
Beard, R. M.
Brodribb, A. S.
Ducker, P. S.
Howell, F. A.
Joy, P. J.
Newstead, F. B.
Poore, P. D.
Rushman, G. B.
Shearer, R. J.

UNIVERSITY OF OXFORD
FINAL B.M., B.Ch., DECEMBER, 1957

Medicine
Burfoot, M. F. O'Sullivan, D. Wright, G. R. K.

Surgery
Burfoot, M. F. O'Sullivan, D. Wright, G. R. K.

Midwifery
Burfoot, M. F. Wright, G. R. K.

The following completed the examination for the degree B.M., B.Ch.:—
O'Sullivan, D. Wright, G. R. K.

ROYAL COLLEGE OF SURGEONS
PRIMARY F.R.C.S., FEBRUARY, 1958

Thompson, S. G. Wyatt, A. P.

SOCIETY OF APOTHECARIES
FINAL EXAMINATION, DECEMBER 1957

Medicine
Casson, A. J.

CONJOINT BOARD
FIRST EXAMINATION, DECEMBER 1957

Pharmacology
Simpson, R. I. D. Davies, D. G. Seeman, I. M.
Rowlands, D. F. Bannerman-Lloyd, F. Tooby, D. J.
Pilkington, R. Woolmore, M. J. F. Johnson, P. A.
Davies, D. J. C.

JANUARY, 1958
FINAL EXAMINATION

Pathology
Ellison, A. J. H. Hedley-White, J. Savage, D. C. L. Laurent, J. M.
Ball, P. J. Martin, J. Chinery, A. R. O. Simons, R. M.

Medicine
Ellison, A. J. H. Laurent, J. M. Chinery, A. R. O.

Surgery
Laurent, J. M. Chinery, A. R. O.

Midwifery
Laurent, J. M. Chinery, A. R. O. Stephenson, C. G.

The following candidates have completed the examination for the Diplomas M.R.C.S., L.R.C.P.:—
Laurent, J. M. Chinery, A. R. O.

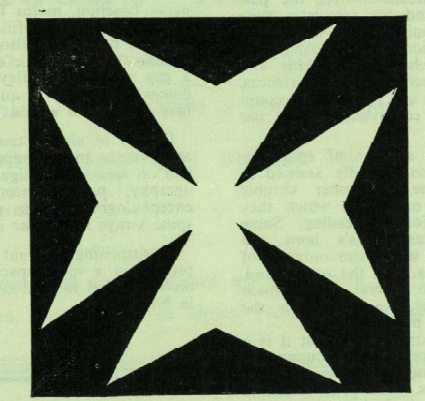
LETTERS TO THE EDITOR

Blessed are the poor in spirit; for theirs is the kingdom of heaven.

Blessed are the meek; for they shall possess the land.

JUSTICE

Blessed are they that mourn; for they shall be comforted.



Blessed are they that hunger and thirst after justice; for they shall have their fill.

PRUDENCE

TEMPERANCE

Blessed ate the merciful; for they shall obtain mercy.

Blessed are the clean of heart; for they shall see God.

FORTITUDE

Blessed are the peace-makers; for they shall be called the children of God.

Blessed are they that suffer persecution for justice' sake; for theirs is the kingdom of heaven.

CROSS OF ST. JOHN

Sir,—*Vol. XII.* January, 1958. Page 13. St. John's Gate by B. M. J. McGrath.

" All members of the Order (of St. John) wore a black robe and cowl having a white cross of eight points on the left breast."

In extension, may it be suggested that you publish in the *Journal* a full-page diagram of the white cross with an explanation of the Legendary significance of the eight points, the Beatitudes, and the four virtues represented be the upper, lower, and two lateral boundaries.

I am, etc.

S. JENKINSON.

Grindleford,
Kilmalcolm,
Renfrew.

Mr. McGrath has prepared a diagram of the Cross and the explanation is below.

Translated extract from the Book of Statutes of the Order, from the Edition of Borgoforte of 1676: " . . . Thus the knights hospitallers, acquitting themselves truly . . . are to wear on their cloaths a cross with eight points, to put them in mind of bearing always in their heart the cross of Jesus Christ, adorned with the eight virtues that attend it . . . " This part of the book is headed by the name " Raimond Dupuy, Master," thereby dating this part of the Rule to c.1118, the time of Dupuy's stewardship.

B. M. J. MCGRATH.

BART'S CLUBS AND SOCIETIES

Dear Sir,

I have been collecting material on the history of the various student clubs and societies associated with this Hospital, and find many gaps in the information available. Numerous Minute Books, for example, are missing, and I invite any old Bart's men who were officers of these clubs, and may still possess official records, to deposit them in this Library. Any information regarding the history of the Decennial Clubs, the Students' Union and affiliated clubs, etc., and in particular, knowledge of the whereabouts of their official records, will be appreciated.

Yours sincerely,
JOHN L. THORNTON,
Librarian.

CHRONIC BRONCHITIS, EMPHYSEMA AND COR PULMONALE by C. H. Stuart-Harris, M.D., F.R.C.P., and T. Hanley, M.D., M.R.C.P. **Published by John Wright and Sons Ltd., Bristol, 1957.** Price

Dr. Stuart-Harris, an ex-student of this Hospital and now Professor of Medicine in the University of Sheffield, has made a special study of non-tuberculous respiratory infections over the past ten years. At first he and his associates were particularly interested in pulmonary heart failure, since when their investigations have touched practically every aspect of chronic bronchitis and emphysema. This book records their experiences, and is a thoroughly critical and up-to-date account of chronic bronchitis, emphysema and cor pulmonale.

The recently developed sciences of epidemiology and statistics have undoubtedly assisted in the understanding of the commoner chronic diseases, but the masses of figures which they inevitably produce make for dry reading. Some of the chapters in Stuart-Harris's book are weighed down by figures, which can only be of interest to a few specialists. On the other hand, there are others of a more general nature which are admirable, particularly the one upon the applied physiology of cor pulmonale.

This is hardly a book for students, but it is a valuable summary of current opinion upon the group of diseases which are vaguely covered by the term chronic bronchitis. The price seems to be rather excessive, and anybody intending to use the index would be well advised to provide himself with a hand lens.

N. O.

PAEDIATRICS FOR NURSES (2nd Edition) by Arthur G. Watkins. **Published by John Wright & Sons Ltd.** Price 15/–.

Doubtless economic considerations have determined the small size and print of this book, and it would be a pity if it were to be deemed slight because of its unimposing appearance. It is in fact a good book on paediatrics for the student nurse taking her general training.

Though the accounts of diseases are clear and concise, the most valuable part of the book is that on the position of the child in the community, the problems of its management, physical and psychological, in hospital, and the national trends in children's diseases. How to keep children out of hospital is just as important as their management after admission, and as a Professor of Child Health the author rightly keeps this aspect before his readers.

W. C. HECTOR.

HANDBOOK OF NEUROLOGICAL EXAMINATION AND CASE RECORDING *by* D. Denny-Brown. Harvard University Press.

Most medical students watch a Neurologist examining his patient with the same detachment that they give to a conjuror. Few, when they qualify, are able to perform an adequate neurological examination, and this deficiency extends even to some consultant physicians.

This little book slips neatly into the pocket of a white coat and should be invaluable for the neurological House Physician. It might also be profitably studied by the senior student.

As well as sections on case history, gait, cranial nerve function, motor function, reflexes and sensation, there are useful examination schemes for aphasia, perceptive disorders and apraxia. The outline for psychiatric examination usefully filled a gap and should allay that sinking feeling that comes to the newly qualified doctor when he is first confronted with a psychotic patient.

Details of simple tests of intellectual function are given in an appendix. There are helpful chapters on special investigations including electromyography, pneumo-encephalography and electro-encephalography; the paragraphs on skull and spine x-rays are rather inadequate.

A surprising amount of information is compressed in a small space, and this book can be recommended to post-graduate students interested in Neurology.

K.W.E.H.

BOOKS RECEIVED

Inclusion in this column does not preclude review at a later date.

Medicine : Essentials for Practitioners and Students *by* Dr. G. E. Beaumont (7th Ed.) J. & A. Churchill. Price 45/-.

Cerebral Palsy in Childhood *by* Grace E. Woods. John Wright & Sons. Price 27/6.

Modern Trends in Gastro Enterology *by* Avery Jones. Butterworths. Price 78/6.

A Contribution to the Study of Portal Hypertension *by* A. H. Hunt. Price 40/-.

Rain Doctor *by* Peter Wingate. Heinemann. Price 15/-.

Medical Telcology *by* Parkes Weber. H. K. Lewis. Price 15/-.

ADDITIONAL NOTICES

The price of the tickets for the View Day Ball is to be £3 10s. 0d. for a double ticket. The increase in price is due to the Park Lane Hotel raising their price per meal and this increase has had to be passed on.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXII APRIL, 1958 No. 4

EDITORIAL

Many students and a number of the staff have enquired as to the fate of the Questionnaire. As is well known within the Hospital the forms were distributed, year by year, early in December and the return was not sufficient to be of statistical use until early January. It was perhaps unfortunate that the project should have been launched so near to the end of the pre-clinical term since inevitably some of these students evaded at first the net and in consequence had to be contacted in the January thereby delaying the analysis.

The total return from the medical college was 85% or nearly 400 completed forms. Of these only one had been answered in a ridiculous manner which is in itself a sufficient comment or the responsible and adult interest that was generally felt towards this enquiry. There were only 2 students both in the first pre-clinical year who absolutely refused to have anything to do with the questionnaire and this is probably a reflection of their maturity of outlook. The missing 15% were felt to be those whose forms were mislaid either on the way out or the way back or those whose natural lethargy prevented any unnecessary activity particularly with Christmas so near.

With the return of an adequate number of forms the *Journal* sub-committee divided up into three splinter groups, one member qualified and left the hospital, another concerned himself with the problem of financing the analysis and report and the third performed a preliminary analysis. This preliminary survey was only of the written comments "Best taught subject: Worse taught subject, etc.", which would have been time consuming and very expensive had they been done by the statistician. The results of these opinions were also co-related to the years so that their value could be further assessed.

The activities of the fund-finding member are at last bursting into fruition and several drug-houses are subscribing to the cost of analysis which is in itself not inconsiderable. The problem of financing any more complex analysis is yet to be faced.

The questionnaire forms are at the moment being analysed by a firm of statisticians and their original survey will be available for publication shortly. It is proposed that the questionnaire results should be published in parts each dealing with a different view of the student's life, i.e., their ambitions, their environment, etc. Also should the *Journal* be able to raise sufficient funds it is hoped to publish the complete survey as a booklet which may not only act as a mirror to the soul of Bart's but enhance the reputation of the Hospital throughout the country breaking down the traditional conservatism and revealing a dynamic, vital, and exciting insight into the future Bart's men. No longer will the other London hospitals be able to say of our Hospital's sons "Super-knowledgable, super-confident, and supercilious" for they will know us for what we are.

Gilbert and Sullivan Society

On March 9th, 1958, the Gilbert and Sullivan Society gave their second performance since their foundation some eighteen months ago. 'Patience' was this year's choice and the success of the evening proved how well-founded this was, since the hall was packed with representatives from all the hospital estates; four rows being occupied exclusively by consultants and their friends which was twice the number reserved at the 'Gondoliers' last year.

The outstanding performance of the evening was universally held to be that of the conductor Brian Richards who, apart from the actual performance, had devoted much valuable time and energy to bullying of a recalcitrant chorus at the rehearsals. He, with the soloists, gave a splendid showing of what Bart's in general and they in particular can do. The narrator for this year was Dr. Lehmann, who provided a delightful and amusing continuo leading the audience gently through an exciting land, decorated with dainty groups of lovelorn maids and aesthetic poets.

For the next performance it is proposed to unite with the Rahere Choir to perform a more serious work at the end of this year and then to present a further comic-opera in the early months of next year.

Wessey Rahere Club

The Spring Dinner of the above Club will take place at the White Hart Hotel, Salisbury, on Saturday, 19th April, 1958.

Mr. John Beattie will, it is hoped, be present as Guest of Honour.

Membership of the Club is open to all Bart's graduates practising in the West Country. Further details will be circulated to members.

At the special request of many members in the Eastern Wessex, the Club is meeting at Salisbury so that Bart's graduates in the Winchester, Portsmouth, Bournemouth area may take part.

Any Bart's graduates within striking distance will be welcome to dine and are asked to write to the Honorary Secretary:—

Mr. A. Daunt Bateman,
11, The Circus,
Bath, Somerset.

Atmosphere cleared?

Mr. R. E. Waller has pointed out that his article entitled "Smog" in the February *Journal* should have carried the title "Researches on Atmospheric Pollution in London." An apology is offered to Mr. Waller for any misunderstanding that may have arisen as a result of this mistake.

ANNOUNCEMENTS

Engagement

KNIGHT-LAWTON.—The engagement is announced between Surg. Lieut. Robert John Knight and Gillian Mary Frances Lawton.

Marriage

GABRIEL - RATCLIFFE.—On March 22nd, Dr. David Wilson Gabriel to Dr. Diana Ratcliffe.

CAIRNS - BANWELL.—On March 27th, 1958, at St. Timothy's Church, Ridley Blvd., Toronto. John David Cairns to Dorothy Mary Banwell.

Births

BUCKLEY.—On February 25th, to Elizabeth, wife of Dr. Anthony R. Buckley, a son.

EVANS.—On February 4th, to Muriel, wife of Robert J. Evans, M.D., a son, Miles Liddiard.

PERFECT.—On March 2nd, at Awali, Bahrain, to Joan, wife of Dr. John Perfect, a daughter (Elizabeth Verdon).

RICE.—On March 15th, to Brita, wife of Dr. Noel Rice, a son (Andrew Sven).

TURNER.—On March 3rd, to Patricia, wife of Dr. John Turner, a daughter (Angela Helen), a sister for Susan and Penelope.

VICKERY. On February 26th, to Betty, wife of Dr. C. M. Vickery, a daughter.

Deaths

BRADLEY. On March 22nd, Edwin John Bradley, M.D., F.R.C.S.(Ed.), aged 67. Qualified 1913.

GRIFFITH.—On March 21st, Dr. Herbert Stuart Griffith. Qualified 1915.

LOWRY.—On March 2nd, Dr. Ernest Ward Lowry, aged 87. Qualified 1907.

VENN.—On March 15th, Dr. John Archibald Venn, aged 74. Elected a Perpetual Student June, 1940.

WILSON.—On February 22nd, Harry Theodore Minden Wilson, D.S.O., Lieut. Col., R.A.M.C. (retired). Qualified 1904.

WINCE.—On March 13th, Dr. Walter George Wince, aged 79. Qualified 1903.

WOOD.—On February 22nd, Dr. Maurice Dale Wood, aged 82. Qualified 1898.

New Addresses

Dr. J. D. Cairns

Office: 1516 Bayview Avenue, York Mills, Toronto, Ontario.
Residence: Apt. 222, 200 Ridley Blvd., Toronto, Ontario.

Dr. W. W. Wells to 12 Sydney Place, Bath.

University of London

Dr. Charles F. Harris has been elected vice-chancellor of London University for the year 1958-59.

MEDICAL STAFF

The following appointments to the medical staff take effect from the dates mentioned:—

Skin Department
Registrar—Miss A. I. Scott, 1.4.58.

Eye Department
Registrar—Mr. M. S. Wilson.

Department of Pathology
Registrar—Miss J. Cook, 1.4.58.

Surgical Professorial Unit
Research Assistant—
Mr. Peter Courtenay, 1.4.58.

Mr. Hosford's Firm
Junior Registrar—
Mr. S. G. Thompson, 1.5.58.

Medical Unit
Junior Registrar—
Mr. R. Crampton, 1.9.58.

Children's Department
Senior Registrar (Chief Assistant)—
Dr. Seymour Mason, June, 1958.
(Replacing Dr. Hugh-Jones for one year, while he is in America).

CALENDAR

Sat.	May 3	Dr. A. W. Spence on duty. Mr. C. Naunton Morgan on duty. Mr. R. A. Bowen on duty. Cricket: v. U.C.H. (A). Tennis: v. Westminster (H).
Sat.	„ 10	Dr. R. Bodley Scott on duty. Mr. R. S. Corbett on duty. Mr. R. W. Ballantine on duty. Cricket: v. R.A.M.C. Crookham (H). Tennis: v. Charing Cross and Royal Dental Hospitals (A).
Sat.	„ 17	Dr. E. R. Cullinan on duty. Mr. J. P. Hosford on duty. Mr. C. Langton Hewer on duty. Cricket: v. Balliol College (A).
Sat.	„ 24	Medical and Surgical Units on duty. Mr. G. H. Ellis on duty. Cricket: v. Queen's College, Cambridge (H).
Sat.	„ 31	Dr. Geoffrey Bourne on duty. Mr. J. B. Hume on duty. Mr. F. T. Evans on duty. Tennis: v. St. Mary's (H).

CANCER AND MEDICAL EDUCATION

by MALCOLM DONALDSON

Everybody agrees that a good general education is essential in order to produce a good doctor, and I have always admired and envied the 'classical man' although I have never been able to make up my mind whether classics makes the good brain better, or whether the good brains are attracted to the classics. Of one thing I am quite certain, that a classical education is worse than useless to an average or subnormal brain, and there must be some better way to train such brains than putting a boy in front of a Latin or Greek grammar for hours on end and construing 10 lines of Latin prose per day. It would have been better training if we had been set to work out jigsaw puzzles.

Coming now to the pre-clinical course I have no doubt that this has improved since my time as a student. The 1st M.B. consisted of a smattering of Zoology, Botany, Chemistry and Physics. These were taught without any reference to medicine which made the last two very boring, but in later years I would have given a great deal to have had a real knowledge concerning biochemistry and physics.

The 2nd M.B. was Anatomy and Physiology, but even these were not really associated with medicine. The one clinical note mentioned in Cunningham's Anatomy was that an abnormal deep circumflex artery sometimes occurred, and might be cut during an operation for hernia. One of my teachers said it occurs once in 7,000 cases, the chance of this person getting hernia is another 1 in 7,000 and if it is cut it is clamped and tied. The fact that I remember it after fifty years shows how important it is for anatomy to be taught in its relation to surgery and medicine. Perhaps it is in these days. There is a story that in the ancient days a physician advised students to forget their physiology as soon as they entered the wards. In my day no encouragement was needed to forget.

Lecture given to the Abernethian Society, October 24th, 1957.

Statistics was another subject much neglected in my time. The idea that "Statistics can prove anything" should be replaced by the idea that "nothing can be proved without statistics."

At this point a word must be said about research. My late colleague Herbert Williamson used to say "Medicine without research is like a body without a soul." In my time there were a number of research scholarships offered, but usually the candidates put in a programme that would take more than a life time to carry out, instead of the year allotted. Some people say researchers, like poets are born and not made, but every poet has to learn to read and write, and therefore it seems reasonable that a person who has a scholarship should be given a set task and it should be seen that he carries this limited task out under supervision.

A research mind is simply an inquisitive mind, and without this no one can be a good doctor. When in S. Africa recently I was struck by the amount of encouragement given to the students in the Johannesburg Medical School to carry out bits of research.

Coming now to the Clinical stage of Medical Education I will start by quoting from a book by Charles Newman "Evolution of Medical Education in the 19th Century" in which he asks "What is the aim of Medical Education?" It would appear that in 1800 the opinion prevailed that "it was to produce a cultured and highly educated gentleman", and nothing else mattered. Then in the latter part of the nineteenth century "technology began to supplant wisdom to the gradual eclipse of the patient." That danger I believe exists even in these days.

To quote again from Newman, "The Medical Profession is failing and for a long time has failed to provide something which the public wants: something the public will have whatever the cost, something that at the present time is supplied by quacks and the smooth West-end doctors. They want to feel that the doctors feel for them." The other day I received a letter from an old lady, a friend of mine, aged 83 who had noticed that in a letter to the press I had used the expression "Family Doctors". She wrote "these are now as extinct as the Dodo and have been replaced by 'expert plumbers'." I answered that I agreed with her to some extent but if there was a choice between an 'expert plumber' and a 'Father Confessor' I would prefer the plumber, but I believe the two can and should be combined.

There are people who deplore the growth of specialization and "the learning of more and more about less and less", but we cannot put the clock back, and indeed which of us would not prefer to be treated by a person who sees diseases like our own every day of his or her life rather than one per year.

The word "specialist" is often used in contra distinction to the Family Doctor sometimes spoken of as the G.P. I think that is quite wrong. General Practice is a Speciality and the most difficult of all specialities to practice, and perhaps the most important, in my time there was no special training for this speciality. It may be asked how can I speak about general practice as I have never experienced it except to act as an unqualified dispenser when I was an impecunious student, which is of course illegal. On the day I qualified I did a locum in the same practice in the Edgware Road for three or four weeks. Luckily the first patient to whom I was called, a Dutchman, diagnosed himself, said he had Malaria, would I give him some quinine. Since I retired, however, I have been giving a great many lectures to the public, and from time to time after these lectures a member of the audience has come to me and complained about their doctor. Of course one does not believe all they say, and one tries to be loyal to the profession, but there is no doubt that there is some truth in their complaints. I believe that many doctors are so busy that they have no time to understand the minds of their patients, and this of course is particularly true in regard to Cancer.

The time is past when the doctor in the village was the 'High Priest', when anything he said was considered absolute truth, and no questions asked. Some doctors still believe that to ask for a second opinion is an insult to them.

It is indeed tragic that a doctor should lose the confidence of his patients, even if this only happens occasionally, but I suggest it is his own fault. Some patients are not fools, and when they ask intelligent questions expect intelligent answers in simple lay language. Of course talking to patients is a bore when the waiting room is full of people, but it is a very important part of the doctor's work "to suffer fools gladly".

What then is the answer to Newman's question 're the aim of Medical Education"? Surely the answer is that we must accept the fact that it is an age of 'Specialization' and that General Practice is a speciality, and students must be trained for all these specialities.

There will be a general pre-specialist training common to all, but in my opinion it should not be so detailed as it is at present. The time for great detail comes after the compulsory Pre-registration hospital appointment by which time the student will know what speciality he or she intends to take up

I am not in a position to suggest a detailed schedule for such a training, but it may be hoped that the College of General Practitioners is busy drawing up a syllabus for this purpose. Here it is only possible to suggest a few points, e.g. that a period of apprenticeship in a general practice, at present voluntary, should be compulsory, and take place after the Pre-registration Appointment and before the appointment as a House Physician. That they should attend a course in nursing. Of course nursing is a separate skilled profession, but sometimes there is no nurse, who then is there to make the patient comfortable? A nurse knows the elements of medicine and the doctor should be taught the elements of nursing. In the training of the Family Doctor great stress should be laid on Psychology (not Psychiatry) because as already mentioned many doctors do not understand their patients.

As far as students are concerned they probably see a sufficient number of cancer cases, but perhaps too little emphasis is laid on "early stage" diagnosis. The description and illustrations in the textbooks in my time were all concerning advanced cases, and the only possible treatment to judge by these books was to order the undertaker.

This perhaps explains the terrible fatalistic attitude adopted by the profession outside the hospitals. The Family Doctor hardly ever sees an "early stage" case, which of

course makes it nice and easy for diagnosis. Often the patient, after being sent to the hospital for palliative treatment, returns to end his days under the care of the G.P. These cases of advanced cancer are perhaps the most difficult type of case to look after in the whole of medicine, and students have no opportunity to learn, because teaching hospitals cannot be filled with dying patients. Some doctors tell the relatives that they can do nothing more, and abandon the case. The patient is then taken to a "quack" and if the tumour is a slow growing one the quack makes a reputation and his fortune.

The apathy of the majority of Family Doctors concerning cancer is appalling. Any attempt to get a discussion in the local branch of the B.M.A. is answered by, "the doctors are not interested and will not attend", and this in a disease which is responsible for about one in every five deaths from all causes.

What then is the remedy for this terrible state of affairs? It has been suggested that patients should go direct to a Cancer Detection Centre, and thus to 'by pass' the Family Doctor. This is done in U.S.A. and in theory is excellent, but in practice it is impossible. At the New York Centre there is a waiting list of over a year. In Canada the idea has been given up, not only because of the expense in finding one unsuspected case of cancer but because such a centre demands the services of many experts and their time is largely wasted which is more important than waste of money.

There is no doubt that the responsibility for the 'Preliminary Diagnosis of Cancer' must be left with the Family Doctor, and the Final diagnosis and treatment will be in the hands of a Team of experts in the hospital.

If this is to be carried out there must be a very great change in the attitude of the Medical Profession towards Cancer, the Family Doctor must be much better trained for the Preliminary diagnosis and given much better facilities, so that he can take smears etc. to send to the Pathologists.

Practitioners seldom see "early stage" cases of cancer because the patient delays on the average six months after noticing a suspicious symptom, and many wait for more than a year, before going to the doctor. The reason for this can be summed up in three words *fear and ignorance*, which can only be overcome by education.

In 1953 the Ministry of Health wrote to 146 Local Health Authorities urging them to start Cancer education schemes for the public, so far only about 17 are doing anything at all, the excuse being that the family doctors in the area are against it.

Cancer is surrounded by a psychological atmosphere that exists in no other disease. I call it 'Cancer Smog'. It is probably true that there are very few cases of true 'Cancer-phobia', and by that I mean patients who are so worried that it interferes with their normal life. It is true that each year there are a few unfortunate people who commit suicide because they suffer from an obsession that they are afflicted with cancer. True 'Cancer-phobia' needs a psychiatrist for treatment.

On the other hand it is an undoubted fact that nearly 100 per cent. of the population suffer from 'Cancer Apprehension' to a greater or less extent. This apprehension can be divided into two types (A) Personal Apprehension, and (B) Impersonal Apprehension. In the first type the patient may notice some symptom such as slight pain for which there is no obvious reason, and they think "Can this be Cancer?" A good example of this occurs frequently in women when they get a little discomfort or pain in the breast, which is often connected with menstruation. It is impossible to say how common is this type of 'Personal Apprehension' because the patient is too nervous to talk about it. If they go to the doctor, they do not mention the real cause of their visit, and if they are not told that it is not cancer they return again and again being diagnosed as Neurasthenics, when they are really 'Cancer Apprehensives'. I used to see a great many such cases in out-patients, and after examining them it was my custom to say, "I am glad to say that there is nothing serious and *no evidence of cancer*." On a great many occasions the patient says "Thank God, that is what I really came about".

The second type. 'Impersonal Apprehension', is very common and consists of Fear that if a person talks about or even mentions the word cancer, the other person will be frightened. Very often the speaker himself will have no fear of the disease. Why people should think that other people are different

to themselves is difficult to understand. I have often demonstrated this 'Impersonal Apprehension' by asking a lecture audience if they would prefer to be told the truth if they suffered from cancer. Nearly 100 per cent. will hold up their hands. If this question is followed by asking "If a friend or relation of yours had cancer, do you think they should be told?" very few hold up their hands. Another example is that members of the 'Cancer Information Association' just started in Oxford are seldom willing to send on pamphlets to their friends "lest their handwriting should be recognised", but they will send me a list of their friends with addresses to whom pamphlets should be sent provided I do not mention their own name.

Unfortunately many doctors, who, of course, do not suffer from 'Personal Apprehension', suffer from 'Impersonal Apprehension' and refuse to discuss cancer with lay people. This keeps up the terrible "Hush, hush" and conspiracy of silence about the disease and deters patients from consulting their doctors. Those who are brave enough to mention the word often get laughed at by their doctor and never mention it again, but go on worrying. I have on several occasions been told, "It is all very well to tell us to go to the doctor, but I could not go to a doctor about Cancer. I hate being laughed at".

There is another thing that prevents people going to a doctor—the feeling that they are being cowardly. Some of you may have experienced this feeling. I certainly did ten years ago, but it did not prevent me seeking advice. And that gave rise to another piece of evidence in connection with the 'Psychology of Cancer'. The day before going into hospital I said to a senior member of the B.E.C.C., "I shall not be able to attend your committee tomorrow because I am going in to be investigated for Carcinoma of the Stomach". To this he replied, "Well, you must know that you have not got it or you would never go in". When I came out after an exploratory laparotomy, which I am glad to say proved that the condition was due to old T.B. adhesions, a colleague said, "Of course, you were the only one who thought it was malignant". In any other disease would anybody have made these remarks? Whilst lying in bed during my investigation I tried to analyse my own feelings, but found it impossible, because I believed that there was not sufficient evidence in favour of malignancy. That may have been a protective mechanism. Fortunately I was never able to experience the effect of being told that I had cancer, but several books have been written on the subject, such as "I Live with Cancer" and "Determined to Live".

This brings up the point—should a doctor tell a patient that he or she is suffering from Cancer? At present the principle nearly always adopted is to tell the relatives everything, but to keep the truth from the patient.

Although it is not possible to be dogmatic on the subject I believe that as a principle this is wrong for the following reasons.

(1) It is extremely doubtful whether it is possible to deceive a patient for more than a short time. The patient will often pretend to be deceived in order to comfort their own relatives and the doctor.

(2) I believe the majority of patients prefer to know the worst.

(3) That when the patient realises the truth he or she believes that the doctor made a mistake and "did not diagnose it in time".

(4) That if years after a relative thinks he has cancer it is difficult to convince him otherwise because he knows the doctor deceived (or tried to) his relative.

(5) Because patients are never told the truth the public never hears about the cures, but only about the fatal cases. This leads to the idea that it is useless to go to the doctor as cancer cannot be cured.

(6) It keeps up the terrible "Hush, hush" and conspiracy of silence.

In 1953 the British Empire Cancer Campaign sent a questionnaire to all General Practitioners in the country, about 20,000, asking if they approved of Cancer Education of the Public. They were only allowed to say yes or no. Of these only 24% answered, and of these 2,148 voted in favour and 2,683 against, a majority against of 435. Since 76% did not answer, statistically these figures are of little value.

The majority of the medical profession who oppose cancer education of the public do so on the grounds that talking about cancer will increase apprehension. Those of us who have been working on this subject know that this is NOT true. In the last few years I have given over 500 lectures to the public, 69 already this year. There is plenty of evidence against this argument. In Manchester 1,200 women were interviewed and asked if they considered more information about cancer should be given to the public—76.0% replied YES, 9.0% said NO, and 15.0% were doubtful.

When I was working in Yorkshire, after each lecture the following printed voting papers were distributed.

"Some people have suggested that lectures such as you have just heard do no good, and indeed may do harm. Please state quite frankly what effect it has had on you, by putting a X against the statement (i) if you think it has increased your worry and that such lectures should not be given; or against (ii) if it has helped you and you think more such lectures should be given. If you are doubtful put a ? instead of a X.

"(i) It has increased my worry and such lectures should not be given.....

"(ii) It has relieved my mind and is helpful. More such lectures should be given....."

Of 5,740 votes 99.1% were in favour, 0.2% against, 0.7% put a ?

It has been argued that it is only the converted that attend these lectures. That is not true. These voluntary organisations such as the Women's Institutes, Townswomen's Guilds, etc., members come to the monthly meetings as a routine, and I don't think ever less than 50% of the members turn up. On one occasion, by mistake, I was billed to talk about 'birds'. When the true nature of the lecture was announced no one left the hall and the votes in favour were 100%. It has been argued that although it is easy enough to interest the audience at the time, later there is a reaction. This is difficult to prove or disprove. Recently I sent round a letter with a return postcard to 50 Institutes which had heard lectures given in 1956 and in the early months of 1957. In this letter I said, "If after the passage of time your Institute thinks the lecture has done harm it will be your duty to let me know. If the opinion is against it please do not hesitate to say so. I shall not feel hurt". The results to date are as follows:—

50 enquiries sent out, 43 answered, every institute being convinced that these lectures were of value, and many of the remarks were most encouraging and a source of satisfaction, which makes the long and dreary hours of motoring in the dark seem well worth while.

Wakefield, who is running the Manchester Cancer Education Campaign, wrote round to all the G.P's in his area, and all agreed that there has been no increase in the number of patients attending their surgeries who had nothing wrong with them.

Another argument used by my opponents is that there are no statistics to prove the value of Cancer Education in saving life. That is true in this country because there has been such a small amount of Cancer Education, but there are some very suggestive figures from other countries. Sometimes it is said that a comparison between the five-year survival rate of those who were treated within six months of noticing symptoms is much the same as those who waited a year or more. The following figures for Cancer of the Cervix from Manchester are sometimes quoted on this point.

Duration in months (i.e., after the symptoms were noticed): 0—3, 4—6, 7—12, 13—24, 24+.

Five-year survival rate: 44%, 39%, 41%, 29%, 44%.

This, of course, is an absolute fallacy, the comparison being between two entirely different types of growth. In the first six months are the quickly growing, early disseminating, very malignant growths, in the second six months are only the slow-growing, slow disseminating tumours. A selction by death.

In spite of this difference in the type of growth, the figures published by Smithers for Cancer of the Breast (B.J. of Radiology, Supplement No. 4) show the value of early diagnosis, the rise in the survival rate does not recover until after 18 months' delay.

Delay in Months	*No. of Patients*	*5-Yr. absolute survival rate*
Under 6	364	43%
Between 6—12	173	28%
Between 12—18	98	26%
Between 18—24	34	41%
Between 24—30	53	26%
Over 30	75	33%

To obtain a true statistical evaluation of Cancer Education it is necessary to collect certain figures (A) the delay in visiting the doctor for certain symptoms whatever the cause, but which of course include cancer, such as painless lump in breast, irregular vaginal bleeding, etc., and (B) the number of early stage cases treated in the hospitals. If the delay goes down and the number of early stage cases goes up that would be proof of the value of Cancer Education, as these two factors can only be affected by knowledge. If the five-year survival is used as a "yard stick", this may be influenced by better treatment and not by the education. Mortality figures are still more likely to be influenced by other factors, especially with an ageing population.

To conclude, it is my opinion that general practice should be considered a very important speciality, with a special training. The importance of understanding the patient's outlook, especially concerning cancer, and "suffering fools gladly" should be emphasised in the training of students.

The Family Doctor should have better Post-graduate training in Cancer Diagnosis and greater facilities for making a preliminary diagnosis.

"Knowledge is the antidote to Fear."
—*Emerson.*

PERIODIC MEDICAL OVERHAUL OF EXECUTIVES

by V. C. MEDVEI

Recently, the question of Periodic Medical Overhaul of Executives has again been in the news. Correspondents in *The Times* discussed its "experimental" application at the B.C.C. The physician who writes on "The way to Health" in the *Sunday Times* said (on the 9th of March) ". . . whereas all argument appears to be for them, I do not know of any doctor who has a routine check-up, and I have never heard of insurance companies reducing their premiums to those who have them." A lighter side of the question was ventilated in the correspondence columns of *"The Times"* of the 1st March, where a Mrs. Delgado wrote: "Nobody has suggested that the housewife should have a periodical health check."

"It may be because she is so fully occupied looking after the busy executive's meals in such a way that his duodenal ulcer is kept under control that she has very little time to have one of her own—let alone any other occupational complaints. The busy executive, she is told, should delegate his duties and confine his work to office hours." "Both are admirable habits which the housewife might—on occasions— like an opportunity of acquiring."

Finally Cedric Carne in the doctor's column ("All in a doctor's day") of *The Sunday Express* of the 5th January, summed up his opinion by saying: "Basically, I don't believe in regular check-ups. People should go regularly to the dentist, even though their teeth seem in good order. But unless a patient feels there is something wrong with him, he should just raise his hat when he sees his doctor and say "Good morning" After all, do those very famous people like Eisenhower avoid illnesses because they have frequent check-ups? On the contrary, many who think of their

bodies as a sort of super-motor-car that needs a regular overhaul seem to become all the more illness prone."

The idea of regular check-ups is, of course, not new. For example, General Motors Ltd. have used the method in the United States for a number of years, and, more recently, also in England. The scheme is voluntary, and encourages every executive with an income of over a thousand pounds per annum to have a complete medical examination by a nominated physician once a year. If considered necessary, radiological and other laboratory examinations can be undertaken and the results are strictly confidential between the examining physician and the executive or the executive's private doctor, should it be considered desirable to inform the latter. The firm itself merely arranges for the examination and pays the necessary fees from a central office. A report on the result of the examination is sent to the person concerned, but no report whatever is given to the Company. If the report contains advice in regard to treatment or action to be taken, it is entirely for the excutive to decide whether or not he is going to accept the advice. In the United States a similar scheme has been in operation for some time, but on a far more elaborate scale. There, apparently, the people participating in the scheme enter a Clinical Centre for a whole day and X-ray and other examinations are carried out as a matter of routine.

L'Etang discussed in an excellent paper *"The Health of Statesmen and Affairs of Nations"*, the disadvantages which may have occurred in World affairs when Woodrow Wilson, Bonar Law, F. D. Roosevelt, Hopkins and Forrestal, Macdonald, Baldwin and Chamberlain, Bevin, Cripps and Keynes were stricken with illness and carried on handling their nations' policies. Quoting this paper, Chapman Pincher demanded in the *Daily Express* that a medical Board should be set up, to decide whether a statesman is fit for his duties and when he should be removed from office in case of ill health. The position is, however, not so simple as may appear at first glance.

Valuable as a scheme of periodic medical overhaul may be, if it is carried out automatically it may have several drawbacks. There are people to whom it may give a sense of false security. It is known that in some cases of impending disaster of the coronary blood vessels of the heart, no clinical symptoms may be present and even examination by means of an electrocardiogram may not show up any obvious changes up to 24 hours before a severe attack occurs. I recollect a very important man in his late forties who had an expert overhaul before going to Switzerland on a holiday. Everything was found to be normal, yet he was laid up with coronary thrombosis on the night after his arrival without having indulged in any physical activities. On the other hand regular medical examinations may cause anxiety in some people. Only recently I had to see a gentleman who has to spend a great deal of his life overseas in an important position. A few years ago while he had a bout of indigestion (he is in his mid-forties) a medical man overseas, whom he had consulted, insisted among other investigations on an electrocardiogram. Happily, no evidence of major organic disease was found but ever since our patient has become heart conscious, insists on repeated electrocardiograms every four to six months (fortunately at his own expense!). He is a keen sportsman but whenever he is out of breath nowadays during his sporting activities he goes to see the nearest doctor to find out if he hasn't got angina of effort. Many of my colleagues have confirmed to me that automatic examinations of people over a certain age are often dreaded by the candidate concerned. There is fear that they may be told that something is wrong with them and the anxiety of a premature end of their career is constantly before their eyes. The voluntary nature of the examination does not always help. Although many people are afraid to go, they develop a guilt complex if they do not volunteer to undergo the periodic examination which has been arranged for them, and even politicians of great standing and personality would dread examination by an important medical board headed by people of the standing of the late Lord Horder or Dawson of Penn as has been suggested.

Besides, if such an idea is carried to its extreme conclusion, I doubt if Nelson would have been allowed to carry on as an Admiral in charge of the Fleet after losing an eye and an arm, and Trafalgar would not have been fought. Whole books have been written on the health of Henry VIII and Elizabeth I (Chamberlin) according to which there were many periods in the lives of these monarchs when their health was below par. Who would have thought that crippled Talleyrand would outlive the giant Mirabeau by so many decades and be an efficient statesman beyond the age of 80. Lord Beaverbrook was known to be an asthmatic long before he entered the Government during the second world war and Roosevelt was paralysed years before he became President and was quite able to carry out his duties until his health eventually broke down in 1942 or 1943.

In deciding the real value of a medical examination a great deal will depend on the examining physician, whether he knows the background, the capacity, the responsibilities, and the tasks of his patient who has the confidence of the patient and who is able to guide him discreetly and successfully. For that reason great personalities in history preferred personal medical attendants who were at the same time their friends. This has always been accepted in the case of Royalty but in modern times Churchill's friendship with Lord Moran proved a very successful arrangement whereas Hitler's tendency to vacillate and surround himself more and more with cranks of doubtful standing and qualifications proved disastrous to him.

The practical application of these remarks is that it is important to have good medical advice from an efficient physician who also knows the work of the executive and is familiar with the whole background of his patient. He will readily be able to suggest the right line of medical examination should this become necessary and generally detect when something is amiss long before it is apparent.

It should also be remembered that an annual examination, even if carried out in form of a combined clinical, laboratory, and radiological investigation and if the results are put before a single medical consultant or a board of consultants they will not give those medical experts a true picture of the possible stress to which he may be subject at home or at work, nor of his ability to respond to stress in the past or at the time of the investigation. It would, in my opinion, be a much better arrangement if the doctor who knows the patient well, would have a chance to compare the stress to which the patient is exposed at the time of the examination and his ability to stand up to them, with the same factors, one or several years before.

I have been working out such a "stress and stress resistance formula" for the past few years which should be sufficiently simple to be applied by the patient's own medical attendant and friend, and have some practical value. By such means it may be possible for people who occupy positions of responsibility to get guidance as regards their physical and mental stamina and their ability to carry out their tasks in a satisfactory manner.

The actual method will be published elsewhere at a later date.

To sum up: Periodic medical examinations imposed by an employer, as it were, from above, carried out by medical men who are strangers to the patient, appear to me of doubtful value; if a man, on the other hand, accepts an offer of a free medical examination by a physician he knows well or in whom he has special confidence, this may mean that he needs reassurance and such an arrangement may prove beneficial.

REFERENCES

CHAMBERLIN, F. (1932). *The Private Character of Henry VIIIth.* London: The Bodley Head.

—— (1921). *The Private Character of Queen Elizabeth.* London: The Bodley Head.

L'ETANG, H. J. C. J. (1958). *Practitioner, 180,* pp. 113-118.

MEDVEI, V. C. (1957). *Public Administration,* pp. 45-52.

MEDICAL PRACTICE IN NEW ZEALAND

by J. F. COPPLESTONE

THE STRIFE that besets the National Health Service when seen from afar in two month old medical journals, appears to have something in it of comic opera and of tragedy. I emigrated to New Zealand two years ago and have since been employed by the Department of Health in industrial and preventive medicine, a job that has far wider ramifications than any similar appointment in the United Kingdom. However, I do not wish to indulge in personal reminiscence but I thought your readers might be interested to hear some of the details of another kind of Health Service, which has sometimes been commented on favourably in the medical press.

The New Zealand Health Service was one of the first of its kind in the world, having been established by the Social Security Act of 1938. There were a few teething troubles but medical benefits have now been in substantially the same form since 1941.

The general practitioner may choose to practice under one of two schemes:—

1. A capitation scheme: this is operated by only one doctor, and is to all intents and purposes defunct.

2. A "fee for service" scheme: a flat rate of up to 7/6d. is paid for every medical service provided whether in the doctor's surgery (or "rooms") or in the patient's home. This service is calculated to take up to half an hour and the doctor can claim extra if it takes longer The doctor can also charge the patient what he wishes in excess: the average total fee charged is in the region of 10/6d. for a consultation and 15/- for a visit but this varies a lot with the doctor and the area.

The doctor may choose to operate this scheme in two different ways. He may enter the patient's name and address on a schedule when he provides the service and charge the patient the excess. Every few weeks he sends in the schedules to the Health Department who pay for all the patients listed. Alternatively, the doctor may charge the patient the whole amount and give him a receipt which the patient brings to the Department and is refunded. This is a more cumbersome system administratively but is favoured by many doctors as they consider it does not endanger that ethereal concept, the doctor-patient relationship. As an aside, it is interesting that in most arguments about health services, it would appear that this relationship is founded fundamentally on the amount the patient has to pay the doctor. Skill and personality appear to play minor roles.

Drugs are supplied under Social Security according to a schedule which lists the names of the drugs and in some cases the conditions for which they may be supplied, without charge to the patient. Generally speaking, the Schedule includes nearly everything in the British Pharmacopoeia, British Pharmaceutical Codex and the British National Formulary (1957) but some of the more elegant preparations marketed under proprietary names are not included unless their price closely approximates the ordinary price of the same drug. If a doctor prescribes some of these, the patient has to pay the difference between the ordinary price and the proprietary price if the drug itself is scheduled. It follows that doctors have to know somewhat more about pharmacology than trade names. Practitioners themselves may order a wide variety of drugs for emergency use as a charge on the Fund.

The public hospitals provide a range of in- and out-patient services similar to those in the United Kingdom and these services are without charge to the patient. Hospital Boards, which may run one or more hospitals within a given territory, are elected bodies but since last year all finance is provided by the central government.

There are a number of private hospitals and a patient in these can obtain a refund of part of what he has had to pay. This is based roughly on what it would have cost for the patient to fill a bed in a public hospital and the rates vary according to the type of private hospital—medical, surgical or maternity. All private hospitals have to be licensed and are regularly inspected by professional staff of the Health Department. As a result they generally achieve a high standard of efficiency and staffing.

Maternity benefits are provided separately. In New Zealand, hospitalisation is practically 100 per cent, even if it means a 40-mile trip to hospital over indifferent roads, and most deliveries are done by general practitioners or specialists. Nurses train chiefly as maternity nurses and the number of midwives is relatively small. A general practitioner who looks after a patient before and after delivery and performs the actual delivery receives eight guineas.

This is necessarily a sketchy outline of the medical part of the Social Security Service. An important difference from National Health Service is in the central control of the Scheme. The profession is represented by the British Medical Association and deals directly with the senior officers of the Department, all of whom are qualified and many of whom have been in practice themselves. Thus doctor deals with doctor and the administration only is carried out by clerical civil servants. On a local level the Medical Officer of Health administers the scheme. This is an advantage that is not altogether appreciated by the profession in this country.

There is no restriction on the buying and selling of practices or on the setting up of new practices. The remoter areas, where no doctor could live economically in practice, but are far from other medical aid, are served by salaried doctors. These include men who, in return for a bursary during their training, give the Department the right to appoint them where it will for three years. They spend the first year in a hospital, but may then, for a period, be sent to one of these "special areas".

Needless to say, the profession are not united in approbation or disapproval of Social Security but most of those who practised before the Scheme started are well enough content. The fact remains that, apart from farmers possibly in these days of high wool prices, doctors have the highest gross average income in the country. This is reflected in the facilities provided since practically every general practitioner has a nurse in his rooms, and the standard of practice generally is high. Its limitations are basically due to the common factor in many problems in this country—a population of just over two million in an area slightly larger than the United Kingdom.

Bart's men are well represented in the Health Department, there being three of us among the twenty Medical Officers of Health and their deputies. However, lest there should be a sudden eflux depriving the "Old Country" of the cream of its profession, I should, perhaps, end by a word of warning. The Otago Medical School in Dunedin turns out about ninety new doctors a year and the larger towns are now approaching saturation point. There is some scope for general practice in country areas but capital would be advisable to tide over the settling-in period. Alternatively, if more capital is available a practice could be purchased. There are often vacancies for assistants and long-term locums while the principal refreshes himself by a trip to the United Kingdom. There are plenty of English doctors out here and degrees and diplomas are reciprocal. I would advise anyone thinking of emigrating: if you appreciate hard work and a rather simpler standard of living in which the family plays a much larger part, and if you have an adaptable and versatile wife, then this is a good country.

Acknowledgement

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UNUSUAL CASES IN GENERAL PRACTICE

by L. S. CASTLEDEN

IN THESE days of rapid travel, the appearance of tropical illnesses in English practice is not rare, the following cases show:—

Case 1

A commercial air-line pilot, aged 32 years. He said he "had a dose of 'flu". He had been flying a route to the west coast of Africa and he had not availed himself of anti-malarial suppressives. Four days before he had a "chill" in the evening with aching in the back and limbs. He had a cough and some sputum.

On examination his temperature was 100.2°F.; pulse rate 90 per minute; respiration rate 22 per minute. There were a few moist sounds in his chest, otherwise no abnormalities could be found.

He was considered to be a case of influenza with bronchitis and he was given "sulphamezathine". After 24 hours' treatment the fever was 102°F. and there were profuse sweats and rigors. The chest condition did not alter. Two blood smears were taken and stained with Leishman's Stain. A surprisingly high number of benign tertian parasites were seen—about two-six affected corpuscles in each field. He was transferred to hospital where the diagnosis of malaria was confirmed. The chest X-ray showed no pneumonia. He made rapid recovery when treated with paludrine.

Case 2

I received an urgent call to go to a village some six miles away. Incidentally there had been a heavy fall of snow the night before, and all the lanes were impassable to motor cars. Accordingly, the children's pony was pressed into service. The patient was found to be a man of 44 years who was on leave from Hong-Kong, where apart from a period as a Japanese P.O.W. he had worked all his life. He had felt unwell while travelling and had dosed himself for malaria. In spite of this his temperature had climbed steadily. He had developed a pain in his right upper abdomen and back and also an aching in the tip of his right shoulder. There was no diarrhœa or vomiting and no cough.

On examination his temperature was 104°F., pulse rate was 100 per minute and respiration rate 20 per minute. His skin was hot and dry. He was sensible and there was no "Typhoid state" or dehydration. The most remarkable finding was that the liver dullness on the right side was a full hand's breadth higher than usual. The liver could also be felt per abdomen and was very tender. The trachea and apex beat were not displaced but no breath sounds could be heard at the right base. Nor were there any added pulmonary sounds. He was straightway suspected of having an amoebic abcess and when the snow melted was investigated at the local hospital. The X-rays showed that the diaphragm was indeed pushed upwards on the right side by the liver. Amoebic cysts were present in the stools.

He was thereupon moved at once to the London School of Tropical Medicine. His liver enlargement did not respond to emetine as rapidly as was hoped but after needling and the removal of quantities of "anchovy" pus he made a good recovery, and returned to Hong-Kong.

Case 3

A little girl of three years had returned from Nigeria with her parents. She had been given a perfunctory dose of "camoquim" for suspected malaria after arrival. However, she had a straightforward attack of acute tonsillitis and was thereafter rather "peeky". It was noticed that she was less well every fourth day. A temperature chart was then taken and it was found that she ran a fever up to 104°F. every fourth night. Clinically, apart from slightly enlarged tonsillar glands, no abnormality was found. The blood smear was never obtained at the right time but she is regarded as a clinical case of malaria. Since a more sustained course of "Camoquin" she has had no further trouble.

Case 4

The sister of the last patient is aged eight years. Amongst other places the family has lived in Calabar district. In fact the father has been clinically diagnosed as suffering from filariasis. Although this little girl returned from Nigeria some ten months previously, she was perfectly well until she developed fugitive swellings which lasted about four days.

When examined, there was no fever. The child looked rather pale but was active and happy. There were two swellings present. On the back of the right hand there was a soft swelling 2½in. x 1in. It was sufficiently large to make it difficult for her to write, but was not unduly tender. The margin of the swelling was more pink than the central area. It was warm to touch but not as hot as an abscess would be. One had the definite impression that this swelling ressembled more the reaction to an insect bite than a cellulitis.

The second swelling was on the right thigh. It had been present 2½ days. It also was subcutaneous. The colour was darker and the swelling less marked, the area of induration being 1in. x ¾in. This lesion was more like a fading lesion of erythema nodosa.

She was referred to the Hospital for Tropical Diseases. The following investigations were done: (1) The filarial skin test, using an antigen prepared from D immitis, the filarial worm of dogs, was positive; (2) The filarial complement fixation test was strongly positive; (3) Blood examinations failed to show any microfilariae of loa loa; apparently the production of embryo worms in any quantity does not occur till about two years after infection — even though adult worms may be already roaming about the body.

The patient was treated with "Banocide" on the strength of these results and no more swellings have appeared.

These cases have a special interest for me because I was fortunate enough to attend a course in tropical diseases during the war. In any case they do show how General Practice even in rural England covers the *whole* field of medicine. Rarities are admittedly the plums in the pudding. But it should be remembered by those setting out into General Practice that in no other medical career will they meet so much variety. Whether the practitioner himself enjoys the job entirely depends on his attitude. He is most likely to be happy if he keeps his interests, both medical and otherwise, as wide as possible.

A NEW ZEALAND VISIT

by J. WATSON

IT WAS a great honour to be selected to represent the Air Training Corps on this reciprocal visit to New Zealand, not only for myself, but for my parents, my Squadron and my school. The time between the news of my selection and the day of departure soon passed. I was absorbed by the vast machinery of the Royal Air Force and really felt that the greatest adventure of my life had started.

My colleague D. A. Noon, now at Cranwell, and I left a wet and cloudy Lyneham in a Hastings of Transport Command and headed for the staging post at

Idris via London, Paris and Marseilles. Next to Cyprus, that barren rock planted by the hand of nature just one hundred and fifty miles west of Palestine. Owing to the fact that we were "fortunate" enough to develop engine trouble we were able to visit Nicosia the capital. Unfortunately this old Crusader's fortress has lost all the atmosphere that a town with its history and background should have. "Coca-cola" signs flash across the sky, while juke-boxes bellow forth the latest hit tunes, and fast American cars speed down the narrow streets. Of course the architectural beauty was clothed in darkness so we finished off the evening by seeing a second rate American film with sub-titles in Greek, French and Arabic.

From Cyprus we flew on to Habbaniya in the middle of Iraq, fifty miles from Baghdad. This oasis revealed to us exactly what man and machine can do with the desert. They have turned a wilderness into a town, with shops, cinema, swimming pools and even a golf course. The wonder of the place is enhanced by the tree lined roads radiating from the central point, the church.

Murepar in Parkistan was the next stop, then on down the coast of India to Ceylon and Negombo, some twenty miles from Colombo. In the evening we were invited by two Pilot Officers to share a taxi into Colombo. On the journey into town we passed through native villages, seeing wealth in the temples that line the road, and poverty and squalor in the streets as children sat or played in the gutter. It seemed strange to see how the modern world has blended with the old: Neon lights proclaiming "Mobilgas gasoline station", illuminated chromium plated facades, while next door the village barber plied his trade by the light of a tallow candle. Colombo with its wide streets proved to be a town with a narrow selection of goods, its redwood and ebony elephants, its diamonds and sapphires and of course, the restaurants selling food ranging from Yorkshire pudding to birds nest soup.

There followed eight hours' flying across the Bay of Bengal en route for Singapore. Despite the adverse weather our navigator brought us on to the coast of Malaya at the exact spot marked on his chart.

The transit hotel at Changi Creek was to prove to be a place of pleasant memories and we were truly sorry to leave Malaya but we had to be in New Zealand on time. En route in the New Zealand Hastings for Darwin we missed the job of quartermaster, no longer were we able to "go up front" with the crew, but we had the consolation that in approximately two days we would be in New Zealand, but first we had to travel across the boundless wastes of Australia from Darwin to Brisbane and then on. Soon through a gap in the clouds I had my first glimpse of New Zealand, the thin white line of surf breaking on the Western beaches. At exactly 16.00 hours (local time), we landed at Whinuappia (pronounced Fu-nu-a-pie).

The few ideas I had about New Zealand were dispelled as we drove from the Airport to Auckland. I had thought it to be a flat, barren country, but instead I saw green fields, pine trees, peach orchards, vineyards and hills. In the evening we were driven to a hot spring for a swim, pausing to admire a New Zealand sunset.

During the ten days in Auckland, we were taken by our host, the New Zealand Air Training Corps, to various places of interest. We fitted in visits to Auckland's famous Phia beach; we broadcast on the commercial radio, advertising the network; we went round an aircraft factory and the War Memorial with its Maori Village. An Air Pageant was another highlight of our stay, owing to the absence of snow Father Christmas arrived by parachute from "Reindeer land" to distribute sweets to the children.

We reluctantly said good-bye to Auckland and headed South East to Gisborne through the Devon-like country of Central North Island. Gisborne is famed throughout New Zealand for its hospitality, and its people certainly made us welcome, with flying at the Aero Club and parties in our honour, coupled with trips out.

On Christmas Eve we were able to see what effect the absence of snow has upon these—dare I use the word?—Colonials. They close the main street and the entire population wearing paper hats congregates to march up and down singing carols, throwing fireworks and streamers. In fact we thoroughly enjoyed this novel way of spending Christmas Eve "While gentlemen in England, then abed should think themselves acursed they were not there," as they thought only of warm fires and holly.

Christmas Day was perhaps a little sad thirteen thousand miles from home, but my host, a farmer, made an excellent job of cheering me up. I was accepted as one of the family and really made to feel at home. My stomach capacity was tested at dinner time as with sixteen friends and relations we sat down to a feast of five chickens, one whole sheep, one leg of ham, various vegetables and of course Christmas pudding.

Our next stop was "Windy Wellington" as the citizens call it, with beautiful blue skies and gusts of wind up to ninety miles an hour. In Wellington we had our only official engagement and that was a visit to the home of the A.O.C., R.N.Z.A.F., Air Vice Marshal Merton, at Lowry Bay. On again across the Cook Straits to the mainland and Nelson. Unfortunately we were there only for one whole day, but we made good use of the surf that pounds the pine tree lined beach. On New Year's Eve the town went mad. We all went to a late showing at a cinema, then at 11.50 amid rockets, bangers, streamers and paper hats we spent the rest of 1954 listening to a pipe band playing Auld Lang Syne. Then on to a party and home at three in the morning.

We said goodbye to Nelson and journeyed on to Christchurch through the Lewis Pass. Christchurch was very English and as usual our hosts were extremely kind. We were completely free to do as we pleased, and spent a wonderful two days swimming from Brighton beach and exploring the town.

Our next stop was Dunedin, and I was determined to pay a visit to the Medical School. Presenting myself at the Inquiry Desk and asking if I could be shown round I was told that it was impossible as everyone was on holiday. Not to be outdone I mentioned that I was hoping to commence my studies at Bart's in the following October. These were the pass words, and soon I was being shown over the School.

From my guide I learn a little of the history of the School and the course of study which the students follow.

The school was opened in 1875, the course being of two years duration. In 1883 the council of the University of Otago tooks steps to improve and extend the medical curriculum and the Dunedin Hospital was made available for the use of the school, with the result that in 1886 a full course of instruction in medicine was made available.

Since then, the school has extended rapidly. In the early part of the century the Physiology Dept. was severed from the Anatomy Dept. In 1911 a Chair of Bacteriology was established and three years later that of Pathology. Then in 1919 the council appointed a Professor of Clinical Medicine and Therapeutics, and a Professor of Systematic Medicine. This was followed in 1931 by the appointment of a Professor of Midwifery and Gynaecology, and in 1939 a full time Professor of Medicine was appointed. 1949 saw the division of the Physiology and Bio-chemistry depts. thus establishing a Chair of Bio-chemistry. The latest development is that the Chair of Bacteriology has been replaced by the Chairs of Micro-biology and Preventative and Social Medicine.

The candidates read for M.B. Ch.B. and entry is by means of a competitive examination. Those wishing to study Medicine take English, a foreign language, Mathematics, Chemistry and Physics for their school leaving certificate. The first 120 are admitted to the course for the Medical Intermediate. This is the equivalent of first M.B. Those who pass go on for the course for the First Professional Examination consisting of Anatomy, Bio-chemistry and Physiology. They then go on to the Second Professional Examination which includes Pathology, Medical Micro-biology, Pharmacology and Therapeutics. This in turn is followed by the Third Professional Examination which is divided into two parts. Part 1 is taken at the end of the fourth year on Preventative Medicine and Medical Jurisprudence. Finally, they are examined on Surgery (Clinical and Operative), Medicine (including Paediatrics), Obstetrics and Gynaecology. Now follows an internship of a year, six months surgical and six months medical, after which he is allowed to go into Practice.

We left Dunedin in boiling sunshine for Invercargill. We visited a Slaughter house and saw sheep being killed for consumption in Great Britain; then on to the Southernmost tip of New Zealand at Bluff, followed by a visit to a Wireless Station which can, if the occasion arises, contact shipping in the Thames; then on to one of the highlights of the tour, a flight through the fiordland of the South.

On again another one hundred and sixty miles to Auckland, and our tour was nearly over. But before we left we were to go to an N.C.O. Camp at Whinuappia, to eat, live and sleep with New Zealand Cadets, sharing their working and leisure hours. They were a great crowd and we really had fun especially when an American singer arrived at the airport and "The English Cadets" were called upon to organise a barrier to stop five thousand screaming female fans from mobbing him.

January 19th dawned grey as if in line with our thoughts, for we were sorry to be leaving New Zealand, our home for the last five weeks. We said our goodbyes, and took our seats, the quartermaster closed the door, the engines burst into life and with a roar our Hastings moved forward: we were going home.

We flew across the Tasman Sea to Brisbane, then on again to Singapore only stopping at Darwin and Jakata to refuel; then to Car Nicabar and Negombo: then on up to Marepar and so to Bahrain and Habbainya. Up early for the flight to Malta via Nicosia across the snow clad desert of Palestine. We landed at Malta, that heroic Island with its magnificent war record, and we had time to visit Valetta with the steep narrow streets of the old town cut off by the now empty moat from the new partly rebuilt area. On again over France to England and Lyneham. A journey of over twenty-eight thousand miles was over.

SPORTS NEWS

VIEWPOINT

Now is the time of year when Winter games come almost apologetically to a close, and Summer ones start to come out of hibernation. There is a relative dearth of obvious activity and the time when some senior students leave the ranks for the house, or elsewhere! Lastly, now is the time when new members of clubs can best make their presence felt. No club can do without them, but it is early in the season that they can best attract attention, and thus establish themselves in the various teams.

The date of Sportsday is in this month's sports calendar. Is it a pious hope that more people will endeavour to be present this year? Besides being one of the social occasions of the year, it involves the Athletics club in a great amount of work, and a heavy financial risk. The cost is well over £100, and rising, and a few pounds extra on programmes and teas can tip the balance.

SPORTS CALENDAR

Wed.	Apr. 2	Golf Club Spring Meeting at Sundridge Park.
Wed.	„ 9	Golf v. Guy's at Croham Hurst.
Wed.	„ 16	Golf v. Westminster at South Herts.
Wed.	„ 23	Golf v. Middlesex at Hendon.
Sat.	„ 26	Tennis v. London House (H).
Sun.	„ 27	Cricket v. London House (H) 2.30 start.
Wed.	„ 30	Tennis v. School of Pharmacy (H).
Th.	May 1	Golf. Beveridge cup meeting at Sunningdale.
Sat.	„ 3	Tennis v. Westminster (H). Cricket v. U.C.H. (A) start 11.30.
Sun.	„ 4	Cricket v. Putney (H) start 11.30.
Sat.	„ 10	Tennis v. Charing Cross and Royal Dental Hospitals (A). Cricket v. R.A.M.C. Crookham (H) start 2.30.
Sun.	„ 11	Cricket v. Hampstead (A) start 11.30.
Wed.	14	Athletics v. Westminster Bank (A) start 6 p.m. Golf. Staff Match at Denham. Tennis v. Guy's (cup match) (A).
Sat.	„ 17	Tennis. Cambridge tour. Emmanuel. Cricket v. Balliol College, Oxford (A) start 11.30.
Sun.	„ 18	Tennis. Cambridge Tour (cont.) Trinity. Cricket v. Romany (H) start 11.30.
Wed.	„ 21	Athletics v. Guy's and 'The London (H) start 2.30. Tennis v. K.C.H. (A).
Sat.	„ 24	Cricket v. Queen's College, Cambridge (H) start 11.30.
Sun.	„ 25	Golf v. Mr. Hankey's Team at Tandridge.
Wed.	„ 28	Golf v. King's College at Sundridge Park. Athletics v. St. Thomas's and Middlesex Hospital (A).
Sat.	„ 31	Tennis v. St. Mary's (H).

WOMEN'S HOCKEY

CUP MATCH

The final of the Women's Inter-Hospital Hockey Cup competition was played on Saturday, March 8th, on the Middlesex Sports ground at Chislehurst, between the Royal Free Hospital and Bart's.

The Bart's women have won this trophy for the past four years and could it be won for the fifth successive time was the thought in the minds of the Bart's spectators. The spectators were treated to a thrilling game and included Mr. J. B. Hume, Mr. Nash, Dr. Lehman, Dr. Blunt and Prof. Wormal.

The Royal Free Hospital had previously beaten Bart's this season and at the beginning of the game it seemed as if the trophy would change hands as the Royal Free launched many attacks on the Bart's goal. The Royal Free played with more assurance and were more purposeful than the Bart's team and there was little to make the Bart's spectators confident of victory. The Bart's goal proved impervious to the Royal Free attacks and after about ten minutes of the first half the Bart's players became more confident and previous isolated attacks on the Royal Free goal gave way to sustained periods of attack. The game was developing into a ding-dong battle with the Bart's defence and forwards combining well. Miss Barnard and Miss Knight were prominent in the defence, covering well and distributing the ball to their forwards where Miss Hartley's stick work and the speed and energy of the wingers of J. Swallow and J. Arnold did much to unsettle the Royal Free defence.

After some exciting play, both teams were now playing well, J. Arnold had a good run up the right wing followed by a centre from which Y. Chambers scored. Soon afterwards the Royal Free equalised. Score 1–1.

The second half started with the score 1–1. The game was exciting to watch and Mr. Hume, Mr. Nash and Prof. Wormal were frequently seen walking up and down the touchline encouraging the Bart's team to greater efforts.

The second Bart's goal was scored by J. Arnold from a centre by J. Swallow. The Royal Free soon equalised from a break away and the score stood at 2–2 at full time.

Two ten minute periods of extra time were played. The Royal Free scored first. This seemed to stir the Bart's team to greater efforts and soon their labours brought the equaliser. J. Hartley scored a good goal from a pass from J. Chambers. The game at this stage was interrupted by Miss Chambers contracting a severe attack of cramp, after some expert attention from the Dean Miss Chambers was able to carry on. A couple of minutes from the end the final goal was scored by Y. Swallow to make it 4–3 and a Bart's victory.

Mr. Nash presented the shield to the Bart's captain, J. Hartley, and congratulated the team on a splendid performance in winning the shield for the fifth successive year. Both teams should be congratulated for playing a game of a high standard and one so exciting to watch.

Team:
I. Tomkin, G. Barraclough, J. Tuft, E. Knight, B. Barnard, Y. Hall, J. Arnold, J. Hartley, J. Chambers, S. James, J. Swallow.

RUGGER

1st XV v. Harlequins Wanderers. Away on March 22nd. Won 9–0.

On a sunny but very cold afternoon at Teddington, the 1st XV gained a highly satisfying and in no way undeserved victory over Harlequins Wanderers, who three weeks previously, had beaten St. Thomas's, this year's Cup Winners, by over twenty points.

Playing on a hard surface for the first time for several months, the Hospital completely outplayed their more illustrious opponents forward in the second half, after an even first half. Kicking off against a stiff breeze, Bart's were on the attack at once. Phillips was soon prominent, when he sucessfully followed up one of Bamford's astute diagonal punts, and he only just failed to score. However, after gathering another of Bamford's kicks, he beat his man and the full-back to score a fine try in the corner. The remainder of the half was fairly even, with Bart's pack holding their heavier opponents in the tight. They were also faster on to the loose ball, when the Harlequins backs were harassed into mistakes by a rampant back row of Mackenzie, Boladz and Randle.

In the second half, Bart's again attacked early, and Phillips and Halls were often prominent in raids on the Harlequins line. However, the opposition were still winning the ball in the line-outs, and set up strong counter attacks which only floundered on a fine defensive. In this Bamford and Mackenzie were very prominent, and it was during such work that Bamford received a nasty blow on his head that necessitated his playing on the wing for a short spell. However, controlling the loose play admirably, Bart's forwards scored a try half way out. Mackenzie was up to touch

down after a forward rush from the Harlequins twenty-five. Further attacks in which Davies was prominent resulted in an excellent try in the closing minutes. Mackenzie was again in the right place to score, with a dash from thirty yards out after a good movement by the Bart's three-quarters. All three of Stevens' kicks only just failed to add the necessary goal points.

This indeed was a most commendable display, and it proves that there is ample skill and spirit still well to the fore in the side before the Welsh Tour at Easter.

Team :

M. Britz ; R. M. Phillips (Capt.), J. Bamford, J. Stevens, G. J. Halls ; R. R. Davies, B. Richards; J. L. C. Dobson, J. W. Hamilton, B. Lofts ; L. R. Thomas, C. C. H. Dale ; G. Randle, W. P. Boladz, J. C. Mackenzie.

1st XV v. Loughborough College. March 8th. Home. Won 11–3.

In a rousing vigorous game, the 1st XV gained an excellent win over Loughborough College whom we have not beaten apparently for twenty-three years and who had previously lost only one game this season. This success was due in the main to another fiery display by the forwards both in the tight and the loose and also to the backs accepting their opportunities when they arose. The final Bart's try was a real gem by R. R. Davies who engineered a brilliant dummy scissors with McMaster to bamboozle the opposition completely and for Davies to touch down under the posts for Stevens to convert. This put the final seal on a highly entertaining and fast display of open rugby in which the Hospital forwards easily kept up with their reputedly fitter opponents.

Kicking off into a stiffish breeze, Loughborough launched a series of attacks which were thrown off quickly by Bart's who shortly took the lead through a neat 30 yard penalty by Stevens. Further raids by the Hospital with wingers Phillips and Halls often prominent tested the opposition defence severely but no score resulted. During the period, the back row of Mackenzie, Harries and Randle were continually harassing the opposing three-quarters into handling errors which several nearly resulted in scores for Bart's. Just before the interval, Stevens kicked another penalty from in front of the posts to give Bart's a well deserved lead of six points.

Immediately after the resumption, Loughborough repeatedly won the ball from line-outs where Thomas was badly missed. They threw everything into attack and scored an excellent try when their full-back as well as a loose forward joined in an orthodox move for them to score wide out, the conversion being missed. Further onslaughts on the Hospital line continued but the defence held and gradually Bart's won more of the ball from the tight and loose scrums again. Here, Hamilton was doing sterling work by repeatedly outstriking his opposite number and Boladz and Pennington were often seen in the thick of vigorous forward exchanges.

The game reached a fitting climax when Rees Davies scored in the closing minutes which crowned a highly satisfactory afternoon from the Bart's point of view.

Team :

M. Britz ; R. M. Phillips (Capt.), A. B. M. McMaster, J. Stevens, G. J. Halls ; R. R. Davies, B. Richards ; J. L. C. Dobson, J. W. Hamilton, B. Lofts, J. Pennington, W. P. Boladz, G. Randle, L. R. Thomas, J. C. Mackenzie.

1st XV v. Aldershot Services. Home. Lost 5–11. March 15th.

Taking the field without the services, through domestic and other reasons, of Mackenzie, Hamilton, Pennington and McMaster, the 1st XV lost to a strong Aldershot Services team by eleven points to five. Although they held their much heavier opponents until the last quarter of an hour and were in fact leading 5–3, Bart's in the end gave way forward and allowed the Services to score two easy tries, resulting from stupid mistakes.

Kicking off on a very sunny afternoon at Chislehurst, Bart's were soon attacking and it seemed at this stage that the more mobile Hospital pack would more than hold their own against the far heavier and more experienced Services eight. With Bamford and Rees Davies being prominent early on, Bart's did most of the attacking and a score soon came after quarter of an hour's play. Breaking left on the Services twenty-five, Davies missed out his inside centre and passed to Bamford who made an outside break for Halls to carry on and score an excellent try half way out for Stevens to convert with a good kick. Thereafter, play was more even with Smith making an able deputy to Hamilton and Thomas and Boladz ensuring a fair supply of the ball from the line-outs.

After the interval, Bart's continued to press hard for a time and several times only failed to score when the vital final pass was dropped. Gradually, the Services pack wore down their opposite numbers and after twenty minutes they kicked a good penalty from thirty-five yards. Towards the close, the Hospital pack became very demoralised and were beaten in all departments of the game. Stoutly though the backs defended, they could not prevent two tries being scored in the last ten minutes for the Services to run out seemingly comfortable winners.

Team :

M. Britz ; R. M. Phillips (Capt.), J. Bamford, J. Stevens, G. J. Halls ; R. R. Davies, B. Richards; J. L. C. Dobson, P. Smith, B. Lofts, W. P. Boladz, C. C. H. Dale, R. P. Davies, L. R. Thomas, G. Randle.

MEN'S HOCKEY

1st XI v. Bandits. Sunday, March 2nd. Lost 2–5.

As always happens for a Sunday match, it was impossible to get out a full side and the result of the match was rather anticipated. It was, however, an enjoyable game against pleasant opponents and played on a hard dry ground.

We started badly and it was not long before a muddled defence had allowed two half-hearted shots to dribble over the line. This inspired our forwards to greater efforts and, following an ex

tremely good run, Anderson scored with a perfect reverse stick shot. The Bandits scored again just before half-time. The second half proved much more even, with both sides attacking equally. Gordon made many good saves in goal and Garrod and Defrates successfully broke up many attacks. Both sides scored again, our goal coming from a very powerful flick by Halls, who had relinquished the oval ball for the afternoon and proved a great success together with Charlton on the right wing. In the closing minutes the Bandits scored again after their inside forwards had torn open our defence.

Team :
A. J. Gordon ; J. A. Garrod, M. Defrates ; N. C. Roles, K. MacKenzie-Ross, C. J. M. O'Keefe ; J. Bousfield, A. S. Anderson, D. N. C. Glover, C. A. C. Charlton, G. J. Halls.

1st XI v. Oxted. Away. Saturday, March 15th. Won 2–1.

This was the sort of match about which one likes to forget rather rapidly ! It was a fine day and a pleasant drive down to Oxted but unfortunately the groundsman had gone on strike and even a self-respecting cow might have hesitated before considering grazing upon the plot of land called a 'pitch'. I think most of the people playing agreed that our opponents were the most robust players we have played for some time. It is a difficult game to describe because it was hardly hockey — perhaps that is why we won . . .

The day was saved, however, by the President of the Club and Mrs. Jaynes, who opened their home in East Grinstead, and their bottles, to us and entertained us extremely well — as far as I remember ! We are very grateful to them both for their kindness.

Team :
C. Craggs ; Dr. J. B. Nichols, J. A. Garrod, C. J. M. O'Keefe, K. MacKenzie-Ross, D. S. Wright, J. Bousfield, A. S. Anderson, D. N. C. Glover, P. J. Kingsley, N. C. Roles.

Inter-Hospital 6-a-Side Competition. Sunday, March 23rd. Won by Bart's.

Beat :	Guy's B.	4—0	
	St. George's	2—0	
	St. Thomas's	4—3	
	St. Mary's	1—0	(Semi-final)
	Guy's A.	2—1	(Final)

This competition was played at Cobham on what was certainly one of the coldest days in recent months, with a bitter East wind blowing. I think this result came as a great surprise to everyone but a side with the speed and fitness which we mustered that afternoon deserved to win. Our tactics were extremely good, playing out to the two wings, Anderson and Drinkwater, who are both extremely fast and capable of beating anyone with speed and stickwork. Glover, at centre-forward proved a foreful player with plenty of dash and determination while Roles and Kingsley at half made a solid combination with MacKenzie-Ross at back. No one can be singled out for praise for everyone played extremely well and with great spirit.

When the final came, we had already played one more game than our opponents and yet we were still far fitter. Drinkwater it was who scored our winning goal in extra time — a fitting person to do so, having been chosen for the Final England Trial.

This was certainly an afternoon to remember and a wonderful way to end off a rather mediocre season. Great credit is due to our team.
K. MacKenzie-Ross ; N. C. Roles, P. J. Kingsley ; A. S. Anderson, D. N. C. Glover, P. Drinkwater.

BOOK REVIEWS

HISTOLOGY (3rd Edition) *by* Arthur Ham. Published Pitman's Medical Publishing Co. Price 80/–.

This is an excellent book though it contains far more information than is required by most medical students. This edition has been very extensively revised and special attention has been given to the rapid advance which has been made in the study of fine structure by electron microscopy. There is a preliminary account of the working principles of both optical and electron microscopes ; unfortunately this does not discuss the question of numerical aperture and the diagram illustrating the path of rays through the two instruments has a fundamental error. Both light rays and the electron beam converge upon the specimen at an angle approximately equal to that taken up by the objective, whereas in the offending diagram these rays are shown as a parallel. There is an adequate explanation of the basic properties of light in the section dealing with phase contrast and interference microscopy, but the explanation of the instruments is not easy to follow and no diagrams are given.

These are only minor criticisms, and in the histological field the quality of the book is high. The account given of the fine structure of striated muscle does not include references to the latest work of the Huxleys and Hanson ; the most recent electron micrographs published by these authors show the separate existence of actin and myosin filaments with a clarity which leaves no room for doubt.

F.J.A.

THE CHILD AND THE FAMILY *by* D. W. Winnicott, F.R.C.P., pp. 147. 12/6.

THE CHILD AND THE OUTSIDE WORLD *by* D. W. Winnicott, F.R.C.P., pp. 190. 16/3. Edited by Janet Hardenberg, M.B. Tavistock Publications Ltd. (1957).

Dr. Winnicott is a unique figure in British paediatrics. An old Bart's man and one-time

editor of the *Journal* he has combined the practice of the paediatrics of sick children with the very detailed psycho-analytical treatment of the emotionally maladjusted and the psychotic. He is essentially a simple and humble-minded physician, full of wonder about the problems presented by his patients and therefore full of wonder about the normal development of the emotional pattern of his fellow beings. Were there any method of studying the psychology of the foetus, Dr. Winnicott would be working hard at it and carefully recording his observations. As it is he has plenty to say about babies, children and their family and social relationships. The lectures and papers published in these two books are aimed at the laity and this includes medical students, nurses and even consulting paediatricians when the detailed analysis of infant behaviour is in question. The reader quickly discerns some of the ingredients of the author's success. Not only is each person important, but each detail is important. Babies cry. He asks why do babies cry? And then he puts himself in the position of the crying baby and of the mother of the crying baby, with sympathy and rare insight, and if his premises are correct his logical conclusions are inescapable. And so he builds up his case and because his problem is broken down into its simplest elements, his explanation is simple, his advice straightforward and practical. And the reader is bound to agree that these details are important, and that if everyone concerned with child care from the neonatal nursery to the school, mother, father, midwife, health visitor, doctor, hospital nurse, nanny, school teacher, understood all that Dr. Winnicott teaches, the world would be less of a jungle for the developing child.

A. W. F.

CEREBRAL PALSY IN CHILDHOOD *by* G. E. Woods, with a foreword by Peter Henderson, Bristol: John Wright & Sons Ltd. (1957) pp.xi, 158. Fig s. 41. Price 27s. 6d.

Dr. Grace Woods has produced an excellent study of cerebral palsy as she has seen it in Bristol during a five year research. In this book her results are carefully set out and add to the sum of medical knowledge about this most difficult subject. In Bristol the number of cerebral palsied children reaching the age of 5 years is 1.90 per 1,000 live births. Cerebral palsy is not a unity but is a convenient label for cases of defective movement due to disease of the brain. The cases are therefore classified according to the movement defect, paraplegia, monoplegia and so on. There are then chapters on the types of movement defect, athetosis, ataxia and rigidity, on the sensory defects, and on the relationships of cerebral palsy with birth process factors and social groups. Epilepsy was found in 38 per cent. and assessment of educability was needed in them all. The author is to be congratulated on this factual statement about the clinical findings and the problems raised in the education of a group of 301 cerebral palsied children which can be read with profit and with real interest.

A. W. F.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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EDITORIAL

SOME MONTHS ago the Annual General Meeting of the Students Union discussed at great length the problem of the View Day Ball. The main controversy was whether to be bound by the traditional conservatism attached to this Hospital in all their doings and hold the Ball at a hotel or to branch out along new and hitherto unexplored paths and hold the dance in a marquee on the lawn at Charterhouse Square. This *Journal* supported a continuance of the well-tried and usually successful dance in the halls of gold to be found at the larger London hotels.

The move to change although passed by a majority at the Annual General Meeting was effectively squashed by the Medical College Council, who felt some qualms about the lawn at College Hall, and so the project was buried under ten inches of top-soil. There was also some question as to the problem of guaranteeing the dance, and this too contributed to the ultimate decision to hold the Ball at the Park Lane Hotel.

The Ball Committee immediately found it necessary to raise the price of admission to £3 10s. this year owing entirely to the hotel raising its charges for the meal, which discouraged many would-be attenders and eventually something under 300 persons took the floor at what should be the main social function of Bart's year. This represented a miserably small proportion of the number who have attended in previous years, and in consequence the dance was run at a heavy loss. It is indeed regrettable that more students, more nurses, and in particular more Staff did not make the effort to support their hospital on this occasion.

To consider the Ball subjectively it was a great success, but this success was entirely due to extraneous factors and not to the evening as arranged.

An objective view revealed but one advantage over the previous years—that of room to move—and the Park Lane Hotel certainly is a more pleasant place when there is no premium on space on the floor or at the bar, although this, as already indicated, was a two-edged sword. The standard of the meal, however, was not as good as might be expected, considering the price was raised to cover an increased cost for food. The Ball Committee had, however, very wisely decided to dispense with those expensive perennials at all dances, the Pipers, and this was a well justified omission.

In consequence of this year's Ball and its various shortcomings, any change must be for the better, and perhaps the idea of a marquee on the lawn could be resurrected with advantage. With the catering done by a reputable firm of outside caterers and an adequate marquee, it must be an improvement on this year's dance.

The work of the Ball Committee should, however, not go unheeded, for they worked hard and long to make the Ball a success, and it is no reflection on them that it failed to come up to expectations, for they depend on both moral and tangible support to make their efforts worthwhile. It is perhaps the woeful lack of this loyalty that was the most tragic and reprehensible feature of the whole affair for every club, society and function should be able to depend on the wholehearted support of the Hospital, from top to bottom, and anything less is not enough.